International Development

Working Paper Series 2022

No.22-210

The economics of abortion: Costs, impacts, values, benefits, and stigma

Ernestina Coast, London School of Economics
Samantha R. Lattof, London School of Economics
Yana van der Meulen Rodgers, Rutgers University
Brittany Moore, Ipas
Cheri Poss, Ipas
Joe Strong, London School of Economics

Published: November 2022

Department of International Development

London School of Economics and Political Science

Houghton Street **Tel: +44 (020) 7955 7425/6252**

London **Fax: +44 (020) 7955-6844**

WC2A 2AE UK **Email: e.coast@lse.ac.uk**

Website: www.lse.ac.uk/InternationalDevelopment

The economics of abortion: Costs, impacts, values, benefits, and stigma

Working Paper

Ernestina Coast, London School of Economics
Samantha R. Lattof, London School of Economics
Yana van der Meulen Rodgers, Rutgers University
Brittany Moore, Ipas
Cheri Poss, Ipas
Joe Strong, London School of Economics

31 October 2020

Abstract

Objective: To systematically search for and synthesize the social science literature on the consequences of abortion-related care, abortion policies, and abortion stigma on economic costs, benefits, impacts, and values at the micro- (i.e., abortion seekers and their households), meso- (i.e., communities and health systems), and macro- (i.e., societies and nation states) levels.

Methods: We conduct a scoping review using the PRISMA extension for Scoping Reviews (PRISMA-ScR) tool. Studies reporting on qualitative and/or quantitative data from any world region are considered. For inclusion, studies must examine one of the following economic outcomes at the micro-, meso-, and/or macro-levels: costs, benefits, impacts, and/or value of abortion-related care or abortion policies.

Results: Our searches yielded 19,653 unique items, of which 365 items were included in our synthesis. The economic levels are operationalized as follows: at the micro-level we examine individual decision making, at the meso-level we consider the impact on abortion services and medical systems in context, and at the macro the impact of access to abortion services on broader indicators (e.g., women's educational attainment). At the micro-economic level, results indicate that economic costs and consequences play an important role in women's trajectories to abortion-related care. However, the types of costs that are studied are often unclear and tend to focus narrowly on costs to and at health facilities. Our evidence suggests that a much broader range of economic costs, impacts and values are likely to be important in a wide range of contexts. At the meso-economic level, we find that adapting to changes in laws and policies is costly for health facilities, and that financial savings can be realized while maintaining or even improving quality of abortion care services. At the macro-economic level, the evidence shows that post-abortion care services are expensive and can constitute a substantial portion of health budgets. Public sector coverage of abortion costs is sparse, and women bear most of the financial costs.

Conclusions: This scoping review has uncovered a wealth of information about the economic costs, impacts, value, and benefits of abortion services and policies. The review also points to knowledge gaps, such as the ways in which women perceive the intersections between costs and quality of care, safety, and risk. Similarly, there is a dearth of methodological variation and innovation, with an abundance of studies using costing methods and regression analysis while other tools seen elsewhere in behavioral studies (such as discrete choice experiments and randomized control trials) are underexploited. This study provides a conceptual mapping of the economics of abortion in a new way, reinforcing some findings already well known while uncovering underexplored questions and methods.

Keywords: abortion services, abortion policy, health economics, scoping review, reproductive health, contraception, termination of pregnancy

Contents

Abbreviations and Acronyms

CAD	Canadian Dollar
CFA	West African CFA franc
CHF	Swiss France
CI	Confidence interval
CINAHL	Cumulative Index to Nursing and Allied Health
D&C	dilation and curettage
EMBASE	Excerpta Medica Database
FDA	United States Food and Drug Administration
FGD	focus group discussion
GDP	Gross Domestic Product
IBSS	International Bibliography of the Social Sciences
INR	Indian Rupee
KS	Kenyan Shilling
LAC	Latin America and the Caribbean
LMIC	Low- and middle-income countries
LMP	Last menstrual period
MA	medical abortion
MTOP	medical termination of pregnancy
MVA	manual vacuum aspiration
NBER	National Bureau of Economic Research
NNAF	National Network of Abortion Funds
NGO	non-governmental organization
OTC	over the counter
OR	odds ratio
PAC	post-abortion care
PICOTS	Patient population, Intervention, Comparator, Outcome, Timing, and Setting
PLN	Polish Zloty
PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses
PRISMA-ScR	PRISMA extension for Scoping Reviews
Rs	Indian Rupee
SD	standard deviation
STI	sexually transmitted infection
STOP	surgical termination of pregnancy
TIAB	title and abstract
TOP	termination of pregnancy
TRAP	Targeted Regulation of Abortion Providers
U.S.	United States
WTP	willingness to pay

Introduction

In 2014, 56.3 million induced abortions were performed globally, up from 50.4 million in 1990 (Sedgh, Bearak et al. 2016). Although the overall abortion rate fell during this period, the total number of abortions performed has risen over time due to population growth. Approximately one quarter of all pregnancies globally ended in abortion in 2014, making abortion one of the most common gynecological practices worldwide. Despite this historical precedent and global prevalence, abortion seekers still have very different experiences with abortion around the world. Pregnant people in higher-income economies generally have greater access to safe abortions, while pregnant people in lower-income countries experience greater health risks in getting abortions due to greater resource-based obstacles to care (i.e., funds to reach point of access), less equipped healthcare infrastructure as well as abortion laws that restrict access to safe abortions. Despite the high incidence of abortion around the globe, we lack synthesis of the known economic consequences – at a variety of scales – of abortion care and abortion policies. Hence the economic consequences of abortion and policies affecting abortion provision are poorly understood.

To address this gap, our study reviews existing evidence on the economics of abortion and develops an economic framework to conceptualize important issues around abortion, especially the costs, benefits, and impacts of abortion. The analysis synthesizes the evidence base and identifies evidence gaps on the costs and benefits of abortion to stakeholders at three different economic levels: micro (abortion seekers and their households), meso (communities and health systems) and macro (societies and nation states). At the micro-level, we provide a comprehensive examination of individual's decision making around contraceptive use, fertility, and abortion. The framework is based on a set of economics tools related to costs and benefits that model preferences and behaviors around fertility and abortion. At the meso-level, we consider the costs and benefits of abortion services in the context in which they take place, particularly communities and medical systems. Finally, at the macro-level, the project explores how access to abortion services and changes in abortion laws affect broad aggregates such as women's labor supply, educational attainment, indicators of societal wellbeing such as crime, and overall GDP.

This report systematically reviews social science literature for studies that have investigated the impact of abortion care (i.e. un/safe abortion, post-abortion care) and abortion policies on economic outcomes at the micro-, meso-, and macro-levels. To achieve this objective, the scoping review answers the following question: What are the economic costs, benefits and consequences of abortion care and policies at the micro-, meso- and macro-levels? Informed by the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) reporting guideline for protocols, this report details our methodological and analytical approaches and results. Studies reporting on qualitative and/or quantitative data from any world region were considered. We searched journals from interdisciplinary fields in order to maximize heterogeneity in the results. For inclusion, studies must examine one of the following economic outcomes at the micro-, meso-, and/or macro-levels: costs, benefits, impacts, and/or value of abortion care or abortion policies. Searches were conducted in eight electronic databases, and we conducted the searches and application of inclusion/exclusion criteria using a rigorous protocol. In addition, the results indicated that abortion-related stigma could have a significant impact across the three economic levels. Therefore, we also extracted information on micro-, meso- and macro-level impacts of abortion stigma on economic outcomes from articles that met the inclusion criteria.

The data extracted in the process of conducting the scoping review were used to inductively develop an economic framework around the economics of abortion. This report is the first to focus on the economic costs, benefits, and impacts of abortion on individuals, households, communities, health systems, and societies. Our goal is to addresses the multiple channels through which abortion can entail economic costs, impacts, values, and benefits.

Background

Abortion is a common feature of people's reproductive lives. An estimated 56 million induced abortions occur annually (Sedgh, Bearak et al. 2016), of which 54.9% (range 49.9%-59.4%, 90% C.I.) are unsafe (Ganatra, Gerdts et al. 2017). Abortion care is a landscape in flux (Coast and Murray 2016), with rapid increases in access to and use of pharmaceuticals to induce abortion (Kapp, Blanchard et al. 2017) and shifting national and international laws, policies, treaties, protocols and funding provision (Barot 2017, Barot 2017). However, the economic implications of abortion – and policies affecting abortion provision (Rodgers 2019) – are poorly understood. Relatively little evidence is of use to policymakers and influencers (Woog, Singh et al. 2007).

Globally, abortion rates have fallen over time, from 40 to 35 abortions per 1000 women[1] of reproductive age between 1990-1994 and 2010-2014. Table 1 shows that most of this decline occurred in developed countries (from 46 to 27 abortions per 1000 women), while the estimated decline in developing countries (from 39 to 37) is much smaller and is not statistically significant. In the face of the overall decline in abortion rates, the absolute number of abortions considered unsafe according to standards set by the World Health Organization remained high, with close to 7 million women in developing countries receiving treatment for abortion complications in 2012, up from 5 million in 2005 (Singh and Maddow-Zimet 2015). Of note, abortion rates declined across regions except Latin America and Africa, the two regions with the most restrictive laws. Table 1 also indicates that the absolute number of abortions increased during the period. All of this growth occurred in developing countries, primarily due to population growth. Similarly, the percent of pregnancies ending in abortion also rose in developing countries (from 21 to 24 percent, with a particularly large increase in Latin America) while it dropped considerably in developed countries (from 39 to 28 percent, with a particularly large drop in Europe). Globally, an average of one quarter of all pregnancies ended in abortion in 2010-2014. Despite intense lobbying efforts by anti-abortion groups, strong pressure from several religious institutions, formidable stigmas surrounding abortion, and highly restrictive abortion laws in numerous countries, abortion remains a common gynecological phenomenon across the globe.

Table 1. Global estimates of induced abortion, 1990-94 and 2010-14 (Sedgh, Bearak et al. 2016)

	# of abortions annually (in millions)		Abortion rate (per 1,000 women aged 15-44)		% of pregnancies ending in abortion	
	1990-94	*2010-14*	*1990-94*	*2010-14*	*1990-94*	*2010-14*
World	50.4	56.3	40	35	23	25
Developed countries	11.8	6.7	46	27	39	28
Developing countries	38.6	49.6	39	37	21	24
Africa	4.6	8.3	33	34	12	15
Asia	31.5	35.8	41	36	23	28
Latin America	4.4	6.5	40	44	23	32
North America	1.6	1.2	25	17	23	17
Europe	8.2	4.4	52	30	42	30
Oceania	0.1	0.1	20	19	16	16

[1] When possible, we use inclusive language in this report and recognize that abortion is not only a "women's issue." Anyone who can get pregnant may need abortion care regardless of how they identify. However, the studies and statistics in this report overwhelmingly frame and analyze abortion as a women's issue. We use authors' framing of abortion in its original form throughout the report, recognizing the dearth of evidence on transgender and non-binary individuals.

A socio-ecological framework identifies three levels of factors – micro (abortion seekers and households), meso (communities and health systems) and macro (societies and nation states) – that help to understand the factors influencing access to abortion services (Coast, Norris et al. 2018). These three levels can also be used to consider the consequences of abortion care and abortion policies. There is increased recognition of the scale and consequences of unsafe abortion, including the costs for both women and health systems, in a range of legal settings (Singh and Maddow-Zimet 2015).

At the micro-level, inequalities in accessing modern contraception and abortion care have been identified in many settings and are associated with individual characteristics including, but not limited to, economic circumstances. For example, in the United States, low-income women experience more financial and structural barriers to obtaining an abortion than higher-income women (Ostrach and Cheyney 2014). In Mozambique, women obtaining illegal abortions were more likely to have less education, earn less income, and live in shantytowns compared to women obtaining legal, safe abortions with high hospital fees (Machungo, Zanconato et al. 1997). Also related to income constraints, the inability of women living in poverty to afford oral contraception is associated with repeat abortions in France (Alouini, Uzan et al. 2002). The implication is that inequality in using contraceptive methods acts as a determinant affecting abortion behavior in addition to (or even instead of) inequality in accessing abortion care.

A review of 28 studies on post-abortion care costs in Africa concluded that studies that addressed indirect costs (e.g., loss of productivity) were "conspicuous by their absence," (Woog, Singh et al. 2007, p. 58). Post-abortion care services are designed to treat women who have complications from abortion and also provide them with birth control counseling, follow-up reproductive healthcare, and contraceptive supplies so as to break the cycle of repeated unwanted pregnancies. Most research focuses on out-of-pocket expenses that women incur for abortion complications. A Nigerian study of the direct costs for women treated for complications of unsafe abortion estimated that nearly three quarters of costs were shouldered by the woman and/or her household (Bankole, Singh et al. 2007). A study from Burkina Faso found that the cost of induced abortion was considerably higher than spontaneous abortion (Ilboudo, Greco et al. 2015), and this study did not account for any costs incurred by women prior to hospitalization.

Most studies do not consider the wider economic impact of abortion care seeking, such as opportunity costs (e.g. foregone work or education), and few studies include costs incurred throughout the care-seeking process beyond what is paid in hospital. Studies of two Asian countries considered women's loss of time and income (Narkavonnakit and Bennett 1981, Potdar, Fetters et al. 2008). Both studies found substantial losses for the women and their households. A study by Sundaram and colleagues of the costs of abortion care seeking in Uganda calculated the impact of associated expenses on the productivity of women and other family members, as well as households' economic responses to unsafe abortion (e.g. sales of assets) (2013). They found that three quarters of women suffered loss of productivity, and over a third experienced deterioration in their economic circumstances following unsafe abortion.

In many countries, a shortage of doctors in the public sector, the inability of women to afford abortions in the private sector, and the aversion by healthcare workers in the public sector toward abortion have all contributed to the stigmatization of abortion and the lack of access to safe abortion services (Ngwena 2010). Abortion laws, ideologies, and practices are closely intertwined with stigmas around abortion in which women who seek one are viewed as straying from feminine ideals that include women's natural fecundity, the irrevocability of their roles as mothers, and their instinctive nurturance of those who need care (Kumar, Hessini et al. 2009). Abortion stigmas vary according to local contexts and can contribute to the perpetuation of restrictive abortion legislation. Even when abortion is legal, social norms and attitudes are often slower to change than legal statutes, so women may still be obtaining clandestine abortions while legally allowed to do so, due to the stigma around abortion.

The widespread dissemination of information through the internet has helped to destigmatize both abortion and contraception, and it has provided healthcare practitioners and women with clinical information about fertility control and safe abortion procedures, including abortion

pills (Crane, Daulaire et al. 2017). Abortion pills are the popular name for medical abortions, which involve taking the medicine mifepristone (which stops the body from producing the hormones necessary for pregnancy) followed by misoprostol (which induces contractions). The World Health Organization approved the combination of mifepristone and misoprostol to induce abortion in the first twelve weeks of pregnancy and it placed the drugs on its list of essential medicines in 2005. However, availability and access to misoprostol and mifepristone is shaped by health system and regulatory framework contexts. This accounts for the wide variation in access, availability and costs across geographies, legalities and social contexts (Berer 2020). The use of these drugs to perform medical abortions is still not a widely available option in lower-income countries. High prices and restrictive regulations, especially in the case of mifepristone, have limited the widespread use of medical abortions. Inequalities in access to both medications at affordable costs is also shaped by variations in essential medicines lists, with only 50 of 158 countries analyzed in the Global Abortion Policies Database including both misoprostol and mifepristone, not necessarily for abortion-related care (Lavelanet, Johnson et al. 2020). By 2011, misoprostol was approved in over 80 countries, mostly for the prevention and treatment of gastric ulcers. However, mifepristone was only approved explicitly for abortion in 45 countries, mostly higher-income countries (Sneeringer, Billings et al. 2012).

In many countries women often use misoprostol by itself, rather than in a combined regimen with mifepristone, because it is widely available from doctors, pharmacies, and the black market not only to treat ulcers but also postpartum hemorrhage. However, when used by itself, misoprostol may cause more side effects and incomplete abortions compared to when it is combined with mifepristone (Coêlho, Teixeira et al. 1993). In these cases women often wind up seeing a healthcare provider for post-abortion care services, especially manual vacuum aspiration (MVA) procedures to complete the abortion. The fact that post-abortion care services are usually exempted from national abortion laws (and from United States funding restrictions) has meant that women can use misoprostol followed by post-abortion care services if necessary to ensure that they have a complete abortion. Thus changes in abortion access and practice have contributed to increasing abortion rates in some countries in the face of highly restrictive national legislation.

Rationale

We know relatively little globally about the individual-level economic burden of seeking and procuring abortion. Costs for individuals and their households do not start at point of treatment; rather, costs are incurred directly and indirectly throughout the treatment pathway (e.g. transport, food, accommodation, loss of income) (Edejer 2003, Leone, Coast et al. 2016). Further, costs borne by the poorest abortion seekers with the least access to contraception and fewest resources are especially high, though infrequently considered. Given these constraints, pregnant people's ability to access resources to procure an abortion is important in every setting. Social and emotional support for or against abortion care is linked to whether, and to whom, the pregnancy is disclosed. A friend or partner providing support may influence the location and type of abortion (Conkling, Karki et al. 2015).

Access to financial resources, frequently linked to social support, may be critical to a person's ability to obtain abortion information and services. In Latin American countries where abortion is illegal, access to financial resources and emotional support were critical for accessing a medically-supervised medical abortion in a clandestine clinic (Zamberlin, Romero et al. 2012). One quarter of urban Mozambican women who sought a first trimester termination at a public hospital delayed care in order to have sufficient funds to pay user fees (Mitchell, Kwizera et al. 2010). A pregnancy has short- and long-term direct and indirect costs for women; these may be exacerbated when the pregnancy is unintended (Gipson, Koenig et al. 2008). Individual circumstances influence whether abortion provides a better outcome for people who are pregnant than bearing a child at that time, and pregnant individuals give many reasons for having an abortion. For example, in Bangladesh, women and their husbands described challenging life circumstances (poor health, poverty) that influenced their decisions to terminate (Gipson and Hindin 2008). These examples from Latin America, Africa, and Asia bolster the case for making a concerted effort to document the costs of seeking and obtaining abortions to individuals, households, and societies.

Methodology

We took a systematic approach to finding evidence on the economics of abortion by conducting a scoping review that includes as widely as possible all of the relevant literature. Informed by the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) reporting guidelines for protocols (Moher, Shamseer et al. 2015) the review was manageable, transparent, and reproducible. Since we were interested in examining what is known about the economic consequences of abortion care and abortion policies, and we expected to uncover varied evidence on this topic, we conducted a scoping review. Like systematic reviews, scoping reviews use a systematic approach to searching, screening, and reporting (Tricco, Lillie et al. 2018). Our scoping review utilized the PRISMA extension for Scoping Reviews (PRISMA-ScR) tool, in order to ensure a systematic approach to searching, screening, and reporting. Published in October 2018, this innovative checklist is the most up-to-date guidance on conducting scoping reviews (Tricco, Lillie et al. 2018).

Inclusion/exclusion criteria

Studies published in peer-reviewed journals on induced abortion and/or post-abortion care in any world region were considered, provided that they report on qualitative and/or quantitative data.[2] More specifically, these data must examine one of the following economic[3] outcomes at the micro-, meso-, and/or macro-levels:

- Economic costs[4] of abortion care or abortion policies
- Economic impacts[5] of abortion care or abortion policies
- Economic benefits[6] of abortion care or abortion policies
- Economic value[7] of abortion care or abortion policies

As indicated in Table 2 showing the PICOTS (Patient population, Intervention, Comparator, Outcome, Timing, and Setting) criteria, the screening criteria differ depending on the level (micro-, meso-, macro-) at which the study occurred. The population changes to account for the fact that we are examining evidence from the individual level to the national level. Items must be published in peer-reviewed journals or in the National Bureau of Economic Research's (NBER) peer-reviewed working paper series, which is considered to be a gold standard in the field of economics. Any NBER working paper that was subsequently published in a peer-reviewed journal was only be considered in its final published version. Items must be published in English, French, Spanish, Dutch, or German. This review includes studies published from 1 September 1994 to 15 January 2019.

Table 2. PICOTS criteria used in the scoping review

PICOTS	*Micro-level*	*Meso-level*	*Macro-level*
Populations	Individuals who obtained abortions or post-abortion care and members of their	Communities and health systems in which individuals obtain abortions or post-abortion	Societies and nation states in which individuals obtain abortions or post-

[2] These data may include policy and legal documents.
[3] Our approach includes economic outcomes related to human capital and women's reproductive labor that are not directly quantified in monetary terms. Such outcomes could include education, mothering, and care work.
[4] 'Economic costs' refer to the amount paid to obtain abortion care or adverse financial outcomes resulting from the implementation of abortion policies.
[5] 'Economic impacts' refer to the economic effect or influence of abortion care or abortion policies.
[6] 'Economic benefits' refer to the advantages or profits gained from receiving abortion care or from the implementation of abortion policies.
[7] 'Economic value' refers to the importance, worth, welfare gains, or utility from receiving abortion care or of the implementation of abortion policies.

	households	care	abortion care
Interventions	Induced abortion (safe/unsafe), post-abortion care, and/or abortion policies		
Control	None		
Outcomes	Quantitative or qualitative data on the: - economic costs of abortion care or abortion policies; - economic impacts of abortion care or abortion policies; - economic benefits of abortion care or abortion policies; or - economic value of abortion care or abortion policies.		
Timeframe	1 September 1994 to 15 January 2019		
Setting	Any		

Items were excluded if they focus on missed abortion, threatened abortion, or miscarriage. In addition, we excluded policy briefs, books, book chapters, editorials, commentaries, and published or unpublished reports from governments and other agencies. By limiting included items to peer-reviewed journal articles or NBER working papers that have been subjected to the scrutiny of other experts in the field, we increased the possibility that our scoping review included items with lower likelihood of the inclusion of errors (Kelly, Sadeghieh et al. 2014).

Search strategy and terms

After first assessing electronic databases for their relevance and coverage of the literature, we selected eight electronic databases for searching:

- Cumulative Index to Nursing and Allied Health (CINAHL)
- EconLit
- Excerpta Medica Database (EMBASE)
- International Bibliography of the Social Sciences (IBSS)
- JSTOR
- PubMed
- ScienceDirect
- Web of Science

These sources were searched using combinations of relevant search terms that we developed and tested for sensitivity in advance of the scoping review. The terms, detailed in Table 3, were adapted to the basic search particulars (e.g., wildcards (*) and truncations, capacity for complex searches) of each electronic database. We supplemented these searches with expert-recommended articles. To obtain these articles, we developed a standardized email asking for suggested articles that we sent to a list of abortion researchers. Any suggested articles were incorporated into our PRISMA flowchart.

The impact terms are broad enough to capture numerous terms that are directly related to economic outcomes, such as health, education, and income. These outcomes capture the mechanisms through which abortions may have economic consequences for individuals, households, and even the macroeconomy. The impact terms “value” and “benefit” are not meant to be mutually exclusive; they are common terms in studies on the economics of abortion. By including them both in the screening process, we were less likely to miss a relevant study.

Table 3. Search terms and their combinations

1. Abortion terms	*2. Economic terms*	*3. Impact terms*
abort*	cost*	cost*
termination of pregnancy	econom*	benefit*
terminate pregnancy	price*	value*
pregnancy termination	financ*	impact*
pregnancy terminations	resource*	
postabortion	fee*	
post-abortion	tax*	
	expenditure*	
	GDP	
	gross domestic product	
	pay*	
	expens*	

Screening process

To ensure compatibility with the standards expected of a scoping review for peer-reviewed publication, we conducted the searches and application of inclusion/exclusion criteria according to the PRISMA-ScR flow approach (Tricco, Lillie et al. 2018). No assessments of items' quality were made, as the purpose of this scoping review is to synthesize and describe the coverage of the evidence.

Once the searches were conducted, citation abstracts for all items were exported into EndNote for screening. After removing duplicates, the remaining items were screened for inclusion, initially on the basis of title and abstract (TIAB). When inclusion or exclusion could not be determined on the basis of TIAB, the person screening the item moved the item forward for full-text screening. To assure quality in TIAB screening, we simultaneously screened 100 randomly selected items for inclusion. Based on our results, we adjusted the inclusion/exclusion criteria as necessary. Given that the results of our individual screenings differed, we screened an additional 100 randomly selected items for inclusion on TIAB based on the refined inclusion/exclusion criteria. The process was repeated one more time until we reached agreement. The remaining items were then divided amongst the authors for full-text screening.[8] Following the full-text screening, studies recommended for exclusion were reviewed by a second researcher to ensure consistency in the application of exclusion criteria.

Data extraction

We simultaneously extracted data into Excel for five randomly selected studies in order to assure quality in data extraction. Following this check for quality assurance, we divided the remaining included studies for data extraction. Data were extracted on the following categories:

- Background information (e.g. author, date, setting, study objective)
- Population

[8] We also included a research assistant, Elaine Zundl, in this process.

- Details of relevant outcomes (both quantitative and qualitative) at the micro-economic, meso-economic, and macro-economic levels
    - Financial cost (the amount paid to obtain abortion care, including transportation costs and opportunity costs when relevant) or adverse financial outcomes from abortion policies
    - Impact (the effect or influence of abortion care or abortion policies)
    - Benefit (advantages or profits gained from receiving abortion care or implementing abortion policies)
    - Value (the importance, worth, welfare gains, or utility of receiving abortion care or implementing abortion policies)
- Secondary outcome data on abortion-related stigma, discrimination, and exclusion
- Context in which the study was conducted (e.g. legal status of abortion, culture, gender norms)

Since this scoping review aimed to synthesize and describe the coverage of the evidence, we did not assess the risk of bias of individual studies. A detailed data extraction template is provided in Appendix A, and the accompanying codebook is available in Appendix B. The detailed search procedure, including databases and search terms, is found in Appendix C.

Data synthesis

After extracting all data, we inductively developed an economic framework around the economics of abortion. The analysis synthesized the evidence base and identified knowledge gaps on the costs, economic impacts, values, and benefits of abortion to stakeholders at the micro-, meso-, and macro-levels.

At the micro-level, our analysis synthesizes the evidence base and identifies evidence gaps on the costs and benefits of abortion to individuals seeking abortions and their households. The framework generates a number of scenarios showing how changes in the cost and availability of modern contraceptive methods and access to safe abortion can impact the health, wellbeing, and economic status of abortion seekers and their households. At the meso-level, we consider the economic costs and impacts of abortion care to communities and health systems and also how health systems bear the costs of abortion restrictions that may increase the number of people seeking post-abortion care.

Finally, at the macro-level, we explore how liberalizing or restricting abortion legislation impacts broad aggregates such as women's labor force participation, women's education, investment in children's human capital, and economic growth. Women's ability to control the timing and number of births through access to modern contraception is linked to higher maternal age at first birth, fewer children, and longer birth intervals. These factors are all linked to improved maternal health, which not only helps women but also has repercussions for healthcare costs and the overall macroeconomy through investment in women's human capital and that of their children. Furthermore, the relationship between women's socioeconomic status and the likelihood of using abortion enables us to infer the types of labor market opportunities for women who had abortions relative to those who did not.

We report the data using a systematic narrative synthesis in which the results are presented narratively and organized thematically, supplemented with tables of descriptive statistics on included studies and their outcomes.

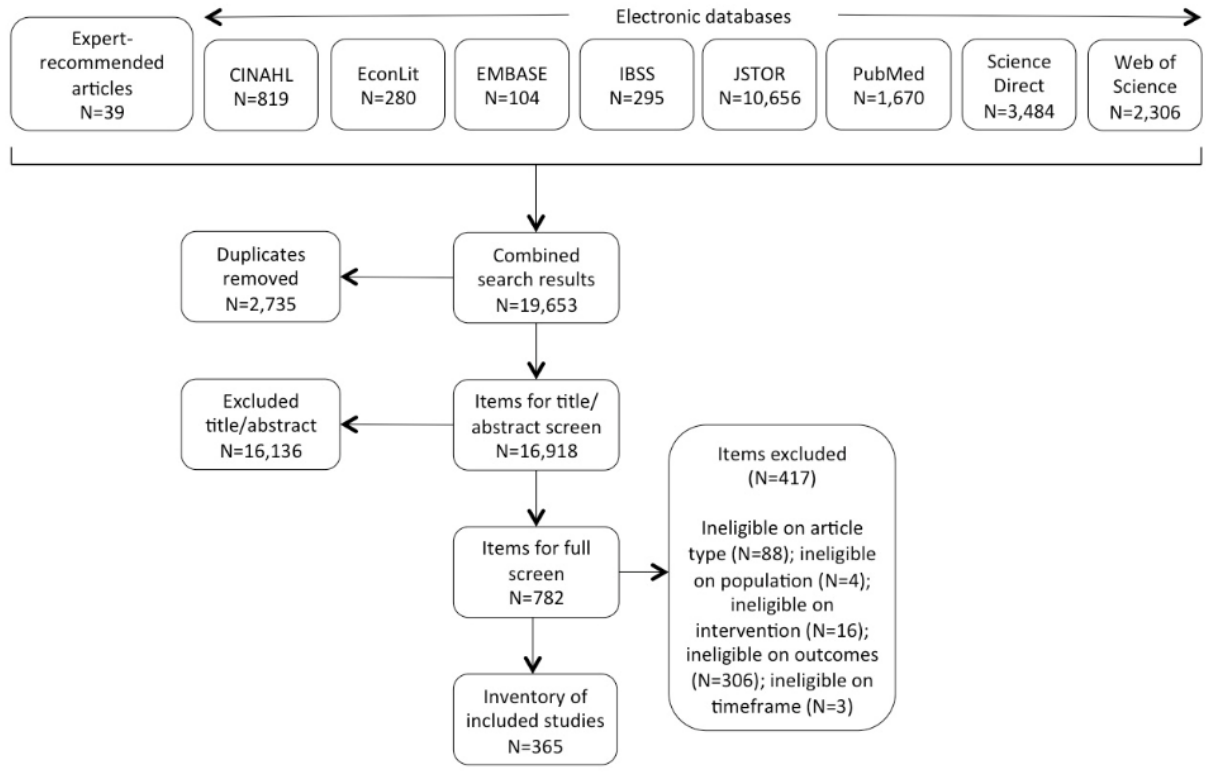
Findings

Descriptive statistics

As shown in Figure 1, the search generated 19,653 items for screening. After duplicate removal, the 16,918 remaining items were screened for inclusion on the basis of TIAB. We determined eligibility of all items, and unclear items were discussed. Where exclusion could not be

determined on the basis of TIAB, the authors screened the full text. Decisions were made in favor of an inclusive approach where questions remained. In total, 365 studies met all the inclusion criteria and were included in the scoping review.

Figure 1. Screening results



Among the countries covered in the 365 studies on the economics of abortion, an overwhelming number examined the United States. Almost one third of all the studies (115 out of 365 studies) focused exclusively on the United States, and an additional seven studies on a selected group of countries included the United States in their analysis (Table 4). This dominance of the United States in studies of abortion not only reflects the political attention focused on abortion, but also the availability of data, the institutional affiliation of authors, the editorial home of journals, and the location of funding and other resources for conducting studies.

After the United States, the country with the most coverage in the final inventory of studies was the United Kingdom (n=22), followed closely by India (n=20). Interestingly, substantially more studies have focused on African countries relative to countries in Asia, even though a far larger share of the world's population resides in Asia. Relatively few studies have focuses on countries in Latin America and the Caribbean, most likely because abortion policies are more restrictive in this region than any other part of the world. These restrictions would also serve as obstacles facing researchers. Noticeably absent with just a few exceptions (including Egypt, Iran, and Israel) are countries in the Middle East and North Africa.

Table 4. Included studies by region and country

Region/country	*# of studies*	*Region/country*	*# of studies*
Northern America	**122**	**Europe**	**48**
United States	115	United Kingdom	22
Canada	7	Romania	4
		Ireland	4
Africa	**68**	France	3
South Africa	13	Poland	2
Ghana	8	Sweden	2
Nigeria	7	Spain	2
Zambia	6	Norway	2
Kenya	6	Netherlands	1
Burkina Faso	4	Switzerland	1
Uganda	4		
Malawi	2	Moldova	1
Mozambique	2	Germany	1
Tanzania	1	Multiple countries	3
Ethiopia	1		
Cote d'Ivoire	1	**Latin America & Caribbean**	**34**
Cameroon	1	Colombia	4
Rwanda	1	Mexico	9
Egypt	1	Brazil	4
Multiple Countries	10	Chile	3
		Guadeloupe	2
Asia	**54**	El Salvador	1
India	20	Cuba	1
Thailand	6	Argentina	1
China	5	Puerto Rico	1
Bangladesh	4	Peru	1
Nepal	4	Multiple countries	7
Vietnam	3		
Iran	2	**Oceana**	**9**
Israel	1	Australia	8
Indonesia	1	New Zealand	1
Pakistan	1		
Cambodia	1	**Cross-Regional Studies**	**30**
Taiwan	1	Global	18
Myanmar	1	Selected countries (including the US)	7
Hong Kong	1	Selected countries (excluding the US)	5
Kazakhstan	1		
Turkey	1		

Multiple countries	1	
	Total	**365**

Note: Each data point represents the number of included studies covering the specified country.

The majority of studies were quantitative in nature, with 190 studies relying exclusively on quantitative methods and another 91 studies including both quantitative and qualitative methods (Table 5). Many (59) of the studies focused on regression analysis. At least two-thirds of the lead authors were women, which may not come as a surprise given that the topic is reproductive health and the study populations are often women of reproductive age. Studies ranged in their level of geographic coverage, with just under one-third of the studies examining abortion outcomes at the national level and the remainder being conducted at the sub-national, local, health facility, and other levels.

Table 5. Characteristics of included studies (n=365)

	No. Studies	*Percent*
Type of Data		
Quantitative	190	52.1
Qualitative	84	23.0
Both	91	24.9
Methodology		
Randomized controlled trial	4	1.1
Controlled clinical trial	2	0.5
Cohort analytic	5	1.4
Cohort (before & after)	6	1.6
Interrupted time series	1	0.3
Qualitative	71	19.5
Mixed methods	45	12.3
Regression	59	16.2
Review Paper	32	8.8
Other	140	38.4
Presumed Gender of 1st Author[9]		
Woman	246	67.4
Man	75	20.5
Unclear	44	12.1
Geographical Level		
National	114	31.2
Sub-national (e.g. state, city)	95	26.0
Local (e.g. village)	13	3.6
Health facility	96	26.3
Other	47	12.9
Study Population		
Ethnic (or race)	2	0.5
National	46	12.6
Religion	1	0.3
Geographical location (e.g. urban/rural, region, facility)	41	11.2
Socio-economic	2	0.5
Age (e.g. adolescents)	12	3.3
Status as abortion seeker	93	25.5
Multiple answers from list	86	23.6

[9] We selected to use gender (a social construction relating to behaviours and attributes based on labels of masculinity and femininity) rather than sex (the biological aspects of an individual as determined by their anatomy, frequently assigned at birth). Author gender assigned on commonly understood gender of names, based on web-searching. Where a name was neutral with respect to gender eg: “Sam”, coded as “Unclear”. Where a name was not identified as commonly masculine or feminine, coded as “Unclear”.

Other, specify	57	15.6
Abortion provider	24	6.6
Not applicable	1	0.3

We extracted data on the costs, economic impacts, benefits, and value of abortion services and abortion policies. To facilitate the analysis, we merged studies on benefits and value. Table 6 details the number of studies that contained data on these economic outcomes, by level of analysis. Numerous studies provided information on multiple indicators. For example, studies included abortion costs faced by individual women (micro-level) as well as costs of abortion services paid by the health systems (meso-level). In total, 308 studies contained data on the economics of abortion at the micro level, 184 studies had data at the meso-level, and 189 studies had data at the macro level, for a total of 681 data points. Hence the total number of data points exceeds the number of studies (365) in our final inventory.

Table 6. Economic content of included studies

Studies on costs					
Study reported on outcome		*# of studies by level*		*Total extractions by level*	
Yes	262	Micro	90	Micro	174
No	103	Meso	42	Meso	116
Total	365	Macro	30	Macro	97
		More than one	100	Total	387
		Total	262		
Studies on economic impact					
Study reported on outcome		*# of studies by level*		*Total extractions by level*	
Yes	140	Micro	48	Micro	76
No	225	Meso	15	Meso	40
Total	365	Macro	42	Macro	66
		More than one	35	Total	182
		Total	140		
Studies on economic benefits or value					
Study reported on outcome		*# of studies by level*		*Total extractions by level*	
Yes	98	Micro	50	Micro	57
No	267	Meso	16	Meso	28
Total	365	Macro	18	Macro	26
		More than one	14	Total	112
		Total	98		
Studies by level of analysis					
Micro-level		*Meso-level*		*Macro-level*	
Costs	174	Costs	116	Costs	97
Econ Impact	76	Econ Impact	40	Econ Impact	66
Benefit/value	58	Benefit/value	28	Benefit/value	26
Total	308	Total	184	Total	189

Note: Total data extractions by level include data extractions for studies with multiple levels.

Given the preponderance of stigma associated with seeking and providing abortion services, we screened every article in the final inventory of included studies for information on abortion-related stigma, discrimination, and exclusion. Just under one quarter (89 out of 365) of the included studies contained information on stigma, and about half of these studies examined stigma at the micro-level (50/89) followed closely by the meso-level (47/89).

As a secondary outcome, the related stigma-based findings within the 89 included articles ranged in relevance to the primary objective of the scoping review. In order to provide key findings on the implications of stigma and its links with economic outcomes, we decided to focus only on the articles that included stigma findings with direct economic links. Of the 89 articles that included evidence on stigma, only 32 included findings that were directly tied to the primary economic outcomes examined in this review (Appendices D-F, J-L, Q, R, V, W). These articles were organized into tables based on the related economic outcomes and are presented within each economic level (micro-, meso-, macro-). Ultimately, a majority of the articles with economic outcome included findings on economic cost (24/32) (Appendices J, Q, V), followed by economic impact (11/32) (Appendices K, R, & W), and finally economic benefit (1/32) (Appendix L).

The remaining articles were organized into tables based on findings that correlated to context, methodology, and non-economic outcomes. Findings that referred to sigma within the general setting of the study were labeled as context (Appendix D). Two articles highlighted how stigma might have played a role in their data collection and were categorized as methodology (Appendix E). Articles that included stigma within their findings as key study outcomes but did not include related information regarding economic consequences were labeled as non-economic outcomes (Appendix F).

Micro-economic costs and consequences of abortion

Micro-economic costs

Micro-level costs of abortion-related care (Appendix G) were the most frequently recorded outcome in our review. Many studies that did not explicitly set out to study micro-level costs include valuable information – quantitative and qualitative – underscoring the important role that economic costs play in people's trajectories to abortion-related care. The research design and level of detail relating to micro-level costs is highly heterogeneous, from cross-sectional direct costs of medical abortion drugs via telemedicine (Murtagh, Wells et al. 2018) to prospective direct and indirect costs of post-abortion compared to safe abortion care (Moore, Dennis et al. 2018). What is clear is that there is a sustained but highly variable evidence base that seeking abortion-related care has costs for adolescents and women, with potential implications for the timing and type of care sought, globally. Which costs are included – whether direct/indirect – is often unclear – either in the framing of the research or in respondent's answers; in facility-based studies there tends to be a narrow focus on costs to, and at, the facility. Our evidence suggests that a much broader range of expenses and costs are likely to be important in a wide range of contexts.

That abortion-related care has micro-level costs is perhaps demonstrated most clearly in evidence from settings where abortion-related services are (theoretically) free-of-charge. The costs to women include indirect and opportunity costs (e.g. transport, accommodation, childcare, etc.). In Bangladesh, although menstrual regulation services are technically free at public sector facilities, women reported that the indirect average total cost for an abortion at primary health center was 67 INR (SD = 137 INR; Range: 0–2700), with costs almost three times higher for women accessing services at urban hospitals (Banerjee, Kumar et al. 2017). In Canada, although abortion is supposedly a funded, medically necessary

procedure, 22.1% of women reported that they paid for their own abortions. The cross-sectional research design means that whether or not these women would later be reimbursed by their provincial government health care plans for the abortion procedure was unknown. In addition, indirect costs were often doubled as the majority of women reported travelling to the clinic with someone (Sethna and Doull 2013). Lack of knowledge of free or low-cost abortion care in public clinics led people to seek private services in South Africa, with fees approximating ZAR 900, which made care highly inaccessible (Gresh and Maharaj 2011).

The reasons for indirect costs of abortion are wide-ranging, including: companion costs (Doran and Hornibrook 2016); childcare; overnight accommodation (Sethna and Doull 2007, Doran and Hornibrook 2014); travel costs (Díaz-Olavarrieta, Cravioto et al. 2012); taking time off work; consumables (e.g. toiletries) (Mutua, Manderson et al. 2018); and unofficial fees (Comendant 2005, Leone, Coast et al. 2016). In contexts where women have to seek multiple referrals or attend follow-up visits, these costs are multiplied (Grossman, Ellertson et al. 2004).

Travel costs represented the most frequently cited indirect abortion-related costs at the micro level (n=48). In South Africa, 81% of care-seekers spent approximately US$ 1.25 to reach a clinic (Cooper, Dickson et al. 2005), though services were free. Costs of travel are linked to clinic location; the cost of travelling to providers in Texas was substantially more for people living in counties without providers (US$ 15.48 averaged over 235 counties) than for those in counties with providers (US$ 3.61 over 19 counties) (Brown and Jewell 1996). A mixed methods study in the US estimated that people seeking abortions in the first trimester spent an average of US$ 18 on travel (range US$ 0-400), whereas those seeking abortions on or after 20 weeks spent an average of US$ 100 (range US$ 0-2,200) (Foster and Kimport 2013). While the majority of people seeking abortions in a study in Canada had no travel/accommodation expenses, those that did paid more than Can$ 100, with one respondent reporting having spent Can$ 4445.05 on travel and hotel accommodation (Sethna and Doull 2007).

Evidence that included relative comparator costs (e.g. average daily wage or monthly salary) was substantially more meaningful than evidence that did not. For example, evidence from Poland showed that illegal abortions cost 2000-4000 PLN (US$500–1000), at a time when the average monthly Polish salary was 2000 PLN (Girard and Nowicka 2002). In Nepal, the basic fee (excluding other related costs) was Rs 645, representing approximately five days' wages for a female laborer (Thapa, Poudel et al. 2004). Some authors reflect on how the relative costs of abortion-related care are likely to impact on the type of care sought. In Burkina Faso abortion costs ranged from a few thousand CFA francs for traditional potions or abortifacients of varying effectiveness, tens of thousands for an injection by a health worker, and up to 200,000 CFA francs for curettage in hygienic conditions. The monthly wage for a maid or caretaker is 20,000–40,000 CFA francs meaning that safer abortion methods were beyond the reach of the poorest population groups (Rossier 2007). In Kenya, where the cost of an abortion ranges from KS 60 for quinine purchased at a pharmacy to 5,000 KS (US$ 60) from a doctor, evidence suggests that even where women knew about a potentially safe option for abortion, the cost was prohibitive and limited them to less expensive options because most women earned less than 220 KS (US$ 2.50) per day, meaning that women sought less expensive options (Marlow, Wamugi et al. 2014).

The ways in which women pay for abortion-related costs are diverse. In the US, abortion care funds represent an important source for some women (Jones, Upadhyay et al. 2013). In diverse contexts – potentially reflecting either an inability to disclose or an absence of any other sources – women seek financing from credit/loans (Dennis, Manski et al. 2014) and informal or backstreet lenders (Bloomer and O'Dowd 2014). A US based case study outlined how a woman required aid from three different funds, as well as using her own funds and receiving financial support from her mother, in order to cover the US$ 2,700 cost of her abortion (Foster and Kimport 2013). In Kenya, evidence suggests the emergence of brokers who assist patients to make payments for a fee. In addition, because patients were often required to make cash payments for procedures, services were restricted to patients with access to a credit/debit card (Mutua, Manderson et al. 2018). Women in all contexts often had to borrow or source money from their social networks (male partners, family, friends), with diverse evidence from Nigeria (Prada, Bankole et al. 2015), US (Foster and Kimport 2013, Blanchard, Meadows et al. 2017, Jerman, Frohwirth et al. 2017), Northern Ireland (Bloomer and O'Dowd 2014), Romania (David and Baban 1996), Australia (Doran and Hornibrook 2016), Vietnam (Gallo and Nghia 2007) and Brazil (Souza, Diniz et al. 2010) and Latin

America (Zamberlin, Romero et al. 2012). The role of men in providing – wittingly or unwittingly – for abortion-related care appears to be an important one in many settings, likely reflecting gendered differences in access to resources. In Zambia, very few men who financially supported women seeking post-abortion care were told the purpose of the care they were supporting (Freeman, Coast et al. 2017). By contrast in Australia, some women's ex-partners knowingly paid the abortion fee (Doran and Hornibrook 2016). There is very limited work that explores how women perceive or feel about the need to obtain money from others. Evidence from the US shows that irrespective of where the assistance came from, women's most common characterization of having to obtain money from others was to feel grateful. Substantial minorities of women who obtained money from abortion funds and family members characterized the experience as "lifesaving," although few women who obtained money from men indicated this response. A few women reported negative emotions such as "resentful," "humiliating," or "angry" (Jones, Upadhyay et al. 2013).

Many of the research designs around micro-level costs are comparative, and compare costs in comparison to some other care seeking, including: different types of medical abortion drugs (Lalley, Jelsema et al. 2001, Murtagh, Wells et al. 2018); medical abortion self-care compared to medical abortion formal care (Manouana, Kadhel et al. 2013); medical compared to surgical abortion (Murthy and Creinin 2003, Lafaurie, Grossman et al. 2005, Schiavon, Collado et al. 2010, Perrin, Berthoud et al. 2011, Aantjes, Gilmoor et al. 2018); safe abortion compared to post-abortion care (Machungo, Zanconato et al. 1997, Prada, Bankole et al. 2015, Leone, Coast et al. 2016, Moore, Dennis et al. 2018); and post-abortion care compared to treatment for spontaneous abortion (Henshaw, Adewole et al. 2008, Banerjee, Andersen et al. 2012, Ilboudo, Greco et al. 2015). There are two patterns that emerge. Micro-level costs for PAC compared to care for a spontaneous abortion are significantly higher, often as a result of complex care-seeking trajectories due to the need for secrecy in restrictive settings. In more recent studies, the costs of PAC are higher than the costs of seeking safe abortion.

Rather than generating actual costing data, a subset of evidence is organized around women's difficulties to afford or pay costs of abortion-related care. In Kazakhstan, 40% of women identified "financial problems" as the "main difficulty" in obtaining an abortion (Agadjanian 2002). A study of women seeking at-home medication abortion in Republic of Ireland and Northern Ireland found that over a third reported difficulty in affording the service donation (Aiken, Gomperts et al. 2017). In the UK, a study of non-resident women who travel to the UK found that more than half of women found it 'difficult or very difficult' to cover the cost of travel.

Studies from the US that reflect the health insurance context find that it was somewhat or very difficult for 41% of respondents to pay for the procedure (52% among women not using health insurance) (Jones, Upadhyay et al. 2013); by contrast, women who used their public insurance to cover their care described the process as easy and straightforward (Dennis, Manski et al. 2015). The use of non-financial measures to assess the micro-level costs of abortion-related care is important, given that – albeit rarely reported – there is evidence that respondents do not know the costs of their care. In Zambia, younger patients were less likely to know the costs that were paid (Moore, Dennis et al. 2018). In a study from Nigeria, about half of the women did not know who bore the cost of treatment (Prada, Bankole et al. 2015). In the US, authors report that there seemed to be a lack of clarity about how the cost of the procedure was calculated (Foster, LaRoche et al. 2017). The inadequacies of data on reported costs for abortion-related care are an important methodological issue that is rarely tackled or evidenced.

The intersection in the evidence between micro-level costs and delay(s) to abortion-related care is substantial, and is organized here in three groups: (1) delays in deciding to seek abortion-related care; (2) delays in reaching abortion-related care; and (3) delays in receiving abortion-related care.

(1) Delays in deciding to seek abortion-related care. Evidence from the US shows that poor women (67%) were more likely to say that they would have preferred to have had the abortion earlier than women above 200% of poverty (50%). The need to take time to make arrangements was the most common reason for delay for the sample as a whole, and low-income women were more likely to have this problem. Women who had second-trimester abortions were more likely to have concerns about cost or about raising money. Half of second- trimester patients reported

that it took them a long time to decide, while only 35% of first-trimester patients said so; this finding was of borderline statistical significance (p=0.06). Second-trimester patients were more likely to cite worries about cost as a reason for delay in deciding (Finer, Frohwirth et al. 2006).

(2) Delays in reaching abortion-related care. In Zambia, the financial costs of seeking an abortion played a role in the timing and complexity of women's care-seeking trajectories, specifically finding money for transport (Coast and Murray 2016). In Ireland, delays in reaching care were largely determined by the need to travel, most frequently to England, which required raising money and a need for secrecy (Aiken, Guthrie et al. 2018).

(3) Delays in receiving abortion-related care. Women who cannot access abortion in Northern Ireland must travel elsewhere to obtain one and pay as private patients; the difficulties in obtaining funds can also lead to delays in obtaining an abortion, thereby increasing its cost (Bloomer and O'Dowd 2014). In Bangladesh, even women who were hospitalized for several days after reaching the hospital directly incurred lower costs than women who did not require hospitalization but visited other providers; many women expressed the burden in terms of managing money and sacrificing regular earnings because of prolonged complications and unsuccessful visits to multiple providers (Banerjee, Andersen et al. 2012). In Kenya, a requirement that patients paid prior to each procedure restricted access to timely care, and inability to pay for services led to multiple referrals (Mutua, Manderson et al. 2018). In Zambia, a referral from a satellite health center reduces registration fee at the hospital, and for poorer women knowing how to navigate the public sector health system in this way made care more affordable but it also added an additional step in their trajectory to the hospital (Coast and Murray 2016). In the US, interactions with health insurance coverage played a role in influencing delays. In one study, although 59.6% of women had insurance, over half of participants paid out-of-pocket, and women with insurance reported complex processes and delays to obtain coverage (Blanchard, Meadows et al. 2017). In a separate study 56% of women reported at least one reason that they were delayed from obtaining an earlier procedure, with the most common reasons being the costs of the procedure, not knowing they were pregnant, and taking time off work (18%) (Karasek, Roberts et al. 2016). In another US study more than half of respondents reported cost as a reason for delay in obtaining an abortion (Roberts, Gould et al. 2014). Delays in raising finances and finding appropriate clinics were lengthy for some people in the US, which led to increased gestational ages and related costs of care, compounding existing financial hardships (Foster and Kimport 2013).

The ways in which actual and/or perceived costs of different types of abortion-related care may impact care-seeking is documented in a wide range of contexts. University students in Ghana consider self-use of medical abortion to be cheaper and more discrete compared to going to a safe medical abortion service provider (Appiah-Agyekum 2018). In Hong Kong, among adolescents and young women who had an illegal and unsafe abortion, the cost of safe abortion services was of great concern to all the respondents (Hung 2010). In India, while cost of services did not prevent women from undergoing an abortion, it did determine the choice of facility; women for whom cost was a concern tended to seek care from those perceived to provide cheaper services, even when they had concerns about the provider's technical skills (Barua and Apte 2007). In Kenya, pregnancy termination in hospital settings and by high-profile providers was considered very costly so women seek inexpensive but unsafe providers. Well-equipped facilities and providers were considered out of the financial reach of most abortion-seekers (Izugbara, Egesa et al. 2015).

In an Australian study, although surgical termination was available close by, women's reasons for not using this service included cost, limited appointment availability, and avoiding protestors who picketed the facility. Women reported that the most important aspects of the medical abortion experience were the supportive services provided by the clinic staff, and the low cost of the medical abortion. Some women reported indirect costs associated with the process including travel time or missing time from work or education (Hulme-Chambers, Temple-Smith et al. 2018).

A small body of evidence considers the pregnancy outcomes for adolescents or women unable to afford the costs of abortion-related care. In a review of a study from Thailand, 3/30 women had abandoned attempts to obtain a termination because of the costs involved (de Bruyn 2003). In Nepal: The landmark 2009 Supreme Court decision in Lakshmi Dhikta v. Nepal centered on a poor, rural woman who was forced to give birth to

her sixth child due to her inability to afford the required fees for an abortion (approximately US$20) (Wu, Maru et al. 2017). In the US, among minors who identified as black or Hispanic, who received Medicaid, or who had lower educational achievement, the risk of unintended birth was even higher than among the general adolescent population. Waiting periods that mandated multiple visits varied from other types of waiting periods, suggesting that it is the financial and time costs imposed by these statutes that impose may alter pregnancy outcome (Coles, Makino et al. 2010). In a US study of people who were refused care, 85.4% turned away from facilities reported that the cost of abortion-related care was the major factor in their in/ability to subsequently obtain an abortion elsewhere (Upadhyay, Weitz et al. 2014)

The evidence base is heavily dominated by evidence about women; we know rather less about the micro-level costs as they pertain to adolescents (Mutungi, Wango et al. 1999, Hung 2010, Jejeebhoy, Kalyanwala et al. 2010, Esia-Donkon, Darteh et al. 2015). This is an important lacuna because, globally, adolescents are less likely to be financially independent (or have ability to access sources of financing) compared to older women. Younger ages may mean higher costs charged for abortion-related services. In India, because the law requires a guardian's consent for abortion care for individuals aged below 18 years, some girls reported that private practitioners were willing to forego this requirement in return for a fee, between three to five times the normal rate (Ganatra and Hirve 2002). Evidence from the US suggests that the costs of abortions were highest for very young adolescents (11-13 years); the authors suggest that this age group may have significant difficulty gathering funds to pay for abortion procedures because they may not be fully employed, may not be comfortable asking parents or support persons for funding assistance, and they may also experience unique burdens, such as co-occurring psychosocial problems, which may increase delays in knowledge of the pregnancy and impact timing of abortions (Ely, Hales et al. 2017b).

Age is, however, just one factor that has important implications for the micro-level costs of abortion. The evidence base demonstrates that who or what a woman is can have substantial implications for how or what costs are required for abortion-related care. Although diverse, this body of evidence together underscores cross-cutting themes of inequity, inequality and power in accessing and paying for abortion-related care. In some settings marital status is important in the ways in which it intersects with care-seeking. In India, unmarried women are particularly vulnerable to unsafe abortions because of their concerns about cost and secrecy, the tendency to delay seeking services and the unwillingness of qualified providers to help them (Ramachandar and Pelto 2004). Migrant status in a range of contexts impacts on the costs and types of abortion-related care that women know about, seek and access (Calkin 2019), including: Guadeloupe (Manouana, Kadhel et al. 2013), Great Britain (Aiken, Guthrie et al. 2018), Thailand (Belton and Whittaker 2007). Provider-dependent factors, including provider assessments of ability to pay are observed in many contexts, including: Zambia (Leone, Coast et al. 2016), Chile (Casas-Becerra 1997, Casas and Vivaldi 2014) and India (Ganatra, Manning et al. 2005). Differential provider pricing based on an ability to pay does not mean, however, that wealthier women always pay more. In some settings it is the poorest women (who may also be young, unmarried, undocumented, less educated) who pay the most for abortion-related care. In Burkina Faso, women from low-income households paid the highest amount of money for the abortion procedure and for subsequent treatment of its complications (Ilboudo, Greco et al. 2015). Factors such as place of residence (Girard and Nowicka 2002, Baird 2015, Cano and Foster 2016), occupational status (Potdar, Fetters et al. 2008), ethnicity (Baird 2017), education (Font-Ribera, Perez et al. 2009, Sundaram, Vlassoff et al. 2013), and HIV status (de Bruyn 2003) are also shown to impact either the costs, or the ability to pay the costs, of abortion-related care. Evidence from the US shows how state-level variation in changing TRAP laws can have differential cost implications across multiple intersections (Austin and Harper 2018).

Interventions to assist women with the costs of abortion related care ranged from informal practices such as the provision of free services on a case-by-case basis to young Ghanaians who do not have money to pay for the services received (Esia-Donkon, Darteh et al. 2015) to informal community support systems in Myanmar for transport and a hospital staff fund with donations for treatment of poor patients (Htay, Sauvarin et al. 2003) to more formal arrangements. These arrangements ranged from individual clinic loan arrangements with individual women in Australia (Doran and Hornibrook 2014) to official sliding fee scales in Mexico City (Friedman, Saavedra-Avendaño et al. 2018) to US funds to assist women

with abortion-related care costs (Ely, Hales et al. 2017b). In Colombia, women who were able to access an advocacy service were eventually able to obtain full insurance coverage, though they had their abortions later than they had desired (Brack, Rochat et al. 2017).

There are issues that emerged from single studies or a limited number of studies that might warrant additional research:

- The cost implications of conditional abortion-related care provision have not been more fully explored. Evidence from India showed that abortion services in the public sector were free only if the woman or her husband accepts some form of contraception, usually sterilization or an IUD, after the abortion (Duggal 2004).
- Evidence on the micro-level costs of abortion-related care for women with disabilities is absent.
- Understanding of the ways in which women perceive the intersections between costs and quality of care and/or safety and/or risk.

Micro-economic impacts

To understand the micro-level economic impacts of abortion (Appendix H), there are six main types of research design or evidence – with varying levels of inference:

- Prospective research designs that explicitly generate evidence from individuals at more than one point in time across their abortion trajectory; there are very few such studies: Zambia (Moore, Dennis et al. 2018) and Uganda (Sundaram, Vlassoff et al. 2013).
- Studies using a range of analytic approaches to understand the impacts associated with policy and/or law changes; these studies are predominantly US-based (Jones and Weitz 2009, Dennis, Manski et al. 2014, Fuentes, Lebenkoff et al. 2016, Cunningham, Lindo et al. 2017, Jerman, Frohwirth et al. 2017, Austin and Harper 2018), with limited evidence from elsewhere (Bloomer and O'Dowd 2014, Molland 2016).
- Studies that evidence (usually retrospectively at the time of, or shortly afterwards, abortion) the economic impacts of dealing with abortion-related care costs
- Studies that compare the economic impacts of different types of abortion care-seeking, including: medical compared to surgical abortion (Wiebe and Janssen 2000, Robson, Kelly et al. 2009); PAC compared to spontaneous abortion (Sjostrand, Quist et al. 1995, Ilboudo, Greco et al. 2015); and safe abortion compared to PAC (Moore, Dennis et al. 2018).
- Studies that (retrospectively) evidence how economic factors are implicated in delays to (Bessett, Gorski et al. 2011, Sowmini 2013, Shankar, Black et al. 2017), or cessation of [4 studies, all from the US], abortion care-seeking.
- Studies that evidence women's reasons for abortion (usually retrospectively) can be used to infer the anticipated impacts of abortion, and give insights into the broad range of economic-related impacts that adolescents and women anticipate as a result of having had an abortion. Just one study explicitly sought to understand women's future aspirations as a result of having had an abortion (Upadhyay, Biggs et al. 2015).

The limited number of prospective studies demonstrate the potential power of such research designs, not only improving our understanding of the overall costs of abortion-related care [see micro economic costs section], but also how these evolve over time. In Zambia, a prospective study showed how factors (age, wealth, education, marital status) intersected to influence not only how adolescents and women financed their care, but also how this had implications for the type of care sought (safe abortion vs. PAC). Delays in fundraising increased both the cost and the risk of the procedure, and emotional impacts of anxiety and frustration were elicited from women (Moore, Dennis et al. 2018). In Uganda, among women who were re-interviewed 2–3 months after receiving PAC, deterioration in either the woman's or her family's economic circumstances was identified, including: lost economic assets, incurred debt, lowered their consumption, or had to work more or give up their jobs (Sundaram, Vlassoff et al. 2013).

A predominantly US-based set of studies use a range of analytic approaches to understand the impacts associated with policy and/or law changes. Qualitative evidence from low income women who had abortions in four American states concludes that restrictive coverage policies appear to force women to take measures to raise money for an abortion that may put their health and wellbeing at risk, promote short and longer-term financial instability, and increase the difficulty of implementing an abortion decision, thereby interfering with women's reproductive life plans. The authors identify "ripple effects" for children, partners, and parents of women seeking abortion services, and hypothesize low-income abortion clients in states without Medicaid coverage of abortion experience significantly more emotional and financial harm than clients in states where coverage is available (Dennis, Manski et al. 2014). Qualitative evidence from patients seeking abortion services identified 15 barriers women encountered while traveling to obtain care, in five groups: travel-related logistical issues, system navigation issues, limited clinic options, financial issues, and state or clinic restrictions (Jerman, Frohwirth et al. 2017).

A legal review of laws targeting abortion providers concludes that regulations unnecessarily requiring abortions to be performed in ASC facilities may force many providers to stop offering services or to raise their prices to levels prohibitive for some women seeking care, leading to hindering of (and possibly precluding) timely access to safe and legal abortion services (Jones and Weitz 2009). A systematic review of the impact of TRAP (Targeted Regulation of Abortion) laws found that TRAP laws may not need to close clinics to have an impact. Laws that increase service costs or decrease availability of appointment slots could increase the time it takes for a woman to obtain an abortion. An increase in gestational age at presentation may limit the number of providers willing to perform an abortion (particularly if the pregnancy has entered the second trimester) and increase out-of-pocket costs to patients. The authors hypothesize that while women with adequate resources are generally able to obtain an abortion with minimal difficulty, regardless of local policies, access-oriented barriers to abortion may introduce special challenges to low-income, young and/or rural women, as these women may be less able to manage increases in cost and distance (Austin and Harper 2018). As a result of the increased mandatory waiting time before obtaining abortion-care from 24 hours to 72 hours in Utah, 47% of pregnant people reported loss of wages, 18% additional childcare costs, 30% increased travel costs and 27% additional expenditures by a family member or friend (Sanders, Conway et al. 2016).

A regression analysis of the effects of Texas abortion-clinic closures on clinic access, abortions, and births using variation generated by law change (House Bill 2 – HB2) found that women who had to travel more than 100 miles (one-way) to reach a clinic increased from 5% to 15%. Travel distance to the nearest clinic was unchanged for women whose nearest abortion clinic was already located in a major city because at least one clinic remained open in these cities (Cunningham, Lindo et al. 2017). Qualitative evidence exploring the impacts of HB2 for women seeking abortion care shortly after clinics closed found that most women spent more money and time than they would have before HB2 to obtain an abortion after their local clinics closed. Women needed to ask for more help than they would have if there had been a local provider, and in the process, they had to reveal their abortion decision to people they might not have told otherwise. After being turned away from closed clinics or having appointments canceled most women who had to arrange transportation or could not take time off of work on the day of the next available appointment were delayed even further. Two women who wanted an abortion did not obtain one despite attempting to schedule an appointment. Insufficient information, time and money led these women to the decision to carry their pregnancies to term (Fuentes, Lebenkoff et al. 2016).

Outside the US, studies from Norway (Molland 2016) and Ireland (Bloomer and O'Dowd 2014) also consider the micro-level impacts of policy or law change. In Norway, Analysis of national data using a difference in difference approach, sought to estimate the benefits of increasing abortion access to teenagers in Oslo. The study concludes that there is "compelling" evidence that expansion of abortion access post-1950 birth cohorts led to a relative reduction in teenage fertility rates with a postponement of fertility rather than its overall reduction. In addition, increased abortion access led to increases in educational investments for these women (Molland 2016). A mixed-methods study of how women in Ireland sought abortion services under conditions of restrictive laws concludes that these laws forced women into "reproductive labor" (Bloomer and O'Dowd 2014). Moreover, regulations and government controls over the sale of abortion-related medication frequently led people to seek

methods from informal providers at inflated prices. A review of studies in Latin American found that requirements of prescriptions are a barrier that encourage pregnant people to seek informal, often more costly medication (Zamberlin, Romero et al. 2012). In Benin, pregnant people frequently reported seeking misoprostol in pharmaceutical markets to avoid navigating obtaining a prescription (Baxerres, Boko et al. 2018).

Studies that evidence (usually retrospectively at the time of, or shortly afterwards, abortion) the economic impacts of dealing with abortion-related care costs identify a range of (often multiple) impacts (education, employment, resources, existing children) in diverse contexts. Two studies from sub-Saharan Africa [Kenya, Zambia] both show how abortion-related care-seeking impacts on education (Mutungi, Wango et al. 1999, Leone, Coast et al. 2016). In Brazil, cohort analyses comparing the outcomes after one year found that the probability that girls with induced abortions would be in school was 6.9 times higher than adolescents whose pregnancies were intended (Bailey, Bruno et al. 2001). A US-focused review of the educational impacts of abortion among adolescents identified better educational outcomes among adolescents choosing abortion compared with those continuing pregnancy (Dragoman and Davis 2008). Studies from South Africa and Zambia consider the employment/work/income impact of abortion-related care seeking; both show missed work and/or lost income as an outcome (Leone, Coast et al. 2016, Lince-Deroche, Fetters et al. 2017a). A study from Vietnam describes how some women had difficulties in obtaining leave from an employer or taking time off from agricultural labor that had prevented them from obtaining abortion-related care earlier (Gallo and Nghia 2007). Three studies compare the employment/work impact of different types of abortion care-seeking (Wiebe and Janssen 2000, Robson, Kelly et al. 2009, Leone, Coast et al. 2016). Studies comparing medical and surgical abortion in the UK and Canada find no significant difference between the two groups (Wiebe and Janssen 2000, Robson, Kelly et al. 2009).

Prospective evidence from Uganda demonstrates the economic impacts for women's existing children and families, including missing school and/or having less food than usual, as a result of abortion-related care-seeking (Sundaram, Vlassoff et al. 2013).

Separate from evidence about how much it costs, or how women finance abortion-related care, is evidence about how paying or securing those costs has economic impacts at the micro-level. Evidence suggests that women – particularly lower income women – forego other costs and expenditures, or are pushed further into debt and/or poverty – in order to fund abortion-related care. In Australia women reported having to forego regular payments (e.g.: bills, food and groceries) to cover abortion costs (Shankar, Black et al. 2017). In Burkina Faso, women reported reducing expenses on essential needs or using their entire savings to pay for their PAC (Ilboudo, Greco et al. 2015). In Bangladesh, the selling of jewelry in order to pay for care was reported to result in "extreme poverty" for some women (Ahmed, Islam et al. 1999). In the US, women put off other payments (e.g. car loan), refrained from "extras" (e.g. meals in restaurants), and used savings (e.g. a "Christmas gift fund"). Women compared the abortion expense in contrast to the long-term financial commitment of raising a child (Margo, McCloskey et al. 2016).

Evidence from sub-Saharan Africa comparing the economic impact of post-abortion care with either spontaneous abortion (Sjostrand, Quist et al. 1995, Ilboudo, Greco et al. 2015) or safe abortion (Leone, Coast et al. 2016, Moore, Dennis et al. 2018) shows in all cases higher micro-level economic impacts for PAC compared to other care-seeking.

Four studies – all from the US – identify the impact of economic costs of abortion-seeking on delays to care-seeking and continuing a pregnancy (Bessett, Gorski et al. 2011, Dennis, Manski et al. 2014, Baum, White et al. 2016, Fuentes, Lebenkoff et al. 2016). Delays linked to difficulties in navigating insurance coverage, referral, securing costs were all implicated in these studies. Dennis and colleagues conclude that more research is needed to quantify the extent of emotional and financial duress placed on women and their families, and how this duress affects individuals and families over time (Dennis, Manski et al. 2014). Studies from India, US and Australia retrospectively) evidence how economic impacts are implicated in delays to abortion care-seeking (Bessett, Gorski et al. 2011, Sowmini 2013, Shankar, Black et al. 2017). In Australia, women who experienced difficulties in financing the abortion had significantly higher odds of presenting for care at later than 9 weeks gestation (Shankar, Black et al. 2017).

Financial concerns were the second most cited reason that rural women in South Africa delayed seeking care (Cooper, Dickson et al. 2005). The Turnaway Study, which recruited abortion seekers from 30 US clinics, found that 36.5% of first trimester patients and 58.3% of turnaway patients reported delays from travel and procedure costs. Of the 21.6% of overall turnaway patients, 85.4% reported travel and procedure costs as at least one reason for not obtaining an abortion (Upadhyay, Weitz et al. 2014). Regression analyses focused on people who had abortions in the second trimester in the US (Jones and Finer 2012, Jones 2017, Jones, Ingerick et al. 2018) revealed associations between payment type and abortion-related care. People who used health insurance were twice as likely to have an abortion at 16+ weeks than those paying out-of-pocket and women in poverty were more likely than other women to have abortions after the first trimester.

At the micro-level, we found one intervention with economic impacts for women. Operations research in Zambia to improve the availability of MA from pharmacists found a significant increase in the number of clients leaving a pharmacy with either information or with the opportunity to purchase MA drugs following the intervention (Hendrickson, Fetters et al. 2016).

Studies that evidence women's reasons for abortion (usually retrospectively) can be used to infer the anticipated impacts of abortion, and give insights into the broad range of economic-related impacts that adolescents and women anticipate as a result of having had an abortion. Reasons reported in the evidence from diverse contexts includes: education (Gallo and Nghia 2007, Aniteye and Mayhew 2011, Chunuan, Kosunvanna et al. 2012, Appiah-Agyekum, Sorkpor et al. 2015, Lince-Deroche, Fetters et al. 2017a), employment/occupation (Gallo and Nghia 2007, Aniteye and Mayhew 2011, Lince-Deroche, Fetters et al. 2017a), wealth/poverty (David and Baban 1996), caring for dependents (Cockrill and Weitz 2010), current and future relationships (Aniteye and Mayhew 2011), and wellbeing of pre-existing children (Aniteye and Mayhew 2011, Foster, LaRoche et al. 2017). However, perceived economic impacts (and reasons for having abortion) are rarely singular and are frequently intertwined (Dragoman and Davis 2008, Cockrill and Weitz 2010, Erfani 2011, Ely, Hales et al. 2017a).

Just one study explicitly sought to understand women's future aspirations as a result of having had an abortion (Upadhyay, Biggs et al. 2015). The authors generated evidence on women's one-year plans post-abortion among three groups of women: First Trimesters (women who presented in the first trimester and received abortions), Near-Limits (women who presented up to 2 weeks under the limit and received abortions), and Parenting Turnaways (women with children who presented up to 3 weeks over the facility's gestational age limit and were turned away). One-year plans were related to areas including education, employment and change in residence. Most goals were aspirational, defined as a positive plan for the next year. First Trimesters and Near-Limits were over 6 times as likely as Parenting Turnaways to report aspirational one-year plans. Among all plans in which achievement was measurable, Near-Limits and Non-Parenting Turnaways were more likely to have both an aspirational plan and to have achieved it than Parenting Turnaways. The authors suggest that ensuring women can have a wanted abortion enables them to maintain a positive future outlook and achieve their aspirational life plans (Upadhyay, Biggs et al. 2015).

The evidence base around the economic impacts of policy or law change is entirely based on evidence from high-income countries, dominated by US studies. We know very little about economic impacts in low- and middle-income countries of policy or law change. More generally, economic impact evidence from LMICs is limited to evidence from a few countries. Many gaps remain in our evidence base around the micro-level economic impacts of abortion, including the indirect economic impact of abortion-related care and the longer term economic impacts – both positive and negative – of abortion-related care.

Micro-economic benefits and value

There are three main groups of studies that deal with the benefits and values of abortion-related care at the micro level (Appendix I):

- Evidence relating to the ways in which laws and policies, including financing and insurance, have benefits and values to women;
- Evidence about the values and benefits of different types of abortion-related care; and
- Evidence derived from women's reasons for having an abortion.

The evidence around the values and benefits of financing – specifically insurance – is US-based and limited to two studies. Qualitative evidence from low-income US women who had an abortion within the past two years shows that when full coverage of abortion in the Medicaid program is available, there is little to no need for women or others in their lives to make financial sacrifices, and there is rarely a scramble for money that provokes feelings of indignity or delays abortion care. The authors conclude that additional evidence is needed to determine if the findings about the benefits of available abortion coverage hold true across the few states where this coverage is available and if there are other unidentified benefits (Dennis, Manski et al. 2014). Survey evidence from US clinic patients seeking an abortion or having an abortion follow-up appointment at purposively sampled facilities suggests that substantial minorities of women who obtained money from abortion funds and family members characterized the experience as "lifesaving," although few women who obtained money from men indicated this response (Jones, Upadhyay et al. 2013).

Evidence about the values and benefits of different types of abortion-related care either uses comparative evidence between surgical and medical abortion (Gibb, Donaldson et al. 1998, Akin, Kocoglu et al. 2005, Hulme-Chambers, Temple-Smith et al. 2018) or considers the perceived benefits of mHealth/telemedicine interventions (Aiken, Gomperts et al. 2017, Aiken, Guthrie et al. 2018, Biggs, Ralph et al. 2018). In Australia, women's reasons for choosing medical abortion in preference to surgical termination varied greatly but the most common responses highlighted the convenience and flexibility of medical abortion and the ability to time it around work and life commitments; the less invasive nature of the process; and that the clinic was the closest location providing medical abortion outside of urban areas (Hulme-Chambers, Temple-Smith et al. 2018). A study from Turkey including women who received either surgical or medical abortion found that women opted for home use of misoprostol rather than clinic use since transportation was a problem. Among women preferring surgical abortion, nearly half said the most important reason for this preference was that it takes a short time. Seven in ten surgical abortion patients said that one of the best features of surgical abortion is that it is done quickly. Among medical abortion patients, 62% reported no surgery as one of the best features, and 25% reported being at home as one of the best features (Akin, Kocoglu et al. 2005).

A UK analysis of women's preferences and strength of preferences (expressed in terms of willingness-to-pay [WTP]) for medical abortion versus surgical vacuum aspiration found that the rating of the importance of choice and social class grouping are the best predictors of WTP. Those with a greater ability to pay do not have systematically different preferences from those with less ability to pay (Gibb, Donaldson et al. 1998). In a similar randomized study using WTP, 90% of women in the medical abortion group and 86% in the surgical abortion group reported being willing to pay, ranging between GBP 40-500 (Howie, Henshaw et al. 1997).

In Ireland/Northern Ireland, a study of women who requested at-home medical abortion through online telemedicine suggests that the experiences of women with few economic and social resources experience inequity in their ability to access safe abortion. Women noted their inability to afford travel abroad, to take time away from children and work, to arrange travel without their families' knowledge, or to travel at all due to migrant status. For some women the need to travel would have caused long delays in accessing care, and for others, it would have rendered care completely impossible (Aiken, Gomperts et al. 2017). Women in the United States were asked about their perceived dis/advantages of three different models of care for medical abortion (advance provision, OTC and online access). For advance provision, OTC and online access, women reported 'could be less expensive' as a potential advantage (35%, 34% and 32%, respectively). For advance provision, OTC and online access, women reported 'could be more expensive' as a potential disadvantage (16%, 20% and 18%, respectively) (Biggs, Ralph et al. 2018). Medical abortion was perceived as safe, practical and cost-effective among pregnant people in Latin America (Zamberlin, Romero et al. 2012) and South Africa (Gresh and Maharaj 2011).

In the larger group of studies dealing with values and benefits evidence derived from women's reasons for having an abortion, the values and benefits included: economic in/ability to afford or cope with a/nother child; pregnancy timing; costs of pregnancy/childbirth (distinct from

costs of a child); partner and others' influences; positive implications for existing children; avoidance of health-related issues; avoiding pregnancy at a young age; continuation of education; and sex-selection.

There is substantial evidence from diverse contexts about the economic values and benefits of avoiding having a/nother child (Johansson, Le Thi Nham et al. 1996, Johnson, Horga et al. 1996, Ahmed, Islam et al. 1999, Belton and Whittaker 2007, Cockrill and Weitz 2010, Aniteye and Mayhew 2011, Banerjee and Andersen 2012, Chunuan, Kosunvanna et al. 2012). In a global review of the reasons women give for obtaining induced abortions in five of the 13 countries for which data existed on the main reason for abortion, limiting childbearing was the most frequently reported reason, ranging from 20% in Nepal to 64% in Azerbaijan (Chae, Desai et al. 2017).

In Cuba, respondents reported that bearing and rearing an "extra" (unplanned) child in light of their financial circumstances made no sense to them. In some instances, participants expressed regret about having to terminate the pregnancy and indicated a desire to have a larger family if they were living under better circumstances. Despite often wanting to have a family, the impracticality of having a child under their current circumstances rendered abortion the logical decision (Bélanger and Flynn 2009). A qualitative case study in South Africa of five women who had induced abortions indicated that four of them considered the detrimental expense of raising a child as a significant dimension of their abortion trajectory (Suffla 1997). In RoI/NI among women who requested at-home medical TOP through online telemedicine initiative, 43.5% said they have no money to raise a child (Aiken, Gomperts et al. 2017). In the US, women described being unprepared to care for a new child in the manner they would like. Often their unreadiness was related to unstable finances, employment or housing, or to their relationship with the man involved in the pregnancy (Margo, McCloskey et al. 2016). In Ghana, the costs of pregnancy/childbirth – as distinct from the costs of raising a child, were of critical importance for university students (Appiah-Agyekum, Sorkpor et al. 2015).

Particularly among adolescents and younger women, the ability to continue with or pursue education, was an important value and benefit of abortion, in settings as diverse as the US (Finer, Frohwirth et al. 2005), Ghana (Aniteye and Mayhew 2011), Brazil (Bailey, Bruno et al. 2001), New Zealand (Fergusson, Boden et al. 2007), Guadeloupe (Flory, Manouana et al. 2014), and India (Ganatra and Hirve 2002).

Relationship issues – whether to avoid violence in a controlling relationship in the UK (Aiken, Guthrie et al. 2018), avoiding becoming a second wife in Ghana (Aniteye and Mayhew 2011), or because of a relationship ended by pregnancy in Colombia (Brack, Rochat et al. 2017) – are layered into the values and benefits that women describe. For unmarried women – whether for issues of stigma in Indonesia (Bennett 2001) or because single motherhood was unaffordable in the US (Finer, Frohwirth et al. 2005) – their marital status further added to the impacts of abortion. Partner-associated reasons – including the influence of a partner's wishes form another component of the benefits and values that can be inferred from women's reasons for abortion in Ghana (Aniteye and Mayhew 2011), India (Kalyanwala, Zavier et al. 2010, Banerjee and Andersen 2012), the US (Chibber, Biggs et al. 2014), Vietnam (Johansson, Le Thi Nham et al. 1996).

Two studies articulated the benefits and values in terms of the positive implications for existing children for a woman to have an abortion in Ireland or Northern Ireland (Aiken, Gomperts et al. 2017) and India (Ganatra and Hirve 2002). The value and benefits of sex selective abortion are inferred – not based on people's reported views – in two studies from Canada (Almond, Edlund et al. 2013) and France (Alouini, Uzan et al. 2002).

Very little evidence specifically uses the language of the economic values and benefits of abortion; much of the evidence included here is based on an interpretation of relevant evidence. Similar to economic costs and impacts, many adolescents and women may perceive or experience multiple intersecting and overlapping values and benefits from abortion (Finer, Frohwirth et al. 2005, Loeber and Wijsen 2008, Margo, McCloskey et al. 2016, Jerman, Frohwirth et al. 2017). We know very little about how the un/wantedness or un/plannedness or ambivalence around pregnancy intersects with economic values and benefits of abortion at the micro-level.

A theme that emerges from the evidence – rarely explicitly (Bennett 2001, Wainer 2008) – is that of identity maintenance as a result of abortion. This is well illustrated by quoting from an Australian study that interviewed women seeking abortion services. The author reports that

the most important change reported by the women was an increased capacity to run their own lives. The women discovered that they could make and carry out difficult decisions, that they could alter the course of events and exert their wishes over their destiny. Single, nulliparous women took mothering seriously and had an abortion to avoid becoming inadequate mothers. Abortion was a challenge to the married women's sense of themselves as good mothers, and their motives related to good mothering. The working class women had histories of managing tough and challenging life events, and they used the strengths, skills and networks they had established and applied those to the abortion decision (Wainer 2008).

Micro-economic costs and consequences of abortion stigma

Costs

Of the 32 included studies with economic outcomes, nearly half examined the implications of stigma on economic cost at the micro level (15/32) (Appendix J). Studies on stigma and the costs of abortion at the micro level were conducted most often in the United States (n=3) and Ireland (n=2). One study examined at the micro-level costs from a global perspective, one a comparative of Burkina Faso and Benin, and the rest of the studies were conducted in individual countries (Bangladesh, India, Hong Kong, Cambodia, Australia, Kenya, Nepal). Evidence on the relationship between stigma and micro-economic cost outcomes came primarily from qualitative studies (n=6) and data from mixed-methods studies (n=5). The synthesis of this data has generated the following two themes regarding the associations between stigma and economic cost at the micro level: (1) The ability to confide in a social support network has an impact on available financial resources to access abortion services; and (2) Abortion stigma can prevent women from accessing accurate information about abortion, which can lead to unnecessary increases in direct and indirect costs.

(1) Women who are unable to confide in and rely on their social support network are less likely to have adequate financial resources to access abortion services (Hung 2010, Baum, White et al. 2016, Aiken, Gomperts et al. 2017). Women who reported having fewer financial resources and a lack of support in seeking abortion services could be due to the fear of being stigmatized by their partner or family members (Baum, White et al. 2016, Aiken, Gomperts et al. 2017). In these cases, women have to make a difficult decision between their desire for confidentiality, the fear of being stigmatized by their social network, and having the financial resources to afford the costs of abortion services. In some cases, lack of financial resources and the fear of stigma from family and friends can prevent some women from seeking abortion services entirely (Wu, Maru et al. 2017).

Conversely, women who could rely on their social support network and received financial support from their partner or family members were able to afford the costs of abortion services. In one study, women who received financial support from family members were able to visit private doctors in confidential settings with higher quality of care (Hung 2010). In addition to the direct cost of service, women's social support networks were found to be essential to help minimize indirect costs associated with clinic visits, including transportation costs and childcare (Baum, White et al. 2016).

(2) *Abortion stigma can prevent women from obtaining correct information about abortion services and laws, which can lead to unnecessary increases in direct and indirect costs of care* (Potdar, Fetters et al. 2008, Doran and Hornibrook 2014). Abortion stigma can make it challenging for women to find accurate and timely information about abortion services. Even in countries where abortion is legal, availability of information on abortion may vary throughout the country (Potdar, Fetters et al. 2008). The desire for secrecy can led people to travel to clinics outside their communities for consultations (Baxerres, Boko et al. 2018). Women may also not feel comfortable asking for information due to the possibility of facing stigma from peers.

Delays in receiving accurate information on abortion services can result in unnecessary increases in direct and indirect costs of care. In Australia, one study participant reported traveling 4 hours for an abortion procedure despite living near a hospital that could have offered the

same service (Doran and Hornibrook 2014). Another study participant had to visit five general practitioners before she was able to receive a referral for abortion services, which significantly delayed the timing of the procedure and resulted in compounded, unnecessary costs (Doran and Hornibrook 2014). Reducing abortion stigma is necessary in order for women to receive accurate information in a timely manner and to reduce costs of service.

More research is needed on how stigma impacts the ability of an individual to find information and their care-seeking behaviors, including directly quantifying the economic effects of stigma on individual costs and opportunity costs in abortion care seeking. The effects of stigma should be better integrated and articulated in studies on economic costs of abortion care. Programmatic interventions aimed at helping with the cost of care should consider the ways in which stigma and available social support networks may impact an individual's ability to access those interventions.

Impact

As detailed in Appendix K, only four articles included data on the economic impact of abortion stigma at the micro level; a significant amount less than the previous section on economic cost and abortion stigma. These studies were conducted in individual countries (Indonesia, Ireland, Columbia, and Zambia). Data was primarily collected through qualitative methods (n=3), though one study used a mixed methods approach. Despite the limited evidence, review of the existing data has been used to develop two emerging themes from the literature highlight the potential economic impact of abortion stigma at the micro level: (1) Having a child without the financial means to support it can lead to greater social stigma than choosing to have an abortion; and (2) Accessing abortion services can lead to loss of employment.

(1) *Having a child outside of marriage, in college, or without the financial means to pay to raise the child can lead to greater social stigma than choosing to have an abortion* (Brack, Rochat et al. 2017, Aiken, Johnson et al. 2018). In Colombia, several study participants claimed that the social stigma attached to having a child in their current unmarried and financial unstable position would outweigh any stigma around having an abortion. The participants also explained that dropping out of school to raise the funds to support a new child would lead to judgement from their families as well (Brack, Rochat et al. 2017). Similarly, study participants in Indonesia said that while they strongly believed that abortion was a sin, it could be acceptable under certain specific circumstances (Bennett 2001). In Ireland, a woman reported a doctor crying after she expressed a desire for abortion and trying to convince her that it was possible to raise a child while at college (Aiken, Johnson et al. 2018). The stigma of having a child when not financially ready to do so was a significant factor in the study participant's decision-making.

(2) Accessing abortion services in a highly stigmatized environment can lead to loss of employment (Moore, Dennis et al. 2018). In Zambia, stigma around receiving abortion services can have a significant impact on a woman's livelihood. One participant mentioned that she travelled to another town to receive abortion care services in an attempt to keep her abortion confidential. However, her employer found out about the procedure and she was ultimately fired from her job as a result (Moore, Dennis et al. 2018).

As seen in both of these emerging themes, abortion care decisions can lead to social stigma and social exclusions, which has clear economic impacts for women. More research is needed to better understand the social stigma and exclusion faced by women and to quantify its economic impacts.

Benefits

Only one of the 32 articles included findings on abortion stigma and economic benefits, which was presented at the micro level (Appendix L). This study was conducted in Cote d'Ivoire and the evidence on the relationship between abortion stigma and benefits were drawn from the qualitative study results. The main emerging theme from this study is: (1) women may act outside of their standard moral or religious values in order to advance their status in society.

(1) *Women may act outside of their standard moral or religious values in order to advance their status in society* (Svanemyr and Sundby 2007). In Cote d'Ivoire, study participants explained how abortion typically fell in strong opposition to their values and norms both in their community and as Muslims. However, they have begun to act outside of their standard moral and religious norms because of a shift in priorities. As Muslim women in Cote d'Ivoire are seeking access to education and financial independence in their communities, they found themselves advocating for abortion access as a means to achieve educational and financial goals for independence (Svanemyr and Sundby 2007).

In general, this scoping review found that more research is needed around the ways in which abortion care and/or related policies provides economic benefits and value at the micro, meso, and macro level. In this area of research, it will be important to understand how abortion and related social norms affect attitudes, behaviors, or how they act as barriers or facilitators to access abortion care.

Meso-economic costs and consequences of abortion

Meso-economic costs

At the meso-economic level, economic costs to health systems are the most frequently reported economic outcome (116/387) (Appendix M). Eighteen of the studies examined abortion costs at the meso-economic level from a global or multi-country perspective. Studies examining meso-economic costs of abortion in a single country show that the evidence base has consolidated around abortion costs in high-income countries to a greater degree than in low- or middle-income countries. Studies on the costs of abortion to health systems and communities are conducted most often in the United States (n=23), United Kingdom (n=12), Mexico (n=4), South Africa (n=4), Australia (n=3), China (n=3), and Uganda (n=3). Evidence on meso-economic costs came primarily from review papers (e.g., literature reviews, systematic reviews) (n=23), economic analyses (e.g., cost-effectiveness analysis, cost estimations, willingness to pay technique) (n=21), and qualitative research (n=19). Across these studies, four themes emerge: (1) within health facilities and health systems, the costs of providing abortion services vary greatly, particularly given the range with which services are identified and costed; (2) financial savings can be realized while maintaining or even improving quality of abortion care services; (3) insurance coverage of abortion services is far from universal; and (4) adapting to changes in laws and policies, particularly targeted regulation of abortion provider laws, is costly for health facilities.

(1) Within health facilities and health systems, costs of providing abortion services vary greatly, particularly given the range with which services are identified and costed (Afable-Munsuz, Gould et al. 2007, Babigumira, Stergachis et al. 2011). Numerous factors influence the costs of providing abortion services in health facilities: the gestational age at which the abortion occurs, the method of abortion (e.g. whether or not anesthesia is required, whether the patient or hospital staff administered medical abortion), the supplies and equipment used, whether contraception is provided, diagnostic tests, management of potential complications, the number of routine follow-up visits required, the number of missed appointments ("no shows"), caseload, frequency of procedures, overhead costs of a hospital stay, the legal environment, regulatory fees, facility type, and facility location (Henshaw 1995, Koontz, Molina de Perez et al. 2003, Duggal 2004, Grossman, Ellertson et al. 2004, Henshaw, Adewole et al. 2008, Font-Ribera, Perez et al. 2009, Díaz-Olavarrieta, Cravioto et al. 2012, Thapa, Neupana et al. 2012, Sethe and Murdoch 2013, Jerman and Jones 2014, Li, Song et al. 2017, Ely, Hales et al. 2018) .

The cost incurred by each of these components may vary greatly even within the same health system. In Mexico, the average cost of treating severe abortion complications in public hospitals ranged from US$ 601 to beyond US$ 2,100 (Levin, Grossman et al. 2009). In Malawi, severe non-surgical abortion-related complications were estimated to cost US$128 and severe surgical complications US$239, whilst abortions cost an estimated US$12-19 dependent on methods (Aantjes, Gilmoor et al. 2018) . Costs to health facilities are increased in locations with patchwork abortion laws. For example, abortion reforms in Mexico's Federal District led women from other states to come seek legal abortions

there; as a result, facilities providing abortion services in the Federal District experienced increases in workloads and costs (Díaz-Olavarrieta, Cravioto et al. 2012). Moreover, in Rwanda, facility type interlinks with geographies, resulting in cost inequalities for PAC services, with regional health facilities charging more (US$239) than district hospitals (US$93) or health centers (US$72) (Aantjes, Gilmoor et al. 2018).

While patients can influence the cost to health facilities of providing abortions through increases in workloads and missed appointments, for example, the health facility costs of providing abortion services also influence patients. The increased costs of providing a second-trimester abortion compared to a first-trimester abortion require clinics to charge higher fees for the procedure, thus potentially delaying or restricting women's access to abortion services (Gallo and Nghia 2007, Foster and Kimport 2013, Payne, Debbink et al. 2013) . It is noteworthy that in many areas in the United States, median charges for abortion remained relatively constant over time; this finding may represent providers' commitments to maintain abortion access and keep services affordable (Jerman and Jones 2014). The influence of patients can also be beneficial to the costs of abortion. In Nepal, procedural costs lessened from US$13.2 in 2005 to US$10.96 in 2010, in part due to the increased volume of people seeking care (Thapa, Neupana et al. 2012).

At least 45 studies costed abortion services or reported costs of abortion services. Significant variation exists in how studies report the costs of abortion to health facilities and the health system (Appendix N), so it is difficult to generalize the findings or make direct comparisons. Studies report on the costs of different methods of abortion (e.g. MVA, D&C, medical abortion, surgical abortion), the costs of abortion in specific locations (e.g. in a nurse-led clinic, in a tertiary hospital), and the type of abortion service (e.g. abortion at 20-weeks gestation, post-abortion care, treatment for septic abortion, treatment of incomplete abortion). Some researchers specify and cost all of the direct and indirect individual components that are involved in the delivery of abortion services, making it easy to understand how the cost was derived (Xia, She et al. 2011). Other researchers do not. Some researchers report the costs for an abortion without specifying the type of abortion (e.g. medical, surgical, early/late gestational age). Other researchers are quite specific about the type service being costed (e.g. manual vacuum aspiration for treating incomplete abortion patients), especially researchers in the United Kingdom who reported costs for different pilot programs (Limacher, Daniel et al. 2006, Sharma and Guthrie 2006, Tupper, Speed Andrews et al. 2007).

In settings where individuals seek unsafe abortions, immense health system resources are required to treat complications resulting from unsafe abortions (Henshaw, Adewole et al. 2008, Parmar, Leone et al. 2017). Public health services often pay for treatment of complications at tertiary hospitals, where costs are greatest (Berer 2000, Ilboudo, Greco et al. 2016). In Ouagadougou, Burkina Faso, the average cost of treating abortion complications in a tertiary hospital (US$ 51.09) was 40% higher than the cost in a secondary-level hospital (US$ 36.50) (Ilboudo, Greco et al. 2016). In Nigeria, while clinic-based MVA and hospital-based MVA are equally effective, hospital-based MVA is the more costly option (Hu, Grossman et al. 2010). Post-abortion morbidity was estimated to cost three times the annual per capital health expenditure in Uganda and five times that in Ethiopia (Aantjes, Gilmoor et al. 2018). When possible, shifting to the provision of simpler procedures to lower-level hospitals or primary clinics would thus minimize costs and lead to financial savings among health systems.

(2) Financial savings can be realized while maintaining or even improving quality of abortion care services (Billings and Benson 2005, Afable-Munsuz, Gould et al. 2007, Benson, Okoh et al. 2012, Battistelli, Magnusson et al. 2018). Reducing costs to health facilities and health systems does not mean reducing the quality of care. For example, without sacrificing quality, it is possible to reduce costs by choosing a local generic abortifacient rather over an imported one (Berer 2005). Health systems can also reduce costs by shifting the location in which abortion care services are provided. In Mexico, shifting from hospital-based MVA to clinic-based MVA would save the health system nearly US$ 100,000 per 1,000 women (Hu, Grossman et al. 2009). In the United Kingdom, shifting outpatient consultations to a nurse telephone clinic service could reduce costs per patient by 18% while simultaneously providing patients with greater convenience (Sharma and Guthrie 2006). In the UK, misoprostol costs GBP 1 per dose, compared to previously used gemeprost, which cost GBP 20 per 1mg pessary, with both being equally effective (Thomas,

Paranjothy et al. 2003). Using a local anesthetic outpatient clinic reduced use of the operating room to one abortion list per week, thus generating approximately GBP 60,000 in annual savings (Pillai, Welsh et al. 2015). Health facilities can even improve service delivery whilst reducing their costs of service delivery. In two Latin American study sites, reorganizing services to an outpatient basis resulted in reductions in the average length of patient stay and significant financial savings that facility administrators were then able to pass on to patients via fee reductions (Billings and Benson 2005).

With treatment of post-abortion complications consuming a significant proportion of health system resources in many settings, decentralizing services and legalizing abortion can produce significant financial savings. Financial models from Uganda show that moving from a conventional, legally restrictive setting to a planned, decentralized, legally permissive setting decreased the mean cost per unsafe abortion complication case by 86% from US$ 45 to US$ 6 (Johnston, Gallo et al. 2007). Offering menstrual regulation care can also reduce the cost of treatment for severe abortion complications, since menstrual regulation care costs 8-13% of the cost of treating severe abortion complications (Johnston, Oliveras et al. 2010). When feasible and appropriate, service delivery for PAC can be moved from an inpatient basis to an outpatient basis. Outpatient MVA for PAC is less expensive than inpatient dilation and curettage, according to findings from multiple studies in Africa and Latin America (Singh 2010, Benson, Okoh et al. 2012).

Given that clinical staff costs tend to be highest for physicians, facilities in which abortion services are provided by a range of providers (e.g. nurse practitioners, physicians' assistants) were able to keep staff costs low without sacrificing time with patients (Afable-Munsuz, Gould et al. 2007). In the United Kingdom, a nurse-led service for termination of pregnancy could maintain the clinic in its current form while saving nearly 40% in costs annually compared to a medically-led clinic with a staff-grade doctor (Harvey and Gaudoin 2005). However, task shifting has logistical and financial costs that can raise health faculties' expenses in the short-term (Battistelli, Magnusson et al. 2018). In the United States, physicians' hourly wages directly impacted the cost differentials of abortions methods. A physician's hourly wage at three times that of a physician assistant would make surgical abortion 10% more expensive than medical abortion; a wage of only two times more would make the cost of surgical and medical abortions equivalent (Creinin 2000). Removing administrative barriers that limit trained midwives' ability to provide routine post-abortion care services and implementing a policy on task shifting could free up physicians to focus on more complicated cases (Benson, Okoh et al. 2012). Yet, the setting (e.g. rural facility) and context (e.g. supply chain, sustainability) must be considered when assessing the feasibility of task shifting. Low-volume, low-income nurse midwives in Ghana reported less sustainable access to MVA than physicians (Graff and Amoyaw 2009).

Costs of providing medical abortion and surgical abortion can be quite similar in some settings, like China (Gan, Zhang et al. 2011). As a result, abortion providers do not need to factor in remuneration when recommend a method to patients. In other settings, however, the costs of providing medical and surgical abortion differ. Surgical abortion in the British National Health Service cost more than medical abortion due to inpatient standard costs and used 8% more resources than medical abortion (Gibb, Donaldson et al. 1998, Robson, Kelly et al. 2009). Costs and savings from surgical abortion techniques also vary by setting. Numerous hospitals in Asia and Latin America also found MVA to produce significantly lower costs to health facilities than sharp curettage (Koontz, Molina de Perez et al. 2003, Choobun, Khanuengkitkong et al. 2012). In El Salvador, an MVA procedure and hospital stay (US$ 54) cost 13% less than sharp curettage and reduced patients' time in hospital by 28% (Koontz, Molina de Perez et al. 2003). In some African countries, the reverse was found: dilation and evacuation was less expensive than medical abortion in South Africa (Lince-Deroche, Constant et al. 2015).

(3) *Insurance coverage of abortion services is far from universal*. Health insurance and public health system effectively disincentivize abortion outright or disincentivize certain methods of abortion, particularly medical abortion. Because Australian insurance companies that provide medical indemnity initially assessed the risks of medical and surgical abortions to be the same, physicians considering incorporating medical abortion into their practices experienced a prohibitive increase in their medical indemnity insurance (Baird 2015). Once this issue was

resolved in 2014, medical abortion access in rural areas improved. In some countries, such as Germany and the United Kingdom, the public health systems have not covered the costs to physicians and health facilities of providing medical abortion using Mifegyne (RU 486) (Crighton and Ebert 2002). When combined with a requirement for special licenses to offer medical abortion services and the high costs of purchasing Mifegyne, the economic disincentives resulted in surgical abortion becoming the more economic method (Crighton and Ebert 2002). These decisions limit patients' access to the full range of abortion care services.

In the United States, private insurance coverage of abortion is restricted in some states, and not all clinics accept third-party payers (Jones and Weitz 2009). When subsidized or public insurance programs like Medicaid exist, staff members at abortion facilities may play an important yet underutilized role in helping patients enroll (Dennis, Manski et al. 2014). Even when women can obtain Medicaid coverage of abortion, providers are not guaranteed reimbursement for qualifying abortions. In six states where Medicaid coverage of abortion is limited to cases of rape, incest and life endangerment, providers were reimbursed for only 41.6% of abortions that should have qualified for Medicaid reimbursement (Kacanek, Dennis et al. 2010). Student health centers in California reported being unaware of medical abortion provision, despite the student health insurance covering abortion services (Raifman, Anderson et al. 2018). In Massachusetts, Medicaid reimbursements do not increase with the increase in costs of abortions post 20-weeks' gestation, confounding costs of later abortions (Haddad, Yanow et al. 2009).

Policies to implement safe abortion services in the public sector can backfire if provider reimbursement is insufficient. Following passage of the Safe Abortion Service Guidelines of 2016 in Nepal, provider reimbursement for free abortion services under the national government scheme was less profitable than abortion services in which clients paid out of pocket (Wu, Maru et al. 2017). Financial incentives could motivate providers to perform abortions in the private sector rather than the public sector, thus reducing access to abortions in public facilities.

(4) Adapting to changes in laws and policies, particularly targeted regulation of abortion provider laws, is costly for health facilities. Following implementation of a new targeted regulation of abortion provider law in Texas, the cost of providing an abortion increased: from 2001 to 2006, the cost of providing an abortion at 20 gestational weeks increased by 37% (US$ 454) compared to other states (Colman and Joyce 2011). Laws can also target the cost of providing a particular type of abortion. In Texas, House Bill 2 increased the cost of medical abortion in most facilities by requiring providers to choose between a drug regimen that was considerably more expensive than the evidence-based regimen or a drug regimen supported by limited evidence (Grossman, Baum et al. 2014). The Partial-Birth Abortion Ban Act (2003), upheld in 2007 by the Supreme Court of the United States, led to three facilities in Massachusetts increasing their charges for second trimester abortion services (Haddad, Yanow et al. 2009).

Meso-economic impacts

Of the 40 studies that reported economic impacts of abortion at the meso-economic level (Appendix O), 28 studies reported impacts on the health system, including on health providers. One-third of the studies examined abortion from a global or multi-country perspective. Studies examining economic impacts of abortion in a single country were most frequently conducted in the United States (n=8), Mexico (n=3), and India (n=2). Evidence came from review papers (e.g., literature reviews, legal reviews, systematic reviews) (n=12), interviews (n=11), and economic analyses (e.g., cost-effectiveness analysis, cost estimations) (n=5). Across these studies, four themes emerged: (1) limited resources negatively affect health facilities' ability to meet client demand and to provide quality abortion care services; (2) American policies on abortion economically impact health systems and facilities both domestically and abroad; (3) a disproportionate amount of health facility resources are required to provide post-abortion care; and (4) switching abortion techniques in health facilities can have positive or negative economic impacts, depending on the reason behind the change.

(1) Limited resources negatively affect health facilities' ability to meet client demand and to provide quality abortion care services. Studies examining the economic impact of limited resources for abortion focused on the impact of staff shortages, insufficient physical resources, low Medicaid reimbursement rates, and costly regulations. Shortages of trained staff affected patient care in countries of all income levels. In France, a hospital lacked trained staff to meet patients' needs for psychological help (Alouini, Uzan et al. 2002). In Kenya, gaps in capacity resulted in longer hospital stays and increased costs of care to the health system (Mutua, Manderson et al. 2018). In Malawi, staff shortages resulted in one or two nurses covering up to 70 patients and the discontinuation of manual vacuum aspiration due to nurse shortages and limited on-the-job training for interns (Cook, de Kok et al. 2017). A large, potentially increasing proportion of unsafe abortion admissions stretches human resources even further, leading health care staff to likely prioritize the easier option over the patient's best interests (Cook, de Kok et al. 2017).

Shortages of physical resources, like manual vacuum aspiration instruments, lead health care providers in Malawi to automatically resort to dilation and curettage even though dilation and curettage is more expensive, is slower and more difficult to perform, requires more staff, and results in more in-patients (Cook, de Kok et al. 2017). Medication stock-outs due to poor supply chain management has resulted in women in Nepal being denied legal abortions (Wu, Maru et al. 2017).

Financially, rates of reimbursement varied. However, some providers in the United States experienced Medicaid reimbursement rates so low that the rates would put providers out of business: one provider was reimbursed only US$ 212 for an abortion that cost US$ 420 (Kacanek, Dennis et al. 2010). Medicaid reimbursements did not always respond to legislative changes: in Massachusetts, following the Partial-Birth Abortion Ban Act (2003), second trimester abortions increased in price, while Medicaid coverage remained at pre-ban levels (Haddad, Yanow et al. 2009). To minimize the financial impact of Medicaid's insufficient reimbursement rates, providers depended on abortion funds, minimized their work with Medicaid, or avoided Medicaid outright by absorbing up to US$ 60,000 annually in free or reduced-cost services (Kacanek, Dennis et al. 2010).

Due to costly regulations, existing health facility resources may be stretched to the point where facilities must accommodate a smaller clientele or close their doors. In numerous countries, funding cuts due to the Global Gag Rule resulted in disruptions to the provision of sexual and reproductive health services, and clinic closures affected hundreds of thousands of underserved clients whose needs are not met by public health services (Crane and Dusenberry 2004, Sagala 2005). In the United States, requiring abortions to be performed in ambulatory surgical centers would cost a facility over US$ 750,000 to comply with the regulations' physical renovations; as such, these costly requirements may result in providers stopping abortions or significantly raising the prices so that quality abortion care is beyond some women's reach (Jones and Weitz 2009).

(2) American policies on abortion economically impact health systems and facilities both in the United States and abroad. Domestically, abortion legislation hinders or prevents health providers from performing abortions by influencing the demand of abortion care and increasing the costs of care. The implementation of House Bill 2 in Texas led clinics to close and increased the average clinic service population from 150,000 clients to 290,000 clients (Cunningham, Lindo et al. 2017). This increase in service population was felt especially by urban clinics. In Dallas-Fort Worth, the average service population increased by 250,000 clients (Cunningham, Lindo et al. 2017). As a result of clinic closures, the remaining clinics were unable to meet demand for abortion services and deliver the same quality of care as before the law ("Fourteenth Amendment" 2016). In North Carolina, abortion providers attempted to minimize the burden of new regulations on patients by implementing telephone counseling in place of two in-person clinic visits (Mercier, Buchbinder et al. 2016). Telephone counseling required significant adaptations, including hiring additional nurses, developing call-center infrastructure, and changing scheduling and work tasks. By explicitly deciding to absorb the financial burden of these changes rather than pass them on to patients, providers worked more hours uncompensated or fundraised to support the increased costs (Mercier, Buchbinder et al. 2016). Clinics are occasionally unable to absorb the financial burden of abortion regulations, particularly when regulations require costly physical renovations. In these cases, providers may stop performing abortion or may increase their prices beyond some clients' reach (Jones and Weitz 2009).

Abroad, the economic impact of American abortion policies extends beyond abortion care. In addition to staff terminations and clinic closures that may particularly affect rural clinics, the Global Gag Rule resulted in the termination of contraceptive supply shipments in 29 countries and programmatic cuts (e.g. to maternal health and well baby care, youth outreach, HIV/AIDS prevention) (Crane and Dusenberry 2004, Sagala 2005, Jones 2015, Wu, Maru et al. 2017).

(3) A disproportionate amount of health facility resources are required to provide post-abortion care. Studies agreed that the costs of post-abortion care were a burden to health systems, requiring a disproportionate amount of health facility resources and stretching overstretched health system resources (Berer 2000, Billings and Benson 2005, Vlassoff, Walker et al. 2009, Coast, Norris et al. 2018). Some studies reported the use of physical resources for post-abortion care, such as up to 50% of hospital gynecological beds in Bangladesh or 25% of the main hospital's blood supply before Guyana liberalized its abortion law (Berer 2000). Other studies reported financial costs of post-abortion care: more than seven times the Tanzanian Ministry of Health's annual per capita budget (Berer 2000) or more than half of facilities' budgets for obstetrics and gynecology (Billings and Benson 2005). Estimates of the annual health system costs of post-abortion care in Africa and Latin America are considerable, ranging from US$ 159 million to US$ 476 million (Vlassoff, Walker et al. 2009).

To reduce the number of patients seeking post-abortion care, it is cost effective to expand contraceptive services and supplies and to provide menstrual regulation and related care. If health systems provided contraceptive services and supplies to prevent unintended pregnancies that result in unsafe abortions, data from Nigeria show that compared with the cost of post-abortion care, the cost-benefit ratio is US$ 4 to US$ 1 (Singh 2010). In Bangladesh, menstrual regulation prevents unnecessary and expensive complications from unsafe abortions, with each case costing the health system a fraction (8-13%) of the cost of treatment for severe abortion complications (Johnston, Oliveras et al. 2010).

(4) Switching abortion techniques can have positive or negative economic impacts on health facilities, depending on the reason behind the changes. Switching abortion techniques (e.g., performing abortion in ambulatory surgery centers, mandating multiple clinic visits) may result in negative economic impacts on health facilities when the changes result from laws designed to make abortion more expensive and difficult to provide (Jones and Weitz 2009, Mercier, Buchbinder et al. 2016). Other times, directives aimed at improving one aspect of abortion services, such as minimizing complications, may negatively impact a different aspect of abortion services. For example, by requiring abortion in Moldova to be performed by obstetrician-gynecologists in hospitals, hospitals had to centralize their services that resulted in higher costs of care and decreased client access to abortion (Comendant 2005).

Changes in abortion techniques can also facilitate financial savings and the expansion of abortion services. In Nepal, medical abortion has expanded access to first-trimester abortion in rural areas, since it does not require facilities to have capacity for surgical abortion (Wu, Maru et al. 2017). In Sweden, a randomized-controlled equivalence trial found provision of medical abortion by nurse-midwives superior to provision by physicians: provision by nurse-midwives was more efficacious and less expensive (Sjostrom, Kopp Kallner et al. 2016). In Malawi, manual vacuum aspiration delivered cheaper (i.e. financial and human resources), easier, and faster abortions (i.e. time to perform the abortion and time to discharge) than dilation and curettage (Cook, de Kok et al. 2017). In Latin America and the Caribbean, however, dilation and curettage produced similar outcomes to manual vacuum aspiration; a reduction in opportunity costs and an increase in service efficiency happened only after the reorganization of services (Billings and Benson 2005).

(5) Complex systems impact abortion-related trajectories of pregnant people. Health system requirements (e.g. prescriptions) and responses to new abortion methods (e.g. medical abortions) impacts the pathways of pregnant people. Where misoprostol is sold with prescription only, pregnant people in Latin America would either have to pay for prescriptions, lie to providers about intended use, ask a third party to obtain a prescription or seek medication through unregulated channels (Zamberlin, Romero et al. 2012). In Brazil, inflated commercial values of

misoprostol and the price fluctuations dependent on facility type encourage non-facility-based procurement, with prices reported as high as US$ 144 despite the mean cost of misoprostol being US$ 6 (Costa 1998). A study of Caribbean states found that hospital-based gynecologists sought to control the provision of Cytotec (misoprostol), whilst abortion providers admitted that the cost of abortions led them to recommend pregnant people buy medications from pharmacies and return to them in case of complications (Pheterson and Azize 2005). The permittance of conscientious objections in Mexico has led to suggestions that objections were based on financial incentives, with providers objecting in public facilities but providing abortion care in their private facilities (Contreras, van Dijk et al. 2011). Where health systems regulations interfere with access to abortion, pregnant people face more complex pathways to obtaining care, including pathways – e.g. seeking medical abortion via unlicensed providers – that might increase potential associated risks.

In reviewing data on studies that reported economic impacts of abortion at the meso-economic level, economic impacts of abortion on communities are rarely studied. The paucity of evidence on this topic does not align with the frequency that abortions occur in communities or the potential economic impact of unsafe abortions on communities. Two studies (2/312) reported the economic impact of abortion on communities, broadly speaking. In New Brunswick, Canada, a regulation from 2015 insufficiently mitigated challenges resulting from the province's refusal to fund abortion care in health clinics (Foster, LaRoche et al. 2017). Researchers found that even if the province completely eliminated the two-physician requirement, the resulting impact on access to affordable, timely abortion care would be marginal (Foster, LaRoche et al. 2017). In India, evidence from a study on prenatal sex selection found that regions with an increasing male-female sex ratio experienced an increase in families' parental education, an increase in maternal age at first birth, and a decrease in the likelihood of rural residence (Hu and Schlosser 2010). The researchers found no association between male-female sex ratio and household wealth index.

Meso-economic benefits and value

Among the 28 studies reported economic benefits or value of abortion at the meso-economic level (Appendix P), studies were most frequently conducted in Mexico (n=5) and the United States (n=3). Evidence came from a variety of study designs ranging from legal analysis to cost-effectiveness analysis to computer-based model simulation. Across these studies, two themes emerged: (1) the benefits of abortion differ by method; and (2) health systems often, but not always, respond to women's needs around abortion.

(1) The benefits of abortion differ by method (Thapa, Poudel et al. 2004, Hu, Grossman et al. 2009, Hu, Grossman et al. 2010, Cheng, Zhou et al. 2012, Pillai, Welsh et al. 2015, Sjostrom, Kopp Kallner et al. 2016, Upadhyay, Johns et al. 2017). Multiple studies compare the benefits of surgical abortion methods to medical abortion methods. The health system benefits, often reported in terms of cost and efficacy, vary depending on where the study occurred. In Nigeria, manual vacuum aspiration in clinics was the least expensive and most effective option relative to unsafe abortion, whereas in Ghana, medical abortion was the most cost-effective option relative to unsafe abortion (Hu, Grossman et al. 2010). In the United Kingdom, replacing surgical abortion procedures in the operating room with manual vacuum aspiration resulted in an annual savings of GBP 60,000 (Pillai, Welsh et al. 2015). In China, 33.1% of rural abortion providers and 38.1% of urban abortion providers reported that an advantage of medical abortion is that it is less expensive than surgical abortion, in addition to medical abortion also being a low-risk alternative without surgery and anesthesia (Cheng, Zhou et al. 2012).

Within-method benefits can be further enhanced by task shifting, service reorganization, and streamlining. In Sweden, task shifting of medical abortion from physicians to nurse-midwives produced direct economic benefits: shorter time providing care, lower salaries among nurse-midwives than physicians, shorter waiting times among patients, and a potentially lower cost to treat complications (Sjostrom, Kopp Kallner et al. 2016). Reorganizing services by treating clinically eligible patients in the manual vacuum aspiration unit rather than the main operating room could free up needed hospital beds by shortening patients' stays and free up physicians and anesthesiologists for other cases (Thapa, Poudel et al. 2004).

Streamlining the protocol for medical abortion to two or three clinic visits rather than four visits, as required in Mexico City in 2005, would reduce the costs of medical abortion without affecting patient safety (Hu, Grossman et al. 2009).

Of course, providing safe abortion instead of unsafe abortion is the most significant factor to improve health outcomes and economic outcomes (Levin, Grossman et al. 2009, Hu, Grossman et al. 2010). Reducing unsafe abortion by increasing access to safe abortion can reduce the costs of care and significantly benefit health systems. In two public referral hospitals in Ouagadougou, Burkina Faso, the hospitals would have saved over US$ 19,778.53 in 2010, had safe abortion care services been available (Ilboudo, Greco et al. 2016). In Mexico City in 2005, a modest increase in access to manual vacuum aspiration would improve access to safe abortion and result in savings of over US$ 50,000 among the three public hospitals and one private clinic being studied (Levin, Grossman et al. 2009).

(2) Health systems often, but not always, respond to women's needs around abortion (Johnston, Ved et al. 2003, Garcete and Winocur 2006, Winocur 2006, Hu, Grossman et al. 2009, Díaz-Olavarrieta, Cravioto et al. 2012, Dennis, Manski et al. 2014, Jarlenski, Hutcheon et al. 2017, Upadhyay, Johns et al. 2017). In settings where policies and laws do not restrict discussions about abortion to clients and providers in facilities providing abortion, a range of health providers can respond to women's needs for pregnancy options counseling and referrals to abortion clinics (Dennis, Manski et al. 2014). By offering medical abortion patients alternative forms of follow-up care (e.g. phone calls, internet communication), health systems may support patients' preferences and needs while simultaneously experiencing potential cost-savings resulting from patients being less likely to seek follow up care from emergency departments (Upadhyay, Johns et al. 2017). In Mexico, liberalizing abortion laws to permit abortion due to rape resulted in a statistically significant increase in women accessing induced abortion in the public sector (Garcete and Winocur 2006). Responding to women's needs around abortion includes expanding access to health insurance that includes abortion coverage. In the United States, state Medicaid coverage of medically necessary abortion reduced the risk of severe maternal morbidity by an average of 16% (Jarlenski, Hutcheon et al. 2017).

At times, the health system fails to meet women's needs around abortion. Access barriers may prevent women from obtaining legal abortions (Winocur 2006). Existing abortion services may be inappropriate or even harmful, lack appropriate referrals, and deliver limited knowledge on contraceptive methods to post-abortion patients (Johnston, Ved et al. 2003). Providers' values may result in a double discourse around abortion. Providers who consciously object to providing abortion in the public sector may willingly overlook these public values to perform abortions in the more profitable private sector (Díaz-Olavarrieta, Cravioto et al. 2012).

Meso-economic costs and consequences of abortion stigma

Costs

The implications of stigma on economic cost is the frequently reported outcome at the meso level (10/32 (Appendix Q). This is similar to the result found at the micro level, though there were a few more articles with cost data at the micro level (15/32). However, we did find that results between micro, meso, and macro level frequently overlapped because stigma is often experienced between an individual and their families, their communities, and/or the health care system. Studies on stigma and the costs of abortion at the meso level were conducted most often in the United States (n=3) while the rest of the studies were conducted in individual countries (Indonesia, Colombia, Poland, Zambia, Mexico, India, Kenya). Evidence on the relationship between stigma and meso-level cost outcomes came mostly from qualitative studies (n=5) followed by mixed methods (n=2), as well as one cohort study and one regression analysis. Review of the evidence within these six articles has generated the following two themes: (1) Stigma from communities and healthcare providers can lead women to abortion care services outside the formal sector, which can have a significant impact of the cost of abortion services; and (2) Insurance companies can create a financial barrier to safe abortion services.

(1) *Community and provider-based stigma around abortion can lead women to abortion care services outside of the formal sector, which can have a significant impact on the cost of abortion services* (Bennett 2001, Ganatra and Hirve 2002, Chełstowska 2011, Marlow, Wamugi et al. 2014, Coast and Murray 2016). Pervasive community-based and perpetuated stigma can lead women to seek abortion services outside of the public sector, which can result in exorbitant, unregulated service fees. Providers outside of the formal sector can capitalize on abortion stigma, using it to charge unofficial and illegal fees to women who are in desperate need of confidential services (Coast and Murray 2016).

In Poland, public-sector doctors will refuse to provide safe, affordable care in their facility because the doctors count on women to "cope" with their abortion needs in the private sector (Chełstowska 2011). Some of these same doctors will refuse to provide care just to refer them to their own private practice. The private practice of abortion services is unregulated and untaxed, which can be an appealing source of income for some providers (Chełstowska 2011). In one study in India, providers would refer to abortion services requested by unmarried adolescents as "illegal" services, even though these cases are legal under the abortion law in India (Ganatra and Hirve 2002). Some providers mentioned that unmarried women were also charged, on average, three to five times the normal rate for an abortion.

One participant from a study in Kenya said that some public-sector providers are willing to provide abortion services, but they only perform those services in their own private practice and for a considerable sum of money, noting that the cost of the service tends to depend on the demand for the service and whether the patient appears to have the means to pay (Marlow, Wamugi et al. 2014). As long as unofficial payments are made outside of the formal health sector, it will continue to be challenging for women to know how much an abortion should cost as well as their legal right to obtain that service within the formal sector (Coast and Murray 2016).

Additional research is needed on how stigma affects the availability and costs of services, particularly in unregulated markets. Governments and NGOs should address ensuring full and accurate information on costs of abortion care, implementing regulations for abortion care payments, and providing funding mechanisms that ensure access to care.

(2) *Insurance companies can create a financial barrier to safe abortion services* (Brack, Rochat et al. 2017). One study in Colombia found that insurance companies, and more specifically company representatives, acted as a barrier to safe, affordable abortion care (Brack, Rochat et al. 2017). This study found that some company representatives refused to provide accurate information about coverage for abortion services, even though they were legally obligated to both provide the information and cover the procedure. It was found that the representatives were religiously motivated to not provide abortion service information (Brack, Rochat et al. 2017). Although this is an emerging theme based on one study, it could lead to significant findings in a focused review of literature around denied or delayed insurance claims despite legal obligation to cover abortion services.

Impact

Four articles included data on the economic impact of abortion stigma at the meso level (Appendix R). A majority of the articles took place in high-income countries (Canada, United Kingdom, United States). Evidence on economic impact of abortion stigma at the meso level was collected through qualitative studies (n=3) and a cross-sectional survey (n=1). Despite the relatively limited evidence, review of the existing data has been used to develop two emerging themes from the literature highlight the potential economic impact of abortion stigma at the meso level: (1) Refusal to provide abortion services or referrals can result in significant delays in care; and (2) Providers may not provide adequate information to women if they have incorrect information regarding public funding for abortion services.

(1) *Refusal to provide abortion services and/or referrals can result in significant delays in care* (Gerdts, DeZordo et al. 2016, Foster, LaRoche et al. 2017, White, Adams et al. 2019). Providers who refuse to provide care or referrals, despite the legal availability of abortion, can lead to significant delays in care. In a study in the United Kingdom, four women reported seeking abortion outside of their home country because of the procedural barriers to legal abortion care (Gerdts, DeZordo et al. 2016). One of the greatest barriers was the obstruction of access to care by clinicians, many of whom refuse to provide care due to their own personal beliefs. In various settings where abortion services are legally permitted,

some abortion providers reported harassment or faced stigma from their colleagues. For example, in Mexico City, obstructing providers and other healthcare professionals would create an atmosphere of hostility in the facility, resulting in longer wait times for abortion services (Contreras, van Dijk et al. 2011).

A study participant in Canada explained how their doctor refused to provide care or refer to another facility because it was against their beliefs (Foster, LaRoche et al. 2017). Others were unable to get referrals from their doctors to receive abortion services in the hospital, which would have been covered by Medicare, because of the doctor's personal beliefs. Even in cases where providers do not hold personal views against abortion, perceptions of abortion opposition in the community can lead facility staff to withhold information about available services to women (White, Adams et al. 2019).

It is important to continue to investigate how refusals to provide abortion care are defined by providers and communicated the their patients (Gerdts, DeZordo et al. 2016), and to determine the overall economic impact on women and their decisions around care.

(2) *Providers may not provide adequate information to women if they have incorrect information regarding public funding for abortion services* (White, Adams et al. 2019). In the United States, confusion regarding state funding and rules regarding abortion that can jeopardize that funding can lead to procedural barriers for women (White, Adams et al. 2019). Facility staff may be reluctant to provide women with information about abortion out of fear that sharing information could threaten their state family planning funding. In an effort to protect their facility and livelihood, some providers may withhold critical, timely information to their patients regarding abortion-related care. Although this is just an emerging theme based on one study, it could be beneficial to investigate further the economic impact of withholding information and/or services based on a lack of clarity around state funding and quantify the extent to which this happens in care settings.

Macro-economic costs and consequences of abortion

Macro-economic costs

As shown in Table 6, our scoping review resulted in 97 articles containing data on the economic costs of abortion care services and abortion policies at the macroeconomic level. This is a substantial amount of evidence. The process of synthesizing this knowledge generated the following four major themes around the economic costs of abortion at the macro level: (1) post-abortion care services are expensive and constitute a substantial portion of health budgets; (2) public sector coverage of abortion costs is scattered around the world, and women often wind up bearing most of the financial costs; (3) restrictive abortion regulations impose financial hardships on women, often resulting in costly delays; and (4) some countries are actively working to provide more cost-effective and innovative options for women seeking abortion services. Of the total of 97 articles with data on the economic costs of abortion, 17 articles had information related to the first theme, 39 articles had data on the second theme, 24 articles related to the third theme, and 17 articles had information on this fourth theme.

(1) Post-abortion care services are expensive and absorb a large portion of health budgets. The accumulated available evidence indicates that many abortions in countries with highly restrictive policies are unsafe and require post-abortion care. Unsafe abortion is a major public health problem, especially in contexts where access to legal abortion is highly restricted. An estimated 7.9% (4.7%-13.2%, 95% C.I.) of maternal deaths are due to unsafe abortion (Say, Chou et al. 2014); unsafe abortion is also a leading cause of maternal morbidity. Globally, almost 300,000 maternal deaths occur each year (Kassebaum, Bertozzi-Villa et al. 2014, Say, Chou et al. 2014). In a comprehensive analysis of maternal mortality around the world using data from 2003 to 2009, Say and colleagues (2014) found that abortion accounts for a higher percentage of maternal mortality in Latin America and the Caribbean than in any other region, followed closely by Sub-Saharan Africa. About 10 percent of all maternal mortality in Latin America and the Caribbean is caused by abortion. This region also has the most restrictive national abortion legislation in the world (Rodgers 2019). In contrast, abortion is found to cause less than one percent of maternal mortality in East Asia, a region with higher income and less

restrictive abortion laws. Note that deaths due to unsafe abortion may be even higher given the likely under-reporting of abortion and the misclassification of abortion as hemorrhages and hypertension disorders (Gerdts, Vohra et al. 2013, Say, Chou et al. 2014).

As a result of efforts by large NGOs such as Ipas and IPPF to prioritize post-abortion care and donor funding for such services, post-abortion care has become the de facto solution to the problem of unsafe abortions. Approximately 50 countries have formal programs for post-abortion care (Suh 2018). At the macro level, the total cost of post-abortion care to public health systems in many countries is substantial. A good portion of this evidence at the macroeconomic level (5 out of a total of 17 articles) comes from Michael Vlassoff and his co-authors. In particular, Vlassoff et al. (2009) estimate that US$171 million is spent annually to treat abortion complications in Africa (Vlassoff, Walker et al. 2009). Additional estimates for a sample of four countries indicate that the total cost of post-abortion care per case ranges from $334 in Rwanda to $972 in Colombia, which constitutes up to 35 percent of annual per capita income depending on the country (Vlassoff, Singh et al. 2016). Governments would save money by refocusing their efforts on providing women with more access to modern contraception. The cost of meeting a woman's unmet need for modern contraceptive supplies and services for one year would amount to just 3 to 12 percent of the average cost of treating a patient who requires post-abortion care (Vlassoff, Singh et al. 2016). In Ethiopia, the annual cost of providing post-abortion cost at the national level, including both direct and indirect costs and satisfying all demand, totals $47 million per year, which comprises a substantial portion of total national expenditures on reproductive health (Vlassoff, Fetters et al. 2012). Using a similar methodology, Vlassoff and his coauthors estimate this cost to be $20.8 million per year in Uganda (Vlassoff, Mugisha et al. 2014) and $2.5 million per year in Rwanda (Vlassoff, Musange et al. 2015).

Studies by other authors also find high post-abortion costs. In Zambia, post-abortion care following an unsafe abortion can cost the health system 2.5 times more than safe abortion care (Parmar, Leone et al. 2017). Other countries for which relatively high post-abortion care costs have been documented include Burkina Faso (Ilboudo, Greco et al. 2016), Malawi (Benson, Gebreselassie et al. 2015), Nigeria (Erim, Resch et al. 2012), South Africa (Kay, Katzenellenbogen et al. 1997), Colombia (Prada, Maddow-Zimet et al. 2013, Rodriguez, Mendoza et al. 2015), and Bangladesh (Johnston, Oliveras et al. 2010, Johnston, Akhter et al. 2012). Costs of care for abortion-related morbidity represented three times the annual per capita health expenditure in Uganda and five times in Ethiopia (Aantjes, Gilmoor et al. 2018). Furthermore, a review of post-abortion care services in seven Latin American countries indicates that treating women who come in with incomplete abortions comprises over half of all the hospitals' budgets for obstetric and gynecological care (Billings and Benson 2005). A similar estimate is derived for Latin America, with findings that treating post-abortion complications can absorb more than half of a healthcare system's expenditures on obstetric care and cost up to $108 million per year to healthcare systems throughout the region (Dzuba, Winikoff et al. 2013).

(2) Public sector coverage of abortion care services is scattered and women often bear most of the financial costs. The cost of obtaining an abortion can be relatively high, especially for low-income women. Very few countries have public sectors that fully cover the financial costs of obtaining an abortion, resulting in large numbers of women globally who are forced to come up with the resources to pay out-of-pocket for abortions. Access to financial resources is particular crucial for women in countries that have banned abortion so that women can access medically-supervised abortion services (Coast, Norris et al. 2018). In countries where abortion is illegal, public health services may absorb the cost of post-abortion care, often in relatively expensive tertiary-level hospitals, but they do not cover access to safe abortions (Berer 2000). Closely related, a number of studies have estimated cost savings if more safe abortions were provided by the public sector. For example, South Africa's public health sector could save over $28 million in a 10-year period if women had access to more cost-effective safe abortion services (Lince-Deroche, Constant et al. 2018). A related strain of this literature estimates cost savings to society from abortion services that have reduced the need for medical and social welfare costs of pregnancies carried to term among at-risk women (Murthy and Creinin 2003).

Those countries that do use public sector funding to cover all or a large portion of the costs of abortion tend to be high-income economies, including Australia (Baird 2017), Canada (Almond, Edlund et al. 2013) and the United Kingdom (Davey 2005, Montouchet, Trussell et al. 2013). Overall, of all countries with liberal abortion laws, 34 countries have full public funding for abortion, 25 countries have partial funding, and 21

countries have no funding at all or only under exceptional cases (Grossman, Grindlay et al. 2016). A disproportionate share of countries providing full public funding are high-income countries. Among lower-income countries, Nepal stands out for having recently instituted a set of safe abortion guidelines that include free abortion services at all government facilities (Wu, Maru et al. 2017). India (where abortion is legal) also provides free abortion services in the public sector, although some states have started to charge various user fees and allowed public providers to have private practices. These changes have resulted in an average induced abortion cost of Rs. 115 (equivalent to four days of per capita income) in the public sector compared to Rs. 801 (about 30 days of per capital income) in the private sector (Duggal 2004). In some countries (such as South Africa) there may be state funding for abortion, but a shortage of trained health personnel and insufficient technology means that state-funded abortions are not available at primary health facilities and local health clinics (Guttmacher, Kapadia et al. 1998).

As noted earlier, about one third of all studies in our scoping review have focused on the United States. Several of these studies on the U.S. have examined how access to Medicaid funding – the national and state-level need based system of public health insurance in the U.S. – affects women's access to abortion and their ability to pay for abortion services. One of the most common state-level regulations in the U.S. is restrictions on Medicaid to pay for abortion services. These state-level restrictions come on top of the Hyde Amendment at the national level restricting the use of federal funds to pay for abortions; abortion is the only reproductive health service that is not covered by federal Medicaid (Gerber Fried 1997). Some states place further restrictions on the use of private insurance to pay for abortion services.

Evidence in our review indicates that in the U.S., state-level restrictions on Medicaid are correlated with reduced abortion rates in states that have such restrictions (Blank, George et al. 1996, Haas-Wilson 1997, Chevrette and Abenhaim 2015), and they contribute to women's resource constraints in seeking abortion services (Foster, Jackson et al. 2008, Ely, Hales et al. 2017a). These financial hardships for women caused by the lack of public funding for abortion have spillover effects on women's reproductive health in that they often cause women to delay seeking abortion care until their pregnancies have advanced into the second trimester (Jones and Weitz 2009, Ely, Hales et al. 2017b). This is a finding that extends to other types of abortion restrictions, as discussed in the next sub-section. Additional research suggests that abortion-related restrictions on public funding for family planning services (as in the domestic gag rule) are costly on a broader scale: without publicly funded family planning services, states would be spending more than $1.2 billion annually in their state Medicaid programs to cover the costs of unplanned births and abortions (Forrest and Samara 1996).

(3) Restrictive abortion regulations impose financial hardships on women, often resulting in costly delays. A growing body of evidence, most of it originating from the United States, shows that rather than reduce the number of abortions, restrictive abortion laws impose financial hardships on women and cause delays in abortion services. In some cases women are forced to wait until their second trimester when abortions are more costly not only more expensive but they are also riskier. As discussed above, one of these regulations is restrictions on access to public sector funding, but there are many others.

Since 2010 there has been an enormous expansion of state-level policies that restrict abortion access for women in the U.S. These policies can be grouped into six major types of restrictive abortion laws enacted by states, each of which the U.S. Supreme Court has found to be constitutional: (1) restrictions on Medicaid funds to pay for abortions for poor women, (2) parental involvement laws that require unmarried teen minors to obtain parental consent or require abortion provider to notify the minor's parent before an abortion is performed, (3) mandatory counseling laws that require providers give to women, at least 24 hours before the procedure, state-mandated abortion-specific medical information about possible risks and side effects, (4) two-visit laws that require women receive the mandatory counseling materials in person, (5) Targeted Regulation of Abortion Provider laws (TRAP laws) that impose on abortion providers a variety of burdensome staffing and physical plant requirements not imposed on other clinics performing comparable medical services, and (6) laws banning a late-term abortion with dilation and extraction, commonly known as partial-birth abortion.

The most common of these state-level restrictions are mandatory counseling laws, which require that women receive a state-authored information packet about fetal development, risks of abortion, and alternatives to abortion. These packets often contain images of the fetus, a practice that is consistent with the strategy of anti-abortion movements to use fetal images and depict fetuses as people in order to persuade women to avoid ending the 'lives of their unborn babies.' Surprisingly, survey data for the U.S. indicate that even if the information in such packets was informative, a high proportion of women (over half of women in the Midwest and about two-thirds of women in the Northeast) did not disagree with the idea of having a mandatory counseling law (Blanchard, Meadows et al. 2017). That said, women in the survey still responded that they were more negatively impacted by state-level abortion restrictions than positively impacted, with the most common negative impacts including delays in receiving care, longer travel, and time away from work (Blanchard, Meadows et al. 2017).

Abortion restrictions have aimed to reduce both abortion demand and supply. A major channel through which they do so is to reduce accessibility and effectively raise the price of abortion, which is associated with fewer abortions (Gober 1997, Ananat, Gruber et al. 2009). Anti-abortion activities by protesters such as picketing and blocking patients can have similar effects, with one set of estimates indicating that anti-abortion activities in the U.S. have raised the price of abortion by about 4 percent reduced the overall abortion rate by 19 percent (Kahane 2000). There is some variation across studies in the demand-side effects of abortion restrictions. For example, Felkey and Lybecker (2018) find very small effects of increasing abortion restrictions and costs on women's use of contraceptives, which ultimately works to raise the probability of unwanted births and illicit abortion procedures. Estimates for minors' demand for abortion suggest that in the U.S., parental involvement laws reduce minors' demand for abortion by anywhere from 13 to 25 percent (Haas-Wilson 1996). Similarly, Medoff finds that both parental notification laws and mandatory counseling laws increase the price of abortion and result in a decline in the demand for abortion by 7 to 14 percent (Medoff 2008b).

On the supply side, recent evidence in Calkin (2019) indicates that state-level abortion restrictions in the U.S. have contributed to clinic closures and reduced operations: as of the time of the study, there were 27 cities in the U.S. considered to be "abortion deserts" because women had to travel over 100 miles to reach the nearest abortion clinic. The inability to travel such distances to reach abortion providers disproportionately affects low-income women who are both income and time constrained. Additional evidence indicates that 89 percent of U.S. counties have no abortion providers within their county borders (Ely, Hales et al. 2017c). Several researchers have focused specifically on the highly restrictive laws in the state of Texas and found that they led to reductions in abortion providers, which in turn led to substantial increases in travel time to reach the nearest provider and increases in waiting time due to patient congestion at the clinics that remained open. The repercussions for women of these hardships included a reduction in the number of abortions and increase in birth rates (Jewell and Brown 2000, Fischer, Royer et al. 2018). Even girls younger than age 18 experienced additional pregnancies and births as a result of the reporting and consent requirements in Texas (Franzini, Marks et al. 2004). Another unanticipated effect was that in the face of greater travel costs due to a reduced supply of licensed abortion providers, some teenagers substituted toward seeking abortions at non-licensed facilities (Jewell and Brown 2000). In this sense, abortion regulations in Texas are no different from abortion bans in highly restrictive countries that cause women to obtain abortions from illicit providers that are often riskier and unsafe.

(4) Some countries are actively working to provide more cost-effective and innovative options for women seeking abortion services. Numerous countries (especially those with lower national income) have limited capacities to enforce and implement legislation. This constraint is especially problematic when countries have moved to liberalize their abortion laws but the actual provision of services has been slow to respond. Countries transitioning from more restrictive to liberalized abortion laws may have insufficient health infrastructure or skilled practitioners to provide the services that have become legally permissible. Counteracting this failure of health infrastructure to keep up with legislative reform are improvements in reproductive-health technologies, the spread of the internet across the globe, the availability of online information on reproductive health, and the ability to order abortion pills online. A growing body of evidence indicates that the increased availability and affordability of misoprostol has made medical abortion more common. Not only do individuals often choose the cheaper option, but so do health

insurance companies and public sector health officials. Because medical abortion does not usually require physicians with surgical skills or surgical facilities, at a national level medical abortion is often considered the cheaper option and more health systems are likely to move to medical abortion in the future (Berer 2005). Exceptions to this argument include Nigeria, where clinic-based MVA is more cost effective than medical abortion (Hu, Grossman et al. 2010). Some countries have experimented with medical abortion via telemedicine and hotlines to reach women seeking abortion services who may otherwise be harder to reach. This option was tried in Australia (Baird 2015) and in several Latin American countries (Drovetta 2015). Some countries including the UK are also moving toward regulatory reforms in which nurses and midwives are allowed to perform more abortion services in order to provide cost savings to national health systems (Sheldon and Fletcher 2017).

Along these lines, some countries have moved more actively toward integrating safe abortion services into a full continuum of reproductive health services in order to reduce maternal mortality. Even when they are legally allowed, abortion services are often separated from other health services. This separation has only served to marginalize women who seek abortions and has made it more difficult to reduce the incidence of unsafe abortions. Adopting a broader strategy aimed at providing women with an integrated package of services for their reproductive health has much potential to reduce global inequities in maternal mortality. Evidence for India (Goldie, Sweet et al. 2010) and Mexico (Hu, Bertozzi et al. 2007) indicates that such an approach is more effective in terms of lives saved as well as more cost effective as compared to a non-integrated strategy without family planning and safe abortion services.

Macro-economic impacts

Table 6 shows that our scoping review resulted in 66 articles containing data on the economic impacts of abortion care services and abortion policies at the macroeconomic level. Most of these studies are on the economic impacts of abortion laws. While much of the literature on the financial costs of abortion care is published in public health and public policy journals, studies in economics journals have tended to pay more attention to the economic impacts of abortion legalization at the macro level. This knowledge can be synthesized into four general themes: (1) impacts of abortion regulations on fertility can have strong spillover effects on women's educational attainment and labor supply, (2) access to abortion services contributes to improvements in children's human capital, (3) abortion liberalization may be associated with reduced crime rates, and (4) the political economy around abortion legislation is nuanced and complicated. Of the total of 66 articles with data on the economic impacts of abortion, 19 articles had information related to the first theme, 8 articles had data on the second theme, 7 articles related to the third theme, and 32 articles had information on this fourth theme.

(1) Impacts of abortion regulations on fertility can have strong spillover effects on women's educational attainment and labor supply. As noted in the previous sub-section, abortion regulations can act to raise the price of abortion to women and result in costly delays. A number of additional studies have focused on different types of abortion laws and estimated how they affect aggregate abortion rates (Medoff 1999, Medoff 2000, Medoff 2008a, Medoff 2008b). Women's fertility rates and even marital rates are also impacted by abortion regulations. In Eastern Europe, regulations that made abortion more accessible led to a large decrease in births (Levine and Staiger 2002) and an increase in marriage rates for non-teenage women (Bowmaker and Emerson 2013). In the U.S. birth rates increased in states with more restrictive policies and higher contraception costs (Matthews, Ribar et al. 1997). Additional evidence for the U.S. indicates that states that funded abortion services had lower birth rates among teenagers (Meier and McFarlane 1994). A study of long-term trends in the U.S. confirms that the legalization of abortion has contributed to a decline in childbearing (largely due to an increase in the number of childless women) (Bailey and Lindo 2017). These changes in childbearing, in turn, contributed to women's economic progress (Bailey and Lindo 2017). Interestingly, fairly recent evidence indicates that the effects of abortion access were even stronger than women's access to the birth control pill in driving women's decisions to delay marriage and childbearing (Myers 2017).

A number of additional studies have linked the legalization of abortion to women's advancement in education and in the labor market. In particular, Kalist (2004) found that by reducing unwanted births, legalization of abortion in the U.S. led to increased labor force participation rates for women, especially for single black women. A similar result was found in Angrist and Evans (2000), with substantial increases in high school graduation, college attendance, and employment for black women who were teenagers when state abortion laws were liberalized. Additional evidence for the United States indicates that women who were denied an abortion because of restrictive state laws not only were less likely to be employed full time, they were also more likely to live in poverty and to require public assistance compared to women who obtained abortions (Foster, Biggs et al. 2018b). Bloom and colleagues (2009) took this point about women's employment one step further and found that lower fertility (instrumented by the legalization of abortion) increases women's labor supply and contributes positively and significantly to GDP growth.

(2) Access to abortion services contributes to improvements in children's human capital. The legalization of abortion is also linked to various measures of children's human capital, largely through a selection effect through which abortion can help to prevent births into relatively disadvantaged households. Several statistical studies have found positive outcomes for children born after the legalization of abortion. In particular, U.S. children born after the Supreme Court's 1973 Roe v Wade ruling were more likely to graduate from college and less likely to be welfare recipients or single parents (2009). Children's outcomes may have improved on average because they were more likely to be born into a household in which they were wanted. Follow-up research indicates that these kinds of effects on cohort characteristics for children whose births were avoided are different for births avoided due to abortion access versus births avoided due to access to the birth control pill (Ananat and Hungerman 2012). Some of these observed effects for children are observed at very early ages. In the U.S., women in states with more restrictive abortion laws had children with greater indicators of delayed child development and poor maternal bonding (Foster, Biggs et al. 2018a). Additional evidence for the U.S. finds that abortion legalization led to a sharp decrease in unintended births, which in turn is associated with increased schooling and greater earnings of children born after abortion legalization (Lin and Pantano 2015). Some of these effects may have a race dimension, with results in Whitaker (2011) pointing to a stronger association between abortion rates and high school graduation rates for black men than for other demographic groups.

There is also evidence on abortion and children's human capital from outside of the U.S. In particular, Romania's abortion ban is associated with worse educational outcomes and labor market achievements of children born after the ban (Pop-Eleches 2006, Malamud, Pop-Eleches et al. 2016). And in Sub-Saharan Africa, abortion law liberalization is linked to greater parental investment in girls' schooling, with the rationale that access to abortion lowers the likelihood of a girl child dropping out of school in the event of an unplanned pregnancy (Azarnert 2009). In Taiwan, when parents had the ability to engage in sex selection following the legalization of abortion, girls born at a higher birth order were born into families where they were wanted and where parents invested in their educations. The outcome was an increase in university attendance for girls born after the legalization of abortion (Kalsi 2015).

(3) Abortion liberalization may be associated with reduced crime rates. Perhaps most famously among studies on abortion in the economics literature, the legalization of abortion has been linked by economists to crime reduction. In a widely-cited study for the U.S., Donohue and Levitt (2001) found that crime rates across states appear to have dropped as a result of Roe v. Wade (2001). Children who were born unwanted before the legalization of abortion grew up in more disadvantaged households and they also grew up to be more disadvantaged as adults. This study has proven rather controversial, with several article-length critiques disputing the findings, only to be countered with further evidence from Donohue and Levitt that abortion legalization does in fact have a causal effect in reducing crime (Donohue and Levitt 2004, Donohue and Levitt 2008, Foote and Goetz 2008). The finding may not be generalizable to other countries, however, with Buonanno et al. (2010) showing that unlike the U.S., abortion rates are not associated with reduced crime in Europe.

(4) The political economy around abortion legislation is nuanced and complicated. The use of national legislation to restrict women's access to abortion and contraception has a long history that varies considerably across regions and countries largely because of ideological considerations

associated with religious and political institutions. This legislative history has contributed to traditional views, stigmas, and social norms around abortion that are deeply ingrained and slow to change. The restrictiveness of legislation varies substantially, from the complete criminalization of all abortions in six predominantly Catholic countries to abortion upon request in countries as diverse as Cambodia, Nepal, Belgium, and the United States. Countries with no restrictions are largely found in the Global North, while countries with the most restrictions tend to be in the Global South, especially in Latin America and the Caribbean and in Sub-Saharan Africa. Legislation not only varies geographically, but it has slowly been changing over time, often from highly restrictive to allowing more grounds upon which women may seek an abortion (Shah, Åhman et al. 2014).

It is almost impossible to cleanly summarize the political economy of these legislative changes, given that most studies uncovered by our scoping review with evidence on this final theme tended to focus on individual countries each with particular contexts and political environments. Several studies in this cluster have pointed to the high costs of post-abortion care as a key impetus to motivate legislative reforms so that more women have access to safe abortions (Berer 2000, Billings and Benson 2005, Vlassoff, Walker et al. 2009, Parmar, Leone et al. 2017). Other studies have pointed to weaknesses in national health systems in providing cost-effective abortions and the need to reform health system financing and to strengthen public abortion services (Duggal 2004, Comendant 2005, Johnston, Oliveras et al. 2010, Coast, Norris et al. 2018, Lince-Deroche, Constant et al. 2018). The studies reviewed in this section make clear that the countries that have seen the most rapid change in women's health indicators are those that have changed their laws at the same time that they have improved their service delivery.

Macro-economic benefits and value

Closely related to these positive economic impacts are the benefits and value of abortion services and abortion law liberalization at the macroeconomic level. Table 6 shows that our scoping review resulted in 26 articles containing data on the economic benefits and value of abortion care services and abortion policies at the macroeconomic level. It proved more difficult to categorize these 26 articles into a set of clear and cohesive themes, largely because they data extracted on benefits and value covered such a diverse set of topics. A more informative approach for this particular sub-section is to give a sense of what some of these additional benefits and values are and which part of the world they were studied. In particular, one set of studies included data on the selection effect of abortion liberalization and additional benefits to children born after liberalization, especially their increased chances of living in better economic circumstances (Gruber, Levine et al. 1997, Ananat, Gruber et al. 2009, Foster, Biggs et al. 2018a, Foster, Biggs et al. 2018b).

Another set of articles had data at the macroeconomic level on sex selection and its value as an industry as well as the influence of institutional factors (Thomas 2007, Almond, Edlund et al. 2013). A small cluster of studies looked at the macro-level benefits of alternative abortion technologies, including MVA and medical abortions (Comendant 2005, Cheng, Zhou et al. 2012, Rodriguez, Mendoza et al. 2015). Several articles included additional data on the benefits to society of integrating abortion into a full set of reproductive health services (Hu, Grossman et al. 2010, Benson, Okoh et al. 2012, Erim, Resch et al. 2012). For example, Hu and colleagues (2007) find that in Mexico, including access to safe abortion into a policy strategy designed to reduce maternal mortality would save about $116 million over the lifetime of a birth cohort. The remaining articles containing extracted data in this section had findings that did not overlap in content or key themes with other articles. The search process underscored the point that abortion care services can have macro-level benefits and values that may not be well known, easily observed, or readily categorized, but they still merit attention when considering reforms to abortion policies and health systems.

Macro-economic costs and consequences of abortion stigma

Costs

As shown in Appendix V, four articles included data on the implications of stigma on economic cost at the macro-level. A majority of the included studies were conducted in high-income countries (United States, Poland, Ireland). Evidence on stigma and economic cost at the macro-

level was collected through a mixed-method study design (n=1), qualitative studies (n=1), a literature review (n=1), and a regression analysis (n=1). Review of the data shared in the four articles has led to the development of one emerging theme: (1) Anti-abortion movements and related political action restrict abortion access for women through legal regulations, which can result in increased financial barriers to care.

(1) *Anti-abortion movements and related political action restrict abortion access for women through legal regulations, which can result in increased financial barriers to care* (Gerber Fried 1997, Gober 1997, Chełstowska 2011). The individual decision to seek abortion services in the United States has become a topic of public discussion, as public opinion has the ability to define how easy, expensive, and safe it is to obtain an abortion (Gober 1997). The anti-abortion movement has been able to remove abortion care from other aspects of reproductive health and to shape public perception of abortion as a burdensome, immoral, and socially stigmatized act. Anti-abortion movements have also led movements to restrict and recriminalize abortion in order to restrict access for women and to reduce public funding for facilities that provide services (Gerber Fried 1997). Leading with an argument of moral values, anti-abortions movements will campaign against public funding for abortion, claiming that people should not be forced to pay for something that is against their moral values.

As aggressive public backlash against abortion builds, more providers are unwilling to perform abortions because of the harassment and intimidation by the anti-abortion movement, the emotional stress of families in crisis, and the relatively low pay to compensation the risk (Gober 1997). As fewer providers are willing to take on abortion service provision, access to abortion services can continue to be more cost prohibitive for women as they may need to visit multiple clinic and/or travel greater distances to seek care.

Due to the restrictive regulations in countries like Poland and Ireland, women must travel outside of their country in order to access abortion services (Chełstowska 2011, Aiken, Johnson et al. 2018). While women of higher socio-economic status have the potential means to travel, women in lower socio-economic classes are less likely to have the resources to do so. At the same time, those most effected by the restrictive regulations around abortion are unlikely to have the political capital on their own to protest the law and enact change, trapping them in discriminatory cycle. As more research is published, it could be beneficial to examine the economic cost implications of legal restrictions and the anti-abortion movements on a national level. More research is also needed on how macro level trends in abortion stigma affect availability, utilization, and costs at the meso and micro levels.

Impact

Only three articles discussed the economic impact of abortion stigma on the macro-level (Appendix W). One of the articles examined economic impact at the global level and the other two studies were conducted in high-income countries (United States and Poland). Evidence was gathered and presented through a mixed-methods study design (n=1), a literature review (n=1), and a regression analysis (n=1). Synthesis of the data from these three articles has led to the following two emerging themes: (1) Monopolization of abortion services within the private sector has led to inequal access to services; and (2) The Global Gag Rule has institutionalized abortion stigma within its global foreign assistance structure.

(1) *The monopolization of abortion services within the private sector has led to inequal access to services due to their unregulated and unsubsidized prices* (Chełstowska 2011). Abortion stigma in Poland has successfully pushed safe, affordable services out of the public sector, which led to the development of a thriving, underground private sector market for abortion services (Chełstowska 2011). Within the private sector, stigmatization of services ensure that the procedures and costs of services remain unregulated. This monopolization of abortion services in the private sector perpetuates social inequality because their services are out-of-reach to a portion of the population that is unable to afford the cost of service.

(2) *The Global Gag Rule has institutionalized abortion stigma within its global foreign assistance structure* (Crane and Dusenberry 2004). The Global Gag Rule has successfully institutionalized abortion stigma within its global foreign assistance structure by enacting restrictions to available funding. Non-government organizations that receive funding from the United States are unable to use that funding for abortion services, referrals, or even to share information regarding abortion, and risk losing their funding if they do not follow these rules. With each new iteration

of the Global Gag Rule, the restrictions have increased. As we are in the most restrictive time yet under the Global Gag Rule, it is critical to collect and analyze evidence on the economic impact of this legislation.

Conclusion

We systematically searched for and synthesized the social science literature on the impact of abortion-related care or abortion policies on economic outcomes using a socio-ecological framework of three levels of factors: micro- (i.e., abortion seekers and their households); meso- (i.e., communities and health systems); and macro- (i.e., societies and nation states) levels. Although relatively few studies are defined explicitly by their authors or their methodology as "economic" studies, our review shows that there is a wealth of economically-relevant information that can be gleaned from the evidence base. For example, whilst very little evidence uses the language of economic values and benefits of abortion, it is possible to infer micro-level values and benefits of abortion-related care by examining people's reasons for abortion. These reasons are rarely singular; abortion-related decision-making is often the result of a complex interplay of factors (wealth, education, status, education, relationship).

Here, we do not repeat the key findings of our synthesis. Instead, we draw out the substantive and methodological implications of our results for future research. At the micro-level, the interplays between economics and delays to abortion-related care are striking. Across diverse contexts and populations, economic factors influence delays to abortion-related decision-making, attempts to seek care and the receipt of care. By unpacking the points at which economic factors introduce or compound delays to abortion-related care, greater insight into the points at which information and services might be better designed to reduce delays can be achieved. By further unpacking the intersectionalities of these economic factors, we can better understand the ways in which health systems and contexts reproduce injustices and inequities. For example, in a wide range of contexts, it is poorer individuals (and adolescents) who are least likely to be able to navigate or surmount barriers to abortion-related care. Delays underpinned by economic factors can thwart care-seeking, affect the type of care sought, and impact the gestational age at which care is sought or reached. Although rarely explicitly included in evidence, the timing of confirmation of pregnancy is also likely to be strongly influenced by intersecting economic factors. We continue to know very little about the ways in which – conceptually separate from delays, but linked in terms of health outcomes – economic factors intersect with concepts of risk/safety and quality of care. Importantly, the ways in which perceptions of economic factors – distinct from the actual policy or health systems context – affect abortion-related care-seeking and its timing. Many gaps remain in our evidence base around the micro-level economic impacts of abortion, including the indirect economic impact of abortion-related care and the longer-term economic impacts – both positive and negative – of abortion-related care. We know very little about how the un/wantedness or un/plannedness or ambivalence around pregnancy intersects with economic values and benefits of abortion at the micro-level.

Methodologically, we know relatively little about the individual-level economic burden of seeking and procuring abortion. Particularly facility-based studies focus on treatment costs, however costs are incurred directly and indirectly throughout the treatment pathway (e.g. transport, food, accommodation, loss of income). Importantly, the limited prospective evidence base suggests that there are likely substantial post-facility economic costs and impacts that are missed by studies that do not include post-facility costs. There is great heterogeneity in what is in/excluded in understandings of individual costs and impacts in individual studies; the evidence base would benefit from a broader understanding of in/direct costs – because studies that focus solely on what abortion seekers pay underestimate the total costs (e.g. of lost income or earnings and payment of bribes). There are hints in the evidence that changing architecture of financial systems will increasingly need to be taken into account in the evidence base; even in resource-poor settings, the use of non-cash payment systems (e.g. debit/credit cards or phone-based payments) may lead to the increasing exclusion of the poorest individuals seeking abortions. Rarely are the conditional contexts of abortion-related care explicitly considered; limited evidence suggests that in some contexts the economic costs or impacts are linked to conditionality of care (e.g.

acceptance of long-acting reversible contraception). Specific sub-groups of abortion care-seekers are not present in the evidence base – transgendered and/or disabled people – and given that they may experience greater barriers to abortion care, it is likely that they may experience higher direct and indirect costs.

At the meso-economic level, we find that adapting to changes in laws and policies is costly for health facilities, and that financial savings can be realized while maintaining or even improving quality of abortion care services. Evidence on reported economic impacts of abortion at the meso-economic level are rarely studied. The paucity of evidence on this topic does not align with the frequency that abortions occur in communities or the potential economic impact of unsafe abortions on communities. Whilst the evidence based on meso-economic costs of post-abortion care and treating complications from unsafe abortion is somewhat evidenced, we know little about how providers of unsafe abortion establish their pricing systems for unsafe abortion. Methodologically, at the meso-economic level, review papers are the most frequent type of study, suggesting that researchers rely on the same body of evidence from a core set of costing papers. This finding raises questions about the timeliness and updating of these costing papers. In addition, evidence relating to the meso-economic reporting of costs does not always include the year and specific currency used (e.g. dollar could refer to Australian dollar, Canadian dollar, or American dollar). It is not always clear if the value given refers to the year of publication or the time the research was conducted.

At the macro-economic level, the evidence shows that post-abortion care services are expensive and can constitute a substantial portion of health budgets. Public sector coverage of abortion costs is sparse, and abortion seekers bear most of the financial costs. In a diverse range of contexts, restrictive abortion regulations impose financial hardships on women, often resulting in costly delays. There are, however, examples of interventions to provide more cost-effective and innovative options for individuals seeking abortion services. The impacts of abortion regulations on fertility can have strong spillover effects on women's educational attainment and labor supply, access to abortion services contributes to improvements in children's human capital, and abortion liberalization may be associated with reduced crime rates. The political economy around abortion legislation is nuanced and complicated, with a disproportionate amount of the global evidence base focused on the United States.

Finally, from a disciplinary and methodological perspective, there is a lack of methodological variation and innovation, which limits our knowledge of the economic impact of abortion. The evidence base has an abundance of studies using costing methods and regression analysis. Study design and methods using behavioral economics approaches (e.g. discrete choice experiments, quasi-experimental designs) are underexploited in the economics of abortion evidence base.

Appendices

Appendix A. Data extraction worksheet

The following fields were used in the data extraction worksheet:

Field Description	Label
Reviewer's initials	Reviewer
Number assigned to each article/study (e.g., 001, 002)	Study ID
First author's surname	Author
Write the full name of the study or article.	Study Name
Year of publication	Publication Date
State the exclusion criteria for the study, or state "none."	Exclusion Criteria
State the inclusion criteria for the study.	Inclusion Criteria
Type of publication	Publication Type$1
If PubTyp = 3, give details.	Publication Type$2
Detail any other publications linked to the study (e.g. papers describing methods, additional analyses)	Other Publications
Assumed sex of the first author based on first name	First Author's Sex
Language of Publication	Language of Publication
List all countries in which the study was conducted	Country
Country(ies) income group	Country Income Group
World region(s)	World Region
State the primary or main objective(s)/aim(s) of the study	Study Objective
At which geographical level did the study occur?	Geographic Level$1
Give specific detail for previous response (e.g. Santillana district (17 villages, 6158 inhabitants). Provide name if only one location unit.	Geographic Level$2
What was the main identifying characteristic of the population/group/stratum targeted?	Study Population$1
Give specific detail for previous response (e.g., Hispanic American; urban poor; Muslim population). Use author's words (with quotation marks)	Study Population$2
Did the study report on the outcome 'costs of abortion-related care?' *'Costs' refer to the amount paid to obtain abortion-related care.*	Critical Outcome$1A
At which level(s) did the study report on the outcome 'costs of abortion-related care': micro, meso, or macro?	Critical Outcome$1B
In the author's words, include the text describing the definition and/or methodology used for the outcome 'costs of abortion-related care.'	Critical Outcome$1C
Report, by level, all outcome data for 'costs of abortion-related care.'	Critical Outcome$1D
Did the study report on the outcome 'economic impacts of abortion-related care?' *'Economic impacts' refer to the economic effect or influence of abortion-related care.*	Critical Outcome$2A
At which level(s) did the study report on the outcome 'economic impacts of abortion-related care': micro, meso, or macro?	Critical Outcome$2B
In the author's words, include the text describing the definition and/or methodology used for the outcome 'economic impacts of abortion-related care.'	Critical Outcome$2C
Report, by level, all outcome data for 'economic impacts of abortion-related care.'	Critical Outcome$2D
Did the study report on the outcome 'economic benefits of abortion-related care?' *'Economic benefits' refer to the advantages or profits gained from receiving abortion-related care.*	Critical Outcome$3A
At which level(s) did the study report on the outcome 'economic benefits of abortion-related care': micro, meso, or macro?	Critical Outcome$3B
In the author's words, include the text describing the definition and/or methodology used for the outcome 'economic benefits of abortion-related care.'	Critical Outcome$3C
Report all outcome data for 'economic benefits of abortion-related care.'	Critical Outcome$3D
Did the study report on the outcome 'value of abortion-related care?' *'Value' refers to the importance, worth, or usefulness of receiving abortion-related care.*	Critical Outcome$4A
At which level(s) did the study report on the outcome 'value of abortion-related care': micro, meso, or macro?	Critical Outcome$4B

In the author's words, include the text describing the definition and/or methodology used for the outcome 'value of abortion-related care.'	Critical Outcome$4C
Report all outcome data for 'value of abortion-related care.'	Critical Outcome$4D
Did the study report on the outcome 'abortion-related stigma?' *This includes abortion-related discrimination and exclusion.*	Secondary Outcome$1A
At which level(s) did the study report on the outcome 'abortion-related stigma': micro, meso, or macro?	Secondary Outcome$1B
In the author's words, include the text describing the definition and/or methodology used for the outcome 'abortion-related stigma.'	Secondary Outcome$1C
Report all outcome data for 'abortion-related stigma.'	Secondary Outcome$1D
What other economic-related aims and outcomes were described or measured? Give details. Mark measured outcomes with (o).	Additional Aims/Outcomes
What was the design of the study?	Study Type$1
Give details of answer above	Study Type$2
What type of data were presented in the evaluation findings/results?	Data Type
In what context was the study conducted? Give details (e.g. legal status of abortion, culture, gender norms).	Context
Include any notes you think are relevant	Notes

Appendix B. Codebook

The following codes were used for the data extraction from included articles:

Variable	Question and instruction	Response options
Reviewer	State your initials	BM CP EC EZ SL YR
Study ID	Number assigned to each article/study (e.g., 001, 002)	#
Author	First author's surname	Text
Study Name	Write the full name of the study or article.	Text
Publication Date	Year of publication	#
Exclusion Criteria	State the exclusion criteria for the study, or state "none." *If study meets exclusion criteria, end data extraction.*	Text
Inclusion Criteria	Does this study meet all inclusion criteria? Check PICOTS, language, year, and publication type (peer-review journal article or NBER working paper). If all criteria are met, state "all." *If all of the inclusion criteria are not met, return to "exclusion criteria."*	All
Publication Type$1	Type of publication	1 = Peer-reviewed journal article 2 = NBER working paper 3 = Other
Publication Type$2	If PubTyp = 3, give details.	Text 99 = not applicable
Other Publications	Detail any other publications linked to the study (e.g. papers describing methods, additional analyses)	Text
First Author's Sex	Indicate if the first author's first name suggests whether the author is a man or a woman. When the name could be unisex (e.g. Sam, Alex), is an initial, or is unclear to which sex it belongs, mark option 3.	1 = Woman 2 = Man 3 = Unclear
Language of publication		1 = English 2 = French 3 = German 4 = Dutch 5 = Spanish 6 = Other
Country	List all countries in which the study was conducted	Text
Country Income Group[10]	Country(ies) income group	1 = Low 2 = Lower-middle 3 = Upper-middle 4 = High 5 = Multiple
World Region[11]	World region(s)	1 = Africa 2 = Asia 3 = Europe

[10] World Bank Atlas method groupings of countries by income: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519

[11] WHO region groupings: Africa, Asia, Europe, Latin America and the Caribbean, Northern America, Oceania: https://unstats.un.org/unsd/methodology/m49/

Variable	Question and instruction	Response options
		4 = Latin America and the Caribbean 5 = Northern America 6 = Oceania 7 = Multiple
Study objective	State the primary or main objective(s) or aim(s) of the study	Text
Geographic Level$1	At which geographical level did the study occur?	1 = National 2 = Sub-national (e.g., region, state, county, district, whole city) 3 = Local (e.g., village, neighborhood) 4 = Health facility 5 = Other 98 = Unclear/not specified
Geographic Level$2	Give specific detail for previous response (e.g. Santillana district (17 villages, 6158 inhabitants). Provide name if only one location unit.	Text 99 = if GeoLvl$1 = 98
Study Population$1	What was the main identifying characteristic of the population/group/stratum the study targeted?	1 = Ethnic (or race) 2 = National 3 = Religion 4 = Language 5 = Indigenous, tribal, or caste-based 6 = Geographical location (e.g. urban/rural, region, facility) 7 = Socio-economic 8 = Age (e.g. adolescents) 9 = Status as abortion seeker 10 = Multiple answers from list 11 = Other, specify 12 = Abortion providers 98 = Unclear/not specified 99 = Not applicable
Study Population$2	Give specific detail for previous response (e.g., Hispanic American; urban poor; Muslim population). Use author's words (with quotation marks)	Text
Critical Outcome$1A	Did the study report on the outcome 'costs of abortion-related care?' *'Costs' refer to the amount paid to obtain abortion-related care.*	0 = No --> go to Critical Outcome$2A 1 = Yes 98 = Unclear/not specified
Critical Outcome$1B	At which level(s) did the study report on the outcome 'costs of abortion-related care': micro, meso, macro	1 = Micro 2 = Meso 3 = Macro 4 = Micro and meso 5 = Meso and macro 6 = Micro and macro 7 = All levels
Critical Outcome$1C	In the author's words, include the text describing the definition and/or methodology used for the outcome 'costs of abortion-related care.'	Text 98 = Unclear/not specified
Critical Outcome$1D	Report all outcome data for 'costs of abortion-related care.'	Text 98 = Unclear/not specified

Variable	Question and instruction	Response options
Critical Outcome$2A	Did the study report on the outcome 'economic impacts of abortion-related care?' *'Economic impacts' refer to the economic effect or influence of abortion-related care.*	0 = No --> go to Critical Outcome$3A 1 = Yes 98 = Unclear/not specified
Critical Outcome$2B	At which level(s) did the study report on the outcome 'economic impacts of abortion-related care': micro, meso, macro	1 = Micro 2 = Meso 3 = Macro 4 = Micro and meso 5 = Meso and macro 6 = Micro and macro 7 = All levels
Critical Outcome$2C	In the author's words, include the text describing the definition and/or methodology used for the outcome 'economic impacts of abortion-related care.'	Text 98 = Unclear/not specified
Critical Outcome$2D	Report all outcome data for 'economic impacts of abortion-related care.'	Text 98 = Unclear/not specified
Critical Outcome$3A	Did the study report on the outcome 'economic benefits of abortion-related care?' *'Economic benefits' refer to the advantages or profits gained from receiving abortion-related care.*	0 = No --> go to Critical Outcome$4A 1 = Yes 98 = Unclear/not specified
Critical Outcome$3B	At which level(s) did the study report on the outcome 'economic benefits of abortion-related care': micro, meso, macro	1 = Micro 2 = Meso 3 = Macro 4 = Micro and meso 5 = Meso and macro 6 = Micro and macro 7 = All levels
Critical Outcome$3C	In the author's words, include the text describing the definition and/or methodology used for the outcome 'economic benefits of abortion-related care.'	Text 98 = unclear/not specified
Critical Outcome$3D	Report all outcome data for 'economic benefits of abortion-related care.'	Text 98 = unclear/not specified
Critical Outcome$4A	Did the study report on the outcome 'value of abortion-related care?' *'Value' refers to the importance, worth, or usefulness of receiving abortion-related care.*	0 = No --> go to Secondary Outcome$1A 1 = Yes 98 = Unclear/not specified
Critical Outcome$4B	At which level(s) did the study report on the outcome 'value of abortion-related care': micro, meso, macro	1 = Micro 2 = Meso 3 = Macro 4 = Micro and meso 5 = Meso and macro 6 = Micro and macro 7 = All levels
Critical Outcome$4C	In the author's words, include the text describing the definition and/or methodology used for the outcome 'value of abortion-related care.'	Text 98 = unclear/not specified
Critical Outcome$4D	Report all outcome data for 'value of abortion-related care.'	Text 98 = unclear/not specified
Secondary Outcome$1A	Did the study report on the outcome 'abortion-related stigma?' *This includes abortion-related discrimination and exclusion.*	0 = No --> go to Secondary Outcome$2A 1 = Yes 98 = Unclear/not specified
Secondary Outcome$1B	At which level(s) did the study report on the outcome 'abortion-related stigma': micro, meso, macro	1 = Micro 2 = Meso 3 = Macro

Variable	Question and instruction	Response options
		4 = Micro and meso 5 = Meso and macro 6 = Micro and macro 7 = All levels 98 = unclear/not specified
Secondary Outcome$1C	In the author's words, include the text describing the definition and/or methodology used for the outcome 'abortion-related stigma.'	Text 98 = unclear/not specified
Secondary Outcome$1D	Report all outcome data for 'abortion-related stigma.'	Text 98 = unclear/not specified
Additional Aims/Outcomes	What other aims and outcomes were described or measured? Give details. Mark measured outcomes with (o).	Text
Study Type$1	What was the design of the study?	1 = Randomized controlled trial 2 = Controlled clinical trial 3 = Cohort analytic (two groups pre + post) 4 = Case-control 5 = Cohort (one group pre + post (before and after)) 6 = Interrupted time series 7 = Qualitative 8 = Mixed methods 9 = Other 10 = Regression analysis 98 = Unclear/not specified
Study Type$2	Give details of answer above	Text 99 = Not applicable
Data Type	What type of data was presented in the evaluation findings/results?	1 = Quantitative 2 = Qualitative 3 = Both
Context	In what context was the study conducted? Give details (e.g. legal status of abortion, culture, gender norms, stigma).	Text
Notes	Include any notes you think are relevant	Text

Appendix C. Final search strategy by database

The full electronic search strategies for all databases, including limits used, appear below:

CINAHL
Search strategy: We searched all sets of search terms (Table 3).
Search options:

- Search mode: Boolean/phrase
- Limit results:
    - Published date: September 1994 to January 2019

Search terms: (abort* OR "termination of pregnancy" OR "terminate pregnancy" OR "pregnancy termination" OR "pregnancy terminations" OR postabortion OR post-abortion) AND (cost* OR econom* OR price* OR financ* OR fee* OR tax* OR expenditure* OR GDP OR "gross domestic product" OR pay* OR expens*) AND (cost* OR benefit* OR value* OR impact*)

EconLit
Search strategy: We searched all sets of search terms (Table 3).
Search options:

- Search mode: Boolean/phrase
- Limit results:
    - Published date: September 1994 to January 2019

Search terms: (abort* OR "termination of pregnancy" OR "terminate pregnancy" OR "pregnancy termination" OR "pregnancy terminations" OR postabortion OR post-abortion) AND (cost* OR econom* OR price* OR financ* OR fee* OR tax* OR expenditure* OR GDP OR "gross domestic product" OR pay* OR expens*) AND (cost* OR benefit* OR value* OR impact*)

EMBASE
Search strategy: We searched modified sets of search terms (Table 3) using the multi-field search. Since EMBASE does not recognize the use of quotation marks for multi-word phrases, searches would include results with the word 'of' (from 'termination of pregnancy'). To exclude the 'of' from searches, we modified the abortion-related search terms, as detailed below. Results were aggregated with duplicates removed before they were added to Endnote.
Search options:

- Limit results:
    - Publication year: 1994 – 15 January 2019

Search terms: (abort* OR postabortion OR post-abortion OR (terminat* AND pregnancy)) AND (cost* OR econom* OR price* OR financ* OR fee* OR tax* OR expenditure* OR GDP OR "gross domestic product" OR pay* OR expens*) AND (cost* OR benefit* OR value* OR impact*)

IBSS
Search strategy: We searched all sets of search terms (Table 3) using the advanced search feature. Test searches returned numerous extraneous results; searches were limited to abstract and title, since all results were screened against TIAB.
Search options:

- Limit results:
    - Publication date: 1 September 1994 – 15 January 2019

- Language:
  - English
  - French
  - Spanish
  - Dutch
  - German
- Source type: Scholarly journals
- Peer-reviewed
- Document type: Article (including original research articles), case report, case study, clinical trial, comparative study, correction/retraction, essay, evaluation studies, literature review, report, review, technical report
- Exclude duplicate items

Search terms: (ti(abort* OR "termination of pregnancy" OR "terminate pregnancy" OR "pregnancy termination" OR "pregnancy terminations" OR postabortion OR post-abortion) AND ti((cost* OR econom* OR price* OR financ* OR fee* OR tax* OR expenditure* OR GDP OR "gross domestic product" OR pay* OR expens*)) AND ti((cost* OR benefit* OR value* OR impact*)) AND la.exact("German" OR "Spanish" OR "English" OR "French" OR "Dutch") AND (rtype.exact("Journal Article" OR "Article" OR "Review" OR "Comparative Study" OR "Case Study" OR "Literature Review" OR "Case_Study" OR "Evaluation Studies" OR "Research Article" OR "Case Reports" OR "article" OR "JOURNAL ARTICLE" OR "Original Research Articles" OR "review" OR "Review article" OR "Clinical Trial" OR "Research article" OR "CLINICAL TRIAL" OR "Clinical Trial, Phase I" OR "Literature_Review" OR "Case Report") AND stype.exact("Scholarly Journals") AND PEER(yes))) OR (ab(abort* OR "termination of pregnancy" OR "terminate pregnancy" OR "pregnancy termination" OR "pregnancy terminations" OR postabortion OR post-abortion) AND ab((cost* OR econom* OR price* OR financ* OR fee* OR tax* OR expenditure* OR GDP OR "gross domestic product" OR pay* OR expens*)) AND ab((cost* OR benefit* OR value* OR impact*)) AND la.exact("German" OR "Spanish" OR "English" OR "French" OR "Dutch" OR "English" OR "Spanish" OR "French" OR "German" OR "Dutch") AND (rtype.exact("Journal Article" OR "Article" OR "Review" OR "Comparative Study" OR "Case Study" OR "Literature Review" OR "Case_Study" OR "Evaluation Studies" OR "Research Article" OR "Case Reports" OR "article" OR "JOURNAL ARTICLE" OR "Original Research Articles" OR "review" OR "Review article" OR "Clinical Trial" OR "Research article" OR "CLINICAL TRIAL" OR "Clinical Trial, Phase I" OR "Literature_Review" OR "Case Report") AND stype.exact("Scholarly Journals") AND la.exact("ENG" OR "SPA" OR "FRE" OR "GER" OR "DUT") AND PEER(yes)))

JSTOR

Search strategy: We searched all search terms (Table 3). Since JSTOR does not permit searches of the length necessary to capture all three sets of search terms in one search, we conducted three separate searches, as detailed below. Searches were conducted using the advanced search feature and 'all content' access type. Results were aggregated with duplicates removed before they were added to Endnote.

Search options:

- Limit results:
  - Content type: Articles
  - Publication date: From September 1994 to 15 January 2019
  - Narrowed by discipline:
    - Economics
    - Feminist & women's studies
    - Health policy
    - Health sciences
    - Population studies
    - Public health

Search terms for Search #1: (abort* OR "termination of pregnancy" OR "terminate pregnancy" OR "pregnancy termination" OR "pregnancy terminations" OR postabortion OR post-abortion) AND (cost* OR econom* OR price*) AND (cost* OR benefit* OR value* OR impact*)
Search terms for Search #2: (abort* OR "termination of pregnancy" OR "terminate pregnancy" OR "pregnancy termination" OR "pregnancy terminations" OR postabortion OR post-abortion) AND (financ* OR fee* OR tax* OR expenditure*) AND (cost* OR benefit* OR value* OR impact*)
Search terms for Search #3: (abort* OR "termination of pregnancy" OR "terminate pregnancy" OR "pregnancy termination" OR "pregnancy terminations" OR postabortion OR post-abortion) AND (GDP OR "gross domestic product") AND (cost* OR benefit* OR value* OR impact*)

PubMed
Search strategy: We searched all sets of search terms (Table 3) using the advanced search builder. Test searches returned numerous extraneous results; we limited searches to TIAB, since these results were screened against TIAB.
Search options:

- Limit results:
  - Publication dates: From 1 September 1994 to 15 January 2019
  - Language:
    - English
    - French
    - Spanish
    - Dutch
    - German

Search terms: ((((abort*[Title/Abstract] OR "termination of pregnancy"[Title/Abstract] OR "terminate pregnancy"[Title/Abstract] OR "pregnancy termination"[Title/Abstract] OR "pregnancy terminations"[Title/Abstract] OR postabortion[Title/Abstract] OR post-abortion[Title/Abstract])) AND (cost*[Title/Abstract] OR econom*[Title/Abstract] OR price*[Title/Abstract] OR financ*[Title/Abstract] OR fee*[Title/Abstract] OR tax*[Title/Abstract] OR expenditure*[Title/Abstract] OR GDP[Title/Abstract] OR "gross domestic product"[Title/Abstract] OR pay*[Title/Abstract] OR expens*[Title/Abstract])) AND (cost*[Title/Abstract] OR benefit*[Title/Abstract] OR value*[Title/Abstract] OR impact*[Title/Abstract]))

ScienceDirect
Search strategy: Since this database does not support wildcards (*) or more than eight Boolean connectors per field, we searched a modified set of abortion- and economic-related search terms (Table 3) using the advanced search feature. We conducted three searches, as detailed below. Results were aggregated with duplicates removed before they were added to Endnote.
Search options:

- Limit results:
  - Article types: Review articles, research articles, case reports, data articles
  - Year(s): 1994-2019

Search terms for Search #1:

- Find articles with these terms: cost OR costs OR economic OR economics OR prices OR price OR finance OR fees OR fee Title, abstract or keywords: abortion OR "termination of pregnancy" OR "terminate pregnancy" OR "pregnancy termination" OR "pregnancy terminations" OR postabortion OR post-abortion

Search terms for Search #2:

- Find articles with these terms: GDP OR “gross domestic product” OR pay OR payment OR payments OR expenses OR expense OR expensive OR tax

- Title, abstract or keywords: abortion OR "termination of pregnancy" OR "terminate pregnancy" OR "pregnancy termination" OR "pregnancy terminations" OR postabortion OR post-abortion

Search terms for Search #3:
- Find articles with these terms: taxes OR expenditure OR expenditures
- Title, abstract or keywords: abortion OR "termination of pregnancy" OR "terminate pregnancy" OR "pregnancy termination" OR "pregnancy terminations" OR postabortion OR post-abortion

Web of Science
Search strategy: We searched all sets of search terms (Table 3) using the advanced search feature and topic (TS) field tag.
Search options:
- Limit results:
  - Article types: Article, abstract of published item, early access
  - Year(s): 1994-2019
  - Language:
    - English
    - French
    - Spanish
    - Dutch
    - German

Search terms: (abort* OR "termination of pregnancy" OR "terminate pregnancy" OR "pregnancy termination" OR "pregnancy terminations" OR postabortion OR post-abortion) AND (cost* OR econom* OR price* OR financ* OR fee* OR tax* OR expenditure* OR GDP OR "gross domestic product" OR pay* OR expens*) AND (cost* OR benefit* OR value* OR impact*)

Appendix D. Summary table of included studies reporting abortion-related stigma and context (n=11)

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
(Bloomer and O'Dowd 2014) [Ireland]	This paper considers abortion tourism in Ireland, both north and south, and how the moral conservatism present in both jurisdictions has impacted on attitudes and access to abortion	Literature on women seeking abortion services in restricted settings.	Literature review and supplemental expert interviews	Micro, Meso, and Macro	The negative stereotypes of women who access abortion mask the fact that many abortions are undertaken to preserve the health and well-being of family members including other children, and that many women who access abortion services continue with other pregnancies. Silence and fear of social ostracism stop other women speaking out to support those who have availed of abortion, and discrimination against those who have accessed it completes the stigma process. Those who provide abortion services are stigmatised by names such as 'murderer', which contributes to the exclusion of pregnancy termination as part of reproductive healthcare by equating it to a crime. The development of the idea of foetal personhood in which the notion that the foetus should be afforded the same rights as a person has increased over the past 10 years. Through the media, culture and art, abortion stigma has become embedded in popular discourse and equates qualities and autonomy of a baby with those of a foetus, which makes its destruction easy to portray as violent, unjust and morally wrong. As policy and law are reflections of the dominant ideology, abortion stigma can be found embedded in the core pillars of many societies. A recent study of abortion education in the UK found widespread evidence of bad practice in schools, including the provision of mis-information and distressing material to students.
(Coast, Norris et al. 2018) [Global]	To present a new conceptual framework for studying trajectories to obtaining abortion-related care.	n/a	Review	Meso; Macro	Conscientious objection to abortion may reflect stigma or violence providers themselves perceive or experience, and/or serve to further stigmatise abortion care-seeking. In contexts where abortion is stigmatised and/or illegal (or perceived to be illegal) in general or at advanced gestational age, women self-induce using household objects, traditional methods, and abortion medications. In some settings, anti-abortion protests outside abortion providers may affect abortion care-seeking by encouraging women to avoid providers where they may have to confront them.
(Ely, Hales et al. 2017a) [United States]	Use a trauma-informed lens to explore abortion-related hardships in a previously understudied group: patients in	Patients in the US who received financial pledges from NNAF to pay for an abortion (n=3,999).	Cross-sectional descriptive analysis	Micro; Macro	This study explored the occurrence of hardships by patients from various regions in the United States. The findings support that patients in the South and Midwest experience the greatest average number of hardships related to abortion and access to care. This finding is not surprising, considering the hostile abortion climate that is present in the Southeast, which the Midwest has recently begun to reflect as well.

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
	the United States who received financial pledges from the National Network of Abortion Funds' (NNAF) Tiller Memorial Fund, to pay for an unaffordable abortion.				
(French, Anthony et al. 2016) [United States]	To assess the association of clinician referral with decision-to-abortion time.	English-speaking women aged 19 years and older presenting for an abortion for all indications at the three abortion clinics in Nebraska [n=263]	Cross-sectional survey	Micro; Meso	The small number of clinician referrals — 16% of which were inappropriate — is likely multifactorial in origin: poor clinician education about where to refer patients, clinician discomfort discussing abortion and a culture of silence among clinicians driven by fear of marginalization. Women in our study may have been unwilling to openly acknowledge that they were considering abortion due to stigma.
(Friedman, Saavedra-Avendaño et al. 2018) [Mexico]	To examine how a legislative discrepancy (legalized access in the city center vs. restricted access in the remainder of the muncipalities in the metropolitan area) affects access to public-sector abortion across the Mexico City Metropolitan Area.	Data from Mexico City's publica abortion program and census for 75 municipalities.	Case-control	Micro; Macro	Stigma has been shown to be an important factor for women seeking abortion in Mexico, which may be more prevalent where abortion is illegal. It is possible that living where abortion is illegal is associated with increased experienced stigma, even when legal abortion is available in another part of the same city. For these reasons, women outside of the legal abortion zone may forgo accessing abortion services, or they may find it more feasible to access abortion illegally or outside of a health facility, which can be safe or may expose them to additional medical and legal risks.
(Garcete and Winocur 2006) [Mexico]	To analyze different aspects that affect access to legal abortion in Mexico City and the characteristics	Women who obtained or solicited legal abortion services between 2002-2006	Analysis of survey data	Macro	9.64% of the total of women who between 2002 and April 2006 requested an ILE (legal pregnancy interruption) received a negative response. However, this office does not resolve with precision, for example, what to do when the victim does not remember the exact date of the rape incident. Several studies of sexual violence confirm that 'forgetting' is a typical reaction, an unconscious mechanism of

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
	that currently define such abortion services				defense; but this is not understood by the Public Ministry. The belief that women are lying is recurrent in the discourse of people who decide the legality of an abortion due to rape.
(Messinger, Mahmud et al. 2017) [Bangladesh]	To investigate the knowledge, attitudes and practices regarding mHealth of both MR [menstrual regulation] clients and formal and informal sexual and reproductive healthcare providers in urban and rural low-income settlements in Bangladesh.	MY clients (n=24) and health service providers (n=24)	Qualitative	Micro	Given the stigma associated with MR, using formal mHealth services or using mobile phones informally to seek health care can help ensure women's privacy regarding obtaining MR service information.
(Payne, Debbink et al. 2013) [Ghana]	To describe major barriers to widespread safe abortion in Ghana through interviews with Ghanaian physicians on the front lines of abortion provision	Ghanaian physicians known for their commitment to safe reproductive health services (n=4)	Qualitative: Open-ended interviews with key informants	Macro	Abortion is stigmatized in Ghana for reasons including the high value placed on motherhood and social sanctions against premarital sexual relationships. Importantly, influential Christian and Muslim communities serve as drivers of societal opinion on such matters. Conservative interpretations within both religious groups consider abortion immoral, though, a wide range of beliefs regarding the permissibility of abortion early in pregnancy exists. Nonetheless, strict religious interpretations and beliefs influence societal attitudes toward women seeking abortion.
(Sutton 2017) [Argentina]	Explore how several clandestine zones build women's bodies in vital ways to the sovereign power of the State, both in dictatorship and in democracy	Women in Argentina	Meta-analysis	Macro	This mandate [penalization of induced abortion] already marks a form of exclusion from full citizenship, an exception to the rule of what are the fundamental rights of the members of the political community. The pregnant body (or body that may become pregnant) would seem to exempt the person in question from full citizenship and from their human rights.
(Wilder 2000) [Israel]				Macro	Although Jewish law condones the use of abortion when the fetus poses a serious physical or psychological threat to the well-being of the mother, the use of abortion as a method of birth control is proscribed. Previous research has documented an inverse association between

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
					religiosity and the acceptance of abortion, and highly religious Jewish women may be less likely to admit having had an abortion because of the social ban on the practice.
(Winikoff, Hassoun et al. 2011) [United States]	To examine the commercial, political, regulatory, and legislative history of the introduction of mifepristone / misoprostol in France and the United States.	n/a	Review	Macro	The technological innovation around medical abortion in the United States would not have been possible without the willingness of French science and industry to engage in abortion research. The attitudes of the French government and public were crucial in allowing registration of an abortion technology without resort to the automatic exceptionalism that has characterized all aspects of abortion research, services, and discussion in the United States.

Appendix E. Summary of studies reporting abortion-related stigma and methodology

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
(Hendrickson, Fetters et al. 2016) [Zambia]	To examine sales practices, knowledge, and behavior of pharmacy workers regarding medical abortion in 2009 and 2011 in Zambia, where hostile and stigmatizing attitudes still result in high rates of unsafe abortion.	Pharmacy workers at government-certified pharmacies in the intervention areas (76 pharmacies in November 2009 and 80 in November 2011)	Descriptive cross-sectional design	Meso	The mystery-client methodology provides a rare opportunity to elicit information about behaviors related to a stigmatized procedure. However, this means that each individual pharmacy worker's position, education, and previous exposure to medical abortion information are unknown to the mystery client, and therefore, the researchers. As part of the pilot study, many pharmacy workers in these pharmacies had participated in a 1-day training program on compassionate treatment for people seeking information about induced abortion, evidence-based regimens for medical abortion, and the provision of referrals to facility-based induced-abortion services.
(Schiavon, Collado et al. 2010) [Mexico]	To know whether factors [fear of staff attitudes, ignorance about the law, lack of information on where to access services, fear of breaches in confidentiality, burdensome requirements] were driving women in Mexico City to continue seeking private abortion services despite the availability of low-cost, safe, legal abortion services in the public sector.	Health providers working in lower middle-class neighborhoods with small community health facilities [n=135 private sector physicians]	Descriptive	Micro; Macro	Since abortion is still highly stigmatized in Mexico and concerns about breaking the law may still exist, there may have been under-reporting on some of the questions, particularly in regard to services before the law changed.

Appendix F. Summary of studies reporting abortion-related stigma in relation to non-economic outcomes

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
(Agadjanian 2002) [Kazakhstan]	To analyze and compare trends in abortion and contraception, women's attitudes toward abortion, and their perceptions of problems associated with abortion and contraception in Kazakhstan.	Kazakh women aged 15-49	Cross-sectional descriptive survey	Macro	Russified Kazakhs and, especially, Europeans are markedly different from non-Russified Kazakhs: The former two groups are significantly less likely to disapprove of abortion outright. Overall, younger women, regardless of ethnicity, were significantly more likely to disapprove of abortion, which may attest to shifting attitudes in society in response to the government's efforts to promote contraception. Notably, moral considerations concerning abortion, the only aspect in which abortion may be seen as radically different from—and even incompatible with—contraception, are of little importance to Kazakhstani women, despite increasing condemnation voiced primarily by Muslim and Orthodox clerics. If the discourse on the immorality of abortion is to have any effect on the generalized tolerance of abortion, its impact will likely differ across the ethnocultural groups.
(Brack, Rochat et al. 2017) [Colombia]	This study sought to identify the key barriers to legal abortion, and to explore the ways they may work separately and together to delay the receipt of high quality, legal abortion care.	Women who obtained a legal abortion in Bogotá (n=17).	Qualitative: in-depth interviews	Micro; Meso	For four of the study participants, stigma associated with abortion led to delays in decision making and in obtaining services. Of the nine study participants who had told their partner about the pregnancy, three felt pressured by their partner to carry the pregnancy to term and to get married. The partners of these three participants voiced religiously motivated antiabortion attitudes; the women stated that this dynamic resulted in delays in decision making and in obtaining services.
(Aiken, Gomperts et al. 2017) [Ireland]	To document the experiences and characteristics of women seeking and completing at-home medical termination of pregnancy through online telemedicine in Ireland and Norther Ireland.	Women resident in Republic of Ireland and Northern Ireland who requested at-home medication abortion through online telemedicine [n=5650]	Cross-sectional descriptive	Micro; Macro	Women spoke of the stigma attached to pregnancy in some social circumstances, the stigma surrounding termination of pregnancy (TOP), and the psychological suffering caused by having to continue a pregnancy they did not want or feel they could continue. Women commonly felt shame and isolation due to the stigma surrounding TOP. The findings of this study suggest that the most negative component of women's experiences with at-home medical TOP is the need to maintain secrecy and silence because of the social stigma and a fear of prosecution engendered by its illegal status.
(Aiken, Guthrie et al. 2018) [United Kingdom]	To examine reasons for seeking abortion services outside the	Women resident in England, Scotland, and Wales who	Cross-sectional descriptive	Micro	Participants indicated that they were ashamed and embarrassed to return to a clinic for an abortion if they have been there previously for an abortion as they believe they will be judged for having another one.

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
	formal healthcare system in Great Britain, where abortion is legally available.	requested at-home medication abortion through online telemedicine. [n=209]			Other participants mentioned that they could not go to their local clinic because their town is small and a family member works there, and everyone would know they had an abortion. These are some reasons women access abortion services outside the health system, despite their availability within the formal system.
(Altshuler, Ojanen-Goldsmith et al. 2017) [United States]	To compare women's needs and preferences in abortion to those in birth To examine ways in which women's needs and preferences in abortion care differ from intrapartum care	Women who had individually experienced both birth and abortion (n=20)	Semi-structured intensive interviews and a validated Individual Level Abortion Stigma scale (ILAS) assessment	Meso	This study used the Individual Level Abortion Stigma scale to measure the degree of personal stigma of the participants. In regards to abortion care, three elements were found to impact results: affirmation as moral decision-makers, ability to determine degree of presence during the abortion process, and provision of care in a discreet manner to avoid being judged by others for having an abortion. Many participants detailed interactions with their providers. The response of the providers had a distinct impact on the internalized stigma of the participant.
(Aniteye and Mayhew 2011) [Ghana]	To explore and understand the reasons why women terminate their pregnancies and their experiences of seeking services in order to know what and how to reform services to reduce unsafe abortion.	Women admitted to the hospitals with incomplete abortions (n=131)	Semi-structured hospital-based survey	Macro	In a country where Christian morals are strong the high proportion of respondents who were single is significant because the social stigma of bearing children out of wedlock is great. Reflecting this, about one third of respondents said they aborted because they were not married and two-thirds said they aborted because of socio-cultural pressures.
(Appiah-Agyekum, Sorkpor et al. 2015) [Ghana]	To explore the factors that are likely to influence abortion decisions among University students in Ghana and their knowledge and perceptions on abortion.	Randomly sampled students of the University of Ghana (n=142)	Qualitative: FGDs	Meso; Macro	The student participants of this study claimed that they were more likely to abort if they felt that the pregnancy will bring shame, disappointment, or resentment from their family. This study further suggests that although a good number of students support the existence of liberal laws, entrenched religious beliefs and doctrines as well as socio-cultural factors may explain the strong anti-abortion sentiments held by some students. While serving as a basis for their support for the banning of abortions, these same factors may account for their refusal to support or undergo abortions even if necessary to preserve their health and/or that of the unborn child, as well as their acceptance and indulgence in abortion stigma.

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
(Appiah-Agyekum 2018) [Ghana]	To explore the abortion experiences of Ghanaian university students	Female undergraduate students at the University of Ghana [n=32]	Qualitative cross-sectional descriptive	Meso	Students who had used the services of blue star facilities in Ghana did not patronize them for subsequent abortions nor recommend their use to their peers because of the unfavorable proximity, stigma attached to persons seen entering or leaving the premises of safe abortion providers, acquired knowledge on administering the drugs, over-bureaucratic administrative processes, waiting time, and cost of services.
(Baird 2015) [Australia]	To describe the context through which medical abortion has become available in Australia since 2013.	Australia	Narrative review	Meso; Macro	The stigma attached to being an abortion provider continues to be a major disincentive for general practitioners, especially in small rural communities. General practitioners have also worried that if they become identified as providers of medical abortion, their practice will be overwhelmed by requests for abortion. Some doctors also expect resistance to provide medical abortion from colleagues and in local communities. A New South Wales sexual and reproductive health referral service reported that in the first year after mifepristone became a subsidised medicine, when about one third of their callers who were seeking an abortion were wanting a medical abortion, some of the small number of general practitioners on their referral list "requested to be removed from our database".
(Banerjee, Andersen et al. 2012) [India]	To compare women with induced abortions with women with spontaneous abortion.	Women of reproductive age who were seeking care for postabortion complications [n=344] at one of 10 hospitals.	Cross-sectional descriptive survey	Micro; Meso	Lack of social support, lack of knowledge about the legality of induced abortion, and abortion-related stigma influenced the type of provider women approached for abortion care.
(Casas and Vivaldi 2014) [Chile]	To describe a study of the criminalisation of abortion as a human rights violation in Chile.	n/a	Review	Macro	The Public Defender acknowledged in a newspaper article that the abortion law has an unequal effect on women, especially the poor. He remarked on the cases of two adolescent girls whose experiences exemplify how medical confidentiality may be violated. They had been raped, yet they were found guilty of illegal abortion and stigmatised twice by the criminal justice system, instead of being protected as victims of sexual violence.
(Casas-Becerra 1997) [Chile]	To highlight the gender and poverty-related discrimination that poor women having abortions face in Chile, and how the	Case review files	Review	Meso; Macro	Most of the cases of women who had abortions in our study (76 per cent) had been reported to the police by the public hospital where they had sought treatment for complications. Save for one, all the hospitals we came across in the files of the Santiago prison were publicly run facilities providing medical care to the poor and indigent. The remaining 24 per cent of the women were reported to the police by partners,

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
	law is used to undermine medical confidentiality .				relatives or employers (11 per cent) and some were found out by police by mere chance (4 per cent). Most of these were charged following a confession by the woman, or were identified at the hospital if they happened to have taken the woman there.
(Chevrette and Abenhaim 2015) [United States]	Assess whether US state-level policies regarding abortion and sexual education are associated with different teen birth and teen abortion rates	National teen birth and teen abortion rates	Regression analysis	Micro	The results of this particular study show that the main determinants of teen births are cultural and dependent on family and peer values, which would agree with recent publications. Teenagers worldwide tend to go along with what is socially accepted by peers and family.
(Chunuan, Kosunvanna et al. 2012) [Thailand]	The purpose of this descriptive study of women from southern Thailand, who had undergone a recent abortion (spontaneous, therapeutic and unsafe), were to obtain data regarding: pregnancy history; number of abortions and cost of abortion related treatments; abortion complications, impacts and related health care services; reasons for having an unsafe abortion; and, circumstances related to an unsafe abortion.	Women that received abortion services from one of six government hospitals	Convenience sample and questionnaire	Macro	Study participants who experienced an unsafe abortion stated they preferred to terminate their pregnancy as soon as possible. No doubt this was because they did not want others to know about their pregnancies. Since Thai women are expected to preserve their virginity and display sexual correctness, women who get pregnant before marriage tend to be morally condemned. Furthermore, premarital and extramarital sex are frowned upon in the Thai culture and there is little sympathy for those who become pregnant out of wedlock, especially since it is believed women, but not men, can control their sexual desires. Thus, having an abortion often is associated with the woman having a lack of morals and virtue.
(Cook, de Kok et al. 2017) [Malawi]				Micro; Meso; Macro	Many health workers described finding PAC challenging due to their personal belief that induced abortion is immoral. These feelings were influenced by religious beliefs and prevailing community beliefs and norms. Participants explained that PAC is often only associated with induced abortions by the public and there tends to be negative

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
					attitudes towards these women, with people considering them 'sinners' or 'criminals'; these words and views were often reflected by health workers. PAC has been promoted as the least contentious service for reducing unsafe abortions' adverse consequences, but it cannot be separated from the socio-cultural, religious and legal status of abortion. Negative attitudes surrounding abortion may lead to delays; women who delay seeking care are at increased risk of more severe complications such as sepsis, resulting in being more likely to require further procedures in theatre rather than MVA as an outpatient. Negative attitudes may also result in providers' negative attitudes towards providing PAC, low prioritization of services and low motivation to improve services.
(David and Baban 1996) [Romania]	Explore, through individual in-depth interviews, psychosocial antecedents and consequences of the Romanian pronatalist policies banning importation of contraception, prohibiting abortion, and imposing tax on childless couples.	Women seeking abortion services prior to the revolution (n=50).	Qualitative: open-ended interviews	Micro	Unmarried women who considered single parenthood a social stigma were in an especially difficult situation.
(de Bruyn 2003) [Global]	Summarises the results of a literature review on the subject of unwanted pregnancy and induced abortion among women living with HIV/AIDS.	Women living with HIV/AIDS	Review	Micro; Meso	In India in 2002, two nurses reported: ''I was working as a nurse in a reputed Mumbai hospital and came to know about being HIV positive when I miscarried. I was bleeding profusely, but the gynaecologist refused to even touch me. I was shifted to a municipal hospital, but had a similar experience there.
(Diniz, d'Oliveira et al. 2012) [Brazil]	To examine equity in health and health care in Brazil, examining unjust disparities between women and men, and between women	Brazil	Review	Meso	A recent study evaluated the quality of abortion care for women admitted to public hospitals in three state capitals. The care provided was far below the standards set by the Brazilian government, and pain management was frequently inappropriate. Sharp curettage (D&C) was the method used in almost all cases, which requires analgesia or deep sedation, hospital admission, longer waits for treatment, an overnight stay of at least 24 hours, and a greater risk of complications.

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
	from different social strata, with a focus on services for contraception, abortion and pregnancy.				Maintaining this outdated practice violates the principle of integrity and the aim of replacing less safe interventions with safer ones. The study also found other forms of discrimination, such as the postponement of curettage until night shifts.
(Dobie, Gober et al. 1998) [United States]	31 family planning clinic sites in rural Washington State were surveyed about their sponsorship, staffing, service provision and population coverage.	Family Planning clinics in rural Washington (n=31).	Cross-sectional survey	Meso	Study results indicated that the two most important reasons for not providing onsite abortions were local community opposition and lack of a trained provider. The two most common reasons rated as unimportant were the moral or religious concerns of staff and the availability of the service at another local facility.
(Doran and Nancarrow 2015) [United States]	To identify the factors that facilitate and hinder access to abortion services for women in developed countries in relation to first-trimester abortions.	n/a	Systematic Review	Meso	Actual or potential harassment influences hospital and provider willingness to provide abortions. One in five advanced clinicians identified fear of anti-abortion harassment as a perceived barrier to offering medical abortion. Several studies explored provider attitudes towards abortion and abortion law. As only 2/114 family physicians surveyed perform surgical abortions it was not surprising that 80% of physicians in this study had moral objections to abortion. Reasons for not providing abortion services were religious and community opposition. Negative attitudes of non-physician staff restricted access to abortion, and impacted women's experiences of abortion services. Some GPs in Norway reported ambivalence towards their own refusal practices related to a non-absolutist conscientious objection stance illustrated by willingness to make certain compromises to refer women. Although most physicians surveyed in the USA did not report an objection to abortion in general, abortion for gender selection was not supported by 75% of participants.
(Doran and Hornibrook 2016) [Australia]	Identify factors that women in rural New South Wales (NSW) experience in accessing abortion services and suggestions about how rural women could be better supported when	Women who sought access to abortion while living in a rural part of NSW (n=13).	Qualitative: in-depth interviews	Micro; Meso; Macro	An emergent theme was of women's experiences of stigma, shame and secrecy. External stigma was exacerbated by protestors, and internalised stigma was linked to feelings of shame and secrecy. Some women discussed the consequences of stigma and the lack of respect for women to make reproductive decisions concerning their own bodies. Stigma and negative characteristics linked to abortion are perpetuated by social and political processes including media portrayals, which in turn influence women's experiences, examples of which have been reported by women in this study. Women in this study point to non-integrated health systems, as evidenced by their

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
	seeking access to an abortion service.				experience of sub-standard primary care where doctors did not readily refer, did not provide accurate information about self-referral options and expressed judgemental attitudes reflective of their moral objections.
(Esia-Donkon, Darteh et al. 2015) [Ghana]	Explore the pre and post experiences of young people (aged 12 to 24) who had their abortion three months prior to the study.	Young people (12-14) who received abortion services at the Planned Parenthood Association of Ghana Cape Coast clinic (n=21).	Qualitative: in-depth interviews	Micro; Meso; Macro	With the perception that abortion was illegal, 'murderous' and sinful, the respondents generally found it difficult to take the decision even though to them, there was no other option available. Some reported that their sexual partners were against the abortion and therefore threatened a break-up of the relationship if the pregnancy was terminated. The respondents were aware of both public and private health facilities where abortion services are provided. However, apart from being a youth friendly centre, the choice of the PPAG clinic was based on other reasons. The location of the facility is convenient in that it does not attract many potential 'gatekeepers' and gossips, and the attitude of staff is youth friendly and compassionate. Psychologically, the respondents were worried about the fact that an 'illegality', a 'crime' and sin had been committed against humanity and God. This guilt led to self-imposed stigma, which was usually reinforced by sermons and talks about abortion at the Church, in the media and no other social platforms.
(Finer, Frohwirth et al. 2005) [United States]	Examine the steps in the process of obtaining abortions and women's reported delays in order to help understand difficulties in accessing abortion services.	Women seeking abortion services (n=1,247). Location and facility details presented in another publication (Finer 2005).	Mixed methods	Micro	Although some described abortion as sinful and wrong, many of those same women, and others, described the indiscriminate bearing of children as a sin, and their abortion as "the right thing" and "a responsible choice." Respondents often acknowledged the complexity of the decision, and described an intense and difficult process of deciding to have an abortion, which took into account the moral weight of their responsibilities to their families, themselves and children they might have in the future.
(Foster, LaRoche et al. 2017) [Canada]	To document women's experiences obtaining abortion care in New Brunswick (NB) before and after the Regulation 84-20 amendment; identify the economic and personal costs	New Brunswick residents who received abortion services (n=36).	Qualitative: semi-structured interviews	Micro; Meso	Referring a woman elsewhere to obtain information or a referral for the procedure compromises patient care, especially when the procedure is time sensitive. Referrals, let alone referrals for referrals, create significant delays in scheduling and further contribute to the burden faced by those women seeking services.

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
	associated with obtaining abortion care; and examine the ways in which geography, age and language-minority status condition access to care.				
(Gerdts, Raifman et al. 2017) [South Africa]	To investigate the reasons for attempting self-induction, methods used, complications, and sources of information about informal sector abortion, and test a recruitment method.	Women [n=41] who sought informal sector abortion services in Cape Town, South Africa using respondent driven sampling (RDS).	Cross-sectional descriptive survey	Micro; Meso	30% of women in our study cited seeking an informal sector abortion because of concerns about privacy, mistreatment and stigma from providers is a striking commentary on the perceptions of quality of abortion care in the formal sector. In a sample population consisting of many sex workers, mistrust of the formal health care system is not unexpected; sex workers seeking abortion in Cape Town likely face a double stigmatization related to abortion and their work.
(Glenton, Sorhaindo et al. 2017) [Bangladesh, Ethiopia, Nepal, South Africa and Uruguay]	To explore factors influencing the implementation of role expansion strategies for non-physician providers to include the delivery of abortion care	Non-physician providers of abortion services within multiple health facilities in each country non-physician providers	Qualitative: Case study, literature review, and key informants	Meso	In South Africa, some nurses, midwives, specialist and non-specialist doctors described feelings of rejection, stigma and negative comments because of their work from colleagues who did not provide abortion care, particularly when delivering second-trimester abortions. South African abortion providers were also reported as avoiding abortion training because of stigma from colleagues.
(Gober 1997) [United States]	This paper investigates the role of access in explaining the variation in state abortion rates.	States in the United States (US)	Regression/Path analysis	Macro	After the Supreme Court's refusal in 1992 to overturn Roe and eliminate the right for women to have abortions, militant antiabortion groups moved the battle over abortion rights from the courts to the streets. The National Abortion Federation estimated that incidents of violence (including bombings, arson, vandalism, death threats, and the stalking of clinic personnel) increased from 131 in 1984 to 434 in 1993. As a response, the Freedom of Access to Clinic Entrances Act was passed in May, 1994. This Act makes it a federal offense to physically obstruct the entrance of an abortion clinic or to use force, threats, or tactics intended to intimidate women seeking abortions.
(Graff and Amoyaw 2009) [Ghana]	Situational analysis to identify barriers to sustainable MVA supply.	Literature review; stakeholders involved with MVA policy,	Situational assessment	Meso	Additional barriers included: negative abortion stigma; high cost of equipment; lack of preferred MVA_ model availability; limited access to MVA trainings; and lack of priority when facility funds are limited.

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
		manufacturing, procurement, training, and provision (n=70).			
(Grindlay, Lane et al. 2013) [United States]	The purpose of this study was to evaluate patients' and providers' experiences with telemedicine provision of medical abortion.	Women receiving telemedicine (n=20) or in-person (n=5) medical abortion services from Planned Parenthood of Heartland clinics in Iowa.	Qualitative: in-depth interviews	Micro	Some participants felt more strongly about their preferences, with several stating that they would choose telemedicine over an in-person visit if all other factors were equal. In two cases, this was because of internalized or anticipated stigma related to the abortion that made it feel easier for the women to talk to the doctor in a more removed manner. Internalized abortion stigma seemed to color some women's perceptions of the telemedicine service. For a few women, the anonymity provided by the videoconference communication insulated them from the interaction with the physician, which they anticipated to be negative, and allowed them to maintain a degree of secrecy about the procedure even from their provider.
(Grossman, Ellertson et al. 2004) [Global]	Review of protocols and existing evidence on follow-up care for abortion.	Global literature on follow-up visits for abortion care.	Literature review	Micro; Meso	Transient feelings of guilt, sadness, or loss are common, but no evidence indicates that routine counseling is essential or even beneficial in coping with these feelings. More serious psychiatric illness after abortion occurs in women with a history of psychiatric illness. Risk factors for more serious postabortion psychosocial difficulties, including coercion to either have or not have the abortion, a genetic or medical indication for the abortion, lack of social supports, and women who demonstrate paralyzing ambivalence about the procedure. Even more difficult to quantify are the potential emotional costs of a postabortion follow-up visit. Women who return for a follow-up visit at an abortion clinic may be forced yet again to cross picket lines, an unfortunate feature of 80% of large facilities that provide abortion.
(Guttmacher, Kapadia et al. 1998) [South Africa]	Article examines the policies that have regulated accessibility of abortion and assesses their impact on reproductive health.	South African policies.	Review of policies and related evidence	Meso; Macro	Under the new act, health care workers are not mandated to perform abortions, or even to refer women to other providers. Their only obligation is to inform women of their rights under the new law. Thus, lack of cooperation by health care workers claiming conscientious objection due to moral or religious conflicts is emerging as a major obstacle for women seeking abortion services.
(Harries, Lince et al. 2012) [South Africa]	To better understand what doctors, nurses and hospital managers involved in second trimester abortion care thought	Abortion-related service providers and managers in the Western Cape Province, South Africa (n=19)	Qualitative: In-depth interviews	Meso	The contentious nature of abortion provision resulted in many providers being stigmatized in their workplace. Stigma was often heightened with second trimester abortion services compared with first trimester services. Related to this abortion services were often located in hidden or difficult to access places where providers who worked

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
	about these services and how they could be improved				there were viewed as performing the 'devil's work', as one nursing manager recounted.
(Haas-Wilson 1996) [Zambia]	Estimate the impact of enforced abortion restrictions on minors' demand for abortion services between 1978-1990	Minors who sought an abortion	Regression analysis	Macro	The proxy measuring the enactment of unenforceable state restrictions, REGS, appears to increase both ABORTIONS/MINORS and ABORTIONS/BIRTHS. The proxy measuring the presence of religious opposition to abortion in the state, BELIEF, appears to decrease ABORTIONS/MINORS, but increase ABORTIONS/BIRTHS. A possible explanation of this result is that increases in BELIEF may be associated with fewer abortions obtained by minors and fewer births to minors, but BELIEF is unrelated to the number of minors in a particular state.
(Henshaw 1995) [United States]	To provide information on the percentage of women who travel long distances to obtain abortion services, the availability of abortion providers for second trimester services, the need to make more than one trip to the abortion facility and the amount abortion providers charge for services. In addition, it presents a measure of antiabortion harassment.	Abortion providers in the United States (n= 1,525)	Cohort	Meso	Another barrier facing many women seeking abortion services and the ability of facilities to provide services is harassment by antiabortion protesters. As in earlier rounds, this study's 1993 survey asked providers to indicate the number of times they had experienced various types of harassment during the previous year. In all, 55% of nonhospital providers reported experiencing at least one of the 10 listed types of harassment during 1992. Harassment is strongly associated with the abortion caseload, with 86% of facilities that performed 400 or more abortions in 1992 reporting some harassment, compared with 29% of providers with a smaller caseload. The questionnaire for nonhospital providers asked for a list of the major problems that affected their ability to provide abortion services over the previous 12 months. Their responses indicate that providers see harassment and other expressions of antiabortion sentiment in the community as their most important problem with respect to abortion. Other referenced problems included picketing (8%), demonstrations and blockades (5%), vandalism and other direct action (8%) and other types or effects of harassment (8%). An additional 11% mentioned the physician shortage or other staffing problems that may be indirectly related to harassment, and 2% named lack of cooperation of police or other authorities.
(Htay, Sauvarin et al. 2003) [Myanmar]	Describes the process undertaken by the Department of Health (DOH) in Myanmar to address the issue of abortion complications, by integrating post-abortion care and	Health-providers [n=285] and post-aboriton women [n=170].	Cross-sectional descriptive survey	Micro; Meso	Study results found that village women tended to delay seeking care for post-abortion complications after an induced abortion for two main reasons — fear of neighbours knowing and fear that health staff in the hospital would blame them. Preliminary post-intervention research has shown that involving midwives in these ways has had positive results, with midwives having improved knowledge and confidence to counsel women post-abortion. Midwives felt that women welcomed their visits and the information they provided. The attitudes of the midwives

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
	contraceptive service delivery into existing health care services				towards women post-abortion were also much more sympathetic than prior to training.
(Hulme-Chambers, Temple-Smith et al. 2018) [Australia]	To understand rural women's experiences in obtaining a medical termination of pregnancy (MToP) through a rural primary healthcare service in Victoria, Australia.	Women aged 16 years and over who attended clinic between February 2016 and 2017 for an appointment related to MToP. [n=18]	Qualitative [semi-structured interviews]	Micro; Meso	A small number of women reported feeling that their GP was obstructionist about MToP referral. As part of the MToP process, women needed to have an ultrasound to confirm intrauterine pregnancy and to obtain the mifepristone and misoprostol from the one pharmacy that the clinic has an arrangement with to stock it. Almost half of women discussed upsetting experiences when obtaining an ultrasound. Women reported feeling like the pharmacist or staff were judgmental as well.
(Izugbara, Egesa et al. 2015) [Kenya]	How, in the context of Kenya's current abortion law as well as severe abortion stigma in the country, do ordinary women perceive and understand abortion safety? How do lay and public health discourses of abortion safety compare?"	A convenience sample of 50 women treated for complications of unsafe abortion at six purposively-selected public facilities in Kenya.	Qualitative cross-sectional descriptive	Micro; Meso	The women we studied generally viewed induced abortion as a problematic and morally-contentious issue that was not permissible in Kenya. Generally, participants felt that they had engaged in a deviant and problematic behavior by procuring an abortion. Hospital-based providers were reportedly condemnatory and judgmental towards women seeking abortion. They reportedly gossiped about women among themselves, called them names and even publicized their abortion. Providers and facilities that act as accomplices and coconspirators with the women were considered key to abortion safety. In the current study, women's abortion safety notions underscored their anxieties, struggles and concerns as everyday people negotiating both an intensely stigmatizing behavior as well as an unsympathetic health system.
(Izugbara and Ukwayi 2003) [Nigeria]	To profile the characteristics and health conditions of the clientele of traditional birth homes (TBHs) in four rural communities in southeastern Nigeria	Users of TBHs and traditional birth attendants (TBAs) in rural southeastern Nigeria	Qualitative interviews	Micro; Meso	Across all age categories, the need for secrecy and privacy over condition was the most frequently mentioned reason for using TBH services. Many of the users noted that privacy was unlikely in hospitals.
(Jejeebhoy, Kalyanwala et al. 2010) [India]	To shed light on the experiences of unmarried young abortion-seekers aged 15–24, compare their experiences	A survey of abortion seekers and in-depth interviews with selected unmarried survey respondents	Cross sectional descriptive: survey and qualitative	Micro	Unmarried young women who reported each of the experiences underlying delayed abortion fared far worse. They were, for example, three to five times more likely than married young women to undergo second trimester abortion if they failed to recognise pregnancy by the second month, if they were excluded from decision-making.

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
	with those of their married counterparts, and explore the proximate factors leading to delays in them obtaining abortions into the second trimester.	[n=795 young women were surveyed: n= 549 unmarried, n=246 married]. In-depth interviews with n=26 randomly selected unmarried survey respondents. Sampled from facilities in two poorly developed neighbouring states in north India with weak health systems.			
(Kishen and Stedman 2010) [Global]	Study examines evidence to suggest that the outcome of first-trimester abortions performed by suitably trained non-medical practitioners is comparable in terms of safety and efficacy to abortions performed by doctors.	Literature and data on national averages of costs to obtain an abortion.	Literature review	Meso	In South Africa, where abortion access has been addressed through trained-midwife participation, some midwives involved in providing abortion services report that they do not always receive the necessary equipment, supplies and supervision they need; that some of their colleagues, as well as members of the community, harass and intimidate them for offering this service.
(Margo, McCloskey et al. 2016) [United States]	To examine the impact of state policies along with other barriers when they seek abortion care	Women in South Carolina	Qualitative	Micro	Some participants anticipated stigmatizing reactions from others, which led to self-protective secretive behavior. One woman compared such reactions to mental health care stigma, saying that she would readily explain her work absence to a colleague if abortion were viewed like any other medical procedure, but as the situation stands, it felt risky to do so.
(Marlow, Wamugi et al. 2014) [Kenya]	To understand the methods married women aged 24–49 and young, unmarried	Focus groups [n=10] conducted in Trans Nzoia and Bungoma county	Qualitative cross-sectional descriptive	Micro; Meso	When women in both ages groups in the study were asked how a woman known or thought to have had an abortion would be treated by her community, all the focus groups discussed how women are ostracized, labelled and stigmatized as killers or murderers, are

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
	women aged ≤ 20 used to induce abortion, the providers they utilized and the social, economic and cultural norms that influenced women's access to safe abortion services in Bungoma and Trans Nzoia counties in western Kenya.	with un/married and younger/older women in rural and urban settings.			perceived to be a bad influence on others, are called prostitutes and accused of being unfaithful to their husbands or boyfriends. Younger women are perceived to be poor candidates for marriage.
(Mutua, Manderson et al. 2018) [Kenya]	To illustrate how the quality of PAC in healthcare facilities is impacted by law and government policy.	Patients [n=21] and providers [n=16] at 16 hospitals in three regions sampled purposively by regional area, level, and reported quality of care.	Qualitative cross-sectional	Micro; Meso; Macro	Some providers also spoke of disrespect to patients (from providers other than themselves) and argued the need for positive attitudes by health providers to encourage timely seeking of PAC services. These attitudes have also been associated with the high incidence of unsafe abortion in the country, and severe complications when women opt to self-medicate complications from unsafe terminations. In addition to age, discrimination occurred on the basis of marital status, with service providers likely to conclude that an abortion was induced if a patient was unmarried. Unmarried patients were therefore more likely to lie about their marital status, in order to gain access to the same level of care as provided to married patients. In addition to delays in seeking care occasioned by legal challenges, as discussed earlier, other forms of service unavailability and stigmatization influenced general patterns of healthcare seeking.
(Mutungi, Wango et al. 1999) [Kenya]	To evaluate the adolescents' behavior regarding induced abortion	Adolescent girls and boys ages 10-19 (n=1820 adolescent, 1048 school girls, 580 school boys, and 192 post abortion patients)	Cross-sectional prospective study	Micro	Many boys shy away from any responsibility and abandon their girlfriends once the girls become pregnant.
(Penfold, Wendot et al. 2018) [Kenya]	To explore the pathways, decision-making, experiences and preferences of women receiving safe	Women [n=22] who had received an abortion or post-abortion care	Qualitative cross-sectional	Micro	Most respondents were satisfied with the clinic and the service they received and women commonly recalled feeling relieved after completing the abortion. However, in a few cases clients recalled a negative experience at certain clinics, being made to feel "guilty".

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
	abortion and post-abortion family planning (PAFP) at private clinics in western Kenya.	service at one of nine clinics.			
(Robson, Kelly et al. 2009) [United Kingdom]	To determine the acceptability, efficacy and costs of medical termination of pregnancy (MTOP) compared with surgical termination of pregnancy (STOP) at less than 14 weeks' gestation, and to understand women's decision-making processes and experiences when accessing the termination service.	Women accepted for termination of pregnancy (TOP) with pregnancies < 14 weeks' gestation on the day of abortion.	A partially randomised preference trial and economic evaluation with follow-up at 2 weeks and 3 months.	Micro	Once women were referred to the hospital, some had trouble locating the clinic and were reluctant to ask for directions, suggesting a degree of stigma attached to attending the TOP clinic.
(Sethna and Doull 2013) [Canada]	To analyse the travel women undertake to access abortion services at freestanding clinics.	Women [n=1186] seeking abortion care at 17 freestanding abortion clinics.	Cross-sectional survey and mapping	Meso	Hospital-based abortion services are essential to women living in some rural and remote communities as they may be the only point of health care access in their community. They may also provide women seeking abortions with a level of safety that can be jeopardized by protesters at freestanding abortion clinics. At the same time, women may wish to avoid hospital-based abortion services because of confidentiality issues, particularly in smaller centers. Anti-abortion hospital staff may also deliberately mislead women about the availability of local abortion services or take a judgemental approach to women seeking abortions.
(Shah, Åhman et al. 2014) [Global]				Micro	Stigma is among the reasons mentioned for seeking an unsafe abortion. Given that these deaths or complications occur following a clandestine or illegal procedure, stigma and fear of punishment deter women and their families from reporting the procedure.
(Singh 2010) [Global]	To review the scientific evidence on the consequences of unsafe abortion, highlight gaps in the evidence base,	Women who had unsafe abortions.	Review	Micro; Meso	Stigma can be very consequential for unmarried and young women because of the strong social sanctions against sexual activity among these groups, as well as their lack of resources and inexperience in seeking healthcare. Potential consequences for unmarried young women suspected of having had an abortion include difficulty finding a partner to marry. Married women may also experience stigma because

Author, year [country]	Aim/objective(s)	Population	Study type	Level	Summary of main findings
	suggest areas where future research efforts are needed, and speculate on the future situation regarding consequences and evidence over the next 5–10 years.				their husband and others may suspect them of infidelity; sociopsychological consequences can also be important, and may result from the attitudes of others, as well as from individuals' own feelings of guilt and shame.
(Wainer 2008) [Australia]	To illuminate an important clinical question that had been inaccessible to researchers until the 1970s: What effect did an abortion have on normally rule abiding women?	Women seeking abortion services	Interviews	Micro	In the 1970s, women who were sexually active and avoided visible pregnancy, either by contraception or abortion, were better able to manage their identity as a good person than a single woman with a visible pregnancy, and so abortion can become a tool of identity management. The study participants produced four descriptions of abortion as an event based on what they thought community beliefs would be. These were that abortion was morally wrong, that it was dangerous, that is was illegal, and that it was necessary/acceptable.
(Whittaker 2002) [Thailand]	To examine the effects of the current laws through the experiences of women who have undergone illegal abortions.	Women of reproductive age	Qualitative	Micro	Among the study participants interviewed, abortion is considered to be a life-destroying act that constitutes a serious Buddhist sin/demerit. Many women cited fear of bap (Buddhist demerit) as the reason why they chose to continue with an unplanned pregnancy.

Appendix G. Summary of studies reporting micro-economic costs

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Aantjes, Gilmoor et al. 2018) [Eastern and Southern Africa]	To identify and synthesize the literature on postabortion care (PAC) in eastern and southern Africa with the aim of reporting on the reach, quality, and costs of these services	Varied by studies on PAC, health workers in PAC, incidence and abortion-related service reviews	Systematic review	Medical abortion (MA) is the cheapest method followed by manual vacuum aspiration (MVA) and then dilatation and curettage (D&C). In Malawi in the absence of complications, researchers estimated MA to cost U$ 12, MVA to cost U$ 19, and D&C to cost U$ 19. In the presence of complications, PAC costs increased to U$ 63 for severe non-surgical complications and U$ 128 for severe surgical complications. In South Africa, researchers estimated MA to cost U$ 61 and MVA to cost U$ 69. In Swaziland, MA cost U$ 75 and D&C cost U$ 115. In Rwanda, PAC costs were higher if treated in regional health facilities (U$ 239) than in district hospitals (U$ 93) or health centres (U$ 72). Treatment costs for one instance of post-abortion morbidity represented more than three times the annual per capita health expenditure in Uganda and more than five times that in Ethiopia. Law reform and provision of
(Agadjanian 2002) [Kazakhstan]	To analyze and compare trends in abortion and contraception, women's attitudes toward abortion, and their perceptions of problems associated with	Kazakh women aged 15-49	Cross-sectional descriptive survey	Of the 63% of respondents in who reported that it was difficult to obtain an abortion, and subsequently asked to identify the "main difficulty", 40% identified "financial problems", with variations between ethnocultural groups (non-Russified

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	abortion and contraception in Kazakhstan.			Kazakhs: 27.8%, Russified Kazakhs: 38.2%, Europeans: 47.7%). 54.2% of all respondents perceived financial problems to be associated with obtaining an abortion.
(Ahmed, Islam et al. 1999) [Bangladesh]	To understand where rural women go for induced abortion, their contraceptive practice prior to and after getting pregnant, their reasons for choosing abortion, who makes the decision for abortion, what complications they develop and where they go for treatment for these.	Women who came to one of two rural hospitals (THCs) or four static clinics (H&FWCs) for an abortion-related reason in two rural sub-districts of Bangladesh (Mirsarai and Abhoynagar). [n=143]	Cross-sectional descriptive	Although MR [menstrual regulation] services are supposed to be free of cost in Bangladesh, most providers charge a fee and for medicines. Information on cost (including payments to providers and for medicines) from 62 women: average cost - 618 Taka (range Taka 50-6,000). Average cost was higher for those who aborted at home or at the provider's place (907 Taka) vs. abortion at a health facility (409 Taka).
(Aiken, Gomperts et al. 2017) [Ireland]	To document the experiences and characteristics of women seeking and completing at-home medical termination of pregnancy through online telemedicine in Ireland and Northern Ireland.	Women resident in Republic of Ireland and Northern Ireland who requested at-home medication abortion through online telemedicine [n=5650]	Cross-sectional descriptive	Difficulty affording the €70 donation (34.6%).
(Aiken, Guthrie et al. 2018) [United Kingdom]	To examine reasons for seeking abortion services outside the formal healthcare system in Great Britain, where abortion is legally available.	Women resident in England, Scotland, and Wales who requested at-home medication abortion through online telemedicine. [n=209]	Cross-sectional descriptive	Reasons for accessing abortion services outside the formal healthcare setting: lack of eligibility of free NHS [National Health Service] services (13.4%), distance or lack of transport to clinic (9.1%). Women ineligible for free non-emergency NHS services face particular barriers paying for abortion care; these women are either undocumented immigrants, or have been admitted under a visa program and considered visitors to rather than naturalized ordinary residents of Great Britain. For many of these women, the minimum cost of abortion would be approximately £545.
(Aiken, Johnson et al. 2018) [Ireland]	(1) to examine the factors affecting whether women in Ireland choose to access abortion by travelling or by using online telemedicine; and (2) to explore	Women (n=38) identified through three organisations: Women on Web, Abortion Support Network, For Reproductive Rights Against Oppression, Sexism and Austerity.	Qualitative in-depth interviews	A respondent outlined the individual cost of seeking abortion-related care while in Ireland (respondent aged 29): "It costs a thousand Euros to go to England, and that's a staggering amount, particularly

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	their experiences in accessing care through each pathway	Criteria: aged over 18, had an abortion within 8 years of study, lived in Ireland at time of abortion, had travelled or used telemedicine to access abortion care.		if you feel that you can't tell your family, and you can't look for support elsewhere. Privacy was a factor as well, because there's this notion of shame in Ireland, of the thought of having to go to a clinic and speak to a nurse. I didn't feel like I wanted anybody helping me, or comforting me, particularly someone I didn't know. The idea of actually being able to be on your own was appealing to me."
(Appiah-Agyekum 2018) [Ghana]	To explore the abortion experiences of Ghanaian university students	Female undergraduate students at the University of Ghana [n=32]	Qualitative cross-sectional descriptive	Students suggest self-use of pharmaceutical substances is cheaper and more discrete vs. going to a safe medical abortion service provider.
(Austin and Harper 2018) [United States]	The impact of TRAP (Targeted Regulation of Abortion Providers) laws on abortion trends and women's health.	n/a	Systematic review	Findings suggest that TRAP laws increase out-of-pocket costs to women, thus women of lower socioeconomic position may face greater challenges in obtaining abortions. Especially for later trimester abortions which are more restricted and costly than first trimester abortions. TRAP laws may not need to close clinics to have an impact on health and other outcomes: some laws may instead increase service costs or decrease availability of appointment slots, both of which could increase the time it takes for a woman to obtain an abortion. An increase in gestational age at presentation may limit the number of providers willing to perform an abortion and increase out-of-pocket costs to patients. Access-oriented barriers to abortion may introduce special challenges to low-income, young and/ or rural women, as these women may be less able to manage increases in cost and distance.
(Ayanore, Pavlova et al. 2017) [Ghana]	To explore what direction women perceive gender roles to influence their reproductive choice and care	Data from women with records of recent birth (max 2 years prior to study) (n=90), health staff (n=16), policymakers (n=6)	Qualitative ethnographic study using focus groups and in-depth interviews	At the community, facility, and district facility levels, PAC services are neither provided nor covered under the antenatal/postnatal fee exemption policy under the health insurance scheme. To

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				account for these charges, staff members asked women to pay (US$ 25) for care.
(Azize-Vargas and Avilés 1997) [Puerto Rico]	To examine the current practice of abortion and the hurdles women face to obtain this service.	Women attending 10 of the 13 private abortion clinics in Colombia. [n=358]	Cross-sectional descriptive	The cost of an abortion up to 12 weeks of pregnancy (US $200- $300), second trimester abortion (US $700-$800). The average monthly salary is US $1,300.28. The majority of women were dependent on someone else for the money to pay for their abortions. Proportion of women who paid for the procedure themselves: Puerto Rican unmarried teens (11%); Puerto Rican adult women (40%) Dominican adult women (60%).
(Babigumira, Stergachis et al. 2011) [Uganda]	To perform a comprehensive assessment of the economic burden of induced abortion in Uganda in terms of its costs.	Uganda	Economic estimation	Patients incurred an average of $62 ($46–$183), 73% of the healthcare costs of induced abortion.
(Baird 2015) [Australia]	To describe the context through which medical abortion has become available in Australia since 2013.	Australia	Narrative review	Medicare, the federal government health insurance scheme, has provided a rebate for the cost of a privately provided surgical abortion procedure since 1974. On average this rebate halves the cost of a surgical procedure; prices vary between clinics and increase sharply for pregnancies over twelve weeks. Average cost of surgical abortion under twelve weeks ranges AU $400-$500 after the rebate. For many poor women and those in non-metropolitan locations even this rebated cost is prohibitive, especially when travel costs are also involved. Recent significant development is the launch of the Tabbott Foundation (2015) offers an Australia-wide telephone consultation home medical termination of pregnancy service and for women with a Medicare card the cost is AU $250. A news report at the end of their first week claimed that the foundation had been “so overwhelmed by prospective patients it cannot meet the demand”.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Baird 2017) [Australia]	A historical examination of the effects of three instances of decriminalization in Australian jurisdictions.	Australia	review	Abortion is provided liberally in Australia, but mostly by private providers. Well-informed women in metropolitan centers with reasonable economic means seeking first trimester abortions are adequately served. While abortions performed at the public hospitals incur little or no cost, access is particularly compromised for Indigenous women in remote communities and others who must travel significant distances to a hospital.
(Banerjee and Andersen 2012) [India]	To understand the pathways through which unsafe abortion leads to post-abortion complications and to describe the experiences of women seeking care for post-abortion complications in Madhya Pradesh.	Women of reproductive age who were seeking care for post-abortion complications [n=344] at one of 10 hospitals.	Cross-sectional descriptive survey	(90%) visited one or more other providers before seeking care from one of the study facilities. The median distance travelled per visit was reported as 3.3, 2.3 and 7.3 km, respectively. The most common reasons that women reported for choosing a particular provider for their first visit include proximity or having no alternative.
(Banerjee, Andersen et al. 2012) [India]	To compare women with induced abortions with women with spontaneous abortion.	Women of reproductive age who were seeking care for post-abortion complications [n=344] at one of 10 hospitals.	Cross-sectional descriptive survey	The average direct cost of treating induced abortion related complications was almost 85% higher (Rs. 721 or $16) than the cost of treating complications of spontaneous abortion (Rs. 390 or $9). No significant variation in the cost of transportation or clinical tests, but patients with induced abortion complications had significantly higher costs for medicine ($P<0.01$), the evacuation procedure ($P<0.01$), and consultancy fees ($P<0.05$). For both groups of patients, the cost of medicines contributed almost half of the total cost (induced: 47%; spontaneous: 37%). Women who visited other providers had higher expenses than women who went to the hospital first. Even women who were hospitalized for several days after reaching the hospital directly incurred lower costs (induced: Rs. 349; spontaneous: Rs. 218) than women who did not require

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				hospitalization but visited other providers (induced: Rs. 841; spontaneous: Rs. 1169). Many women expressed the burden in terms of managing money and sacrificing regular earnings because of prolonged complications and unsuccessful visits to multiple providers.
(Banerjee, Andersen et al. 2015) [India]	To describe young women's experiences with unwanted pregnancy and abortion, identify their sources of information, knowledge of SRHR and describe their health-seeking behaviours	Young married (n=690) and unmarried women (n=691) (15-24 year-olds) in three rural communities	Cross sectional survey	Of the 23 married women who reported induced abortions, only 4% sought treatment from facilities where such services are virtually free
(Banerjee, Kumar et al. 2017) [India]	To understand the socio-economic profile of women seeking abortion services in public health facilities and out of pocket cost accessing abortion services.	Women [n=1036] presenting at 1 of 19 facilities for abortion or PAC services.	Cross-sectional descriptive facility-based survey.	Although abortion services are technically free at public sector facilities, women reported that the indirect average total cost for an abortion at primary health centre was 67 INR (SD = 137 INR; Range: 0–2700), while the same cost was almost three times for women accessed services at urban hospitals. The total indirect cost of accessing abortion services had no significant association with women's economic profile at primary level facilities. Significant associations observed at the secondary level facilities. Poor women spent more on average (305 INR) than women from middle (188 INR) and rich households (154 INR), when seeking care at urban hospitals. Poor women who visited secondary level urban hospitals spent almost five times more than poor women who visited primary level facilities (305 INR vs 69 INR; $p < 0.001$), while women from middle (56 INR vs 188 INR; $p < 0.001$), and rich (75 INR vs 154 INR; $p < 0.023$), households spent three and two times more respectively.
(Barua and Apte 2007) [India]	To explore quality of care received by women seeking	Women clients [n=107] who had had an abortion in the two years prior to the study. Key informants [n=16]	Cross-sectional qualitative descriptive	A factor influencing choice of provider was cost, reported by over half the clients (63/107). While cost of services did not

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	abortion services in selected settings in Jharkhand.	comprised doctors (who did not provide abortion services), anganwadi workers, ngo representatives, dais (traditional birth attendants) and government providers. Service providers included certified and uncertified practitioners, those from allopathic and traditional systems of medicine, and from government and private facilities.		prevent women from undergoing an abortion, it did determine the choice of facility. Women who could not afford fees charged by private qualified providers sought care from government or unqualified providers. Women clearly linked cost with quality. Women for whom cost was a concern tended to seek care from those perceived to provide cheaper services, even when they had concerns about the provider's technical skills. Cost was less likely to be reported as the leading criterion underlying the choice of a provider. In the tribal block, cost was a key factor; women were unanimous about the need for free, cheap or subsidised medicines, and free services.
(Baum, White et al. 2016) [United States]	To explore qualitatively the experiences of women who were most affected by the law [HB2]: those who had to travel farther to reach a facility and those desiring medication abortion.	Purposive sample of women [n=20] attending 10 abortion clinics in Texas	Qualitative cross-sectional	Following the passing of the TRAP law House Bill 2 (HB 2) by the Texas legislature, one of the United States' most restrictive TRAP laws, abortion clinic closures resulted in an increased number of Texas women of reproductive age living farther from an open facility, meaning that more women had to travel longer distances to obtain abortion care. Women described the stress of having to get to unfamiliar cities and coordinate transportation, and extra costs such as staying in a hotel, fuel and transportation. Women reported difficulty with out-of-pocket costs and loss of earning associated with travel, and the need for some women to have to ask for help with these costs.
(Baxerres, Boko et al. 2018) [Benin and Burkina Faso]	To document the means women use to obtain abortions in the capital cities of Benin and Burkina Faso To learn whether or not use of misoprostol has become an	Women in Cotonou (n=21) and in Ouagadougou (n=13), including 5 secondary school students	Qualitative in-depth interviews	Six women self-managed their abortions, citing little or no money to access clinics as one of their reasons. Women reported paying 10,000 CFA [16.18 USD) for general consultations in Benin and

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	alternative to other methods of abortion and the implications for future practice			a further 15,000-55,000 CFA (24.50-89 USD) for abortion services. Women in Burkina Faso reported paying 30,000 CFA (48.50 USD) in public health facilities and 60,000 CFA (97 USD) in private facilities for abortion services.
(Belton and Whittaker 2007) [Thailand]	To examine the needs for reproductive services of Burmese migrant workers along the border with Thailand.	Women experiencing any type of early pregnancy loss; traditional midwife trainers [n=50].	Cross-sectional descriptive	Women had to pay 2300 Baht ($US 56) on average for their hospital bill for post-abortion care. The majority of Burmese women in Thailand earn less than 3000 Baht ($US 73) a month. Induced abortions conducted by trained Thai medical staff at private clinics in regional towns cost 3000-7500 Baht (US$70-$174) depending on the service and gestation of the pregnancy. However, their illegality forces the prices up and there is little follow-up care. Undocumented workers are unable to travel to such clinics, and the need to show documentation and the prohibitive cost mean women rarely access these services.
(Benson, Nicholson et al. 1996) [sub-Saharan Africa]	To document the magnitude of abortion complications in Commonwealth member countries.	Sub-Saharan African Commonwealth member countries	Review	Cost-related issues were mentioned in many of the published articles reviewed for this monograph. Brief descriptions of the cost of obtaining an induced abortion, the average length of stay for women treated for abortion complications, and the time needed to perform an evacuation procedure were among the points cited.
(Berer 2000) [Gobal]	To examine the changes in policy and health service provision required to make abortions safe.	n/a	review	Where abortion is clandestine and unsafe, women (or their partners and families) are buying drugs and other means of self-induced abortion and/or paying clandestine providers, while public health services and women are paying for the treatment of abortion complications. Costs (economic and social) incurred for unsafe abortions include not only acute care, however, but also the longer-term complications of

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				damage to reproductive organs, pelvic inflammatory disease, and secondary infertility. Costs for families, especially for a woman's existing children, also include those that result from a maternal death. Unsafe abortion situations are characterised by a lack of equity in cost, safety and quality of care. Women may or may not be charged a fee at the point of service, but safety means affordability for the poorest of women as well as for those who can pay.
(Berer 2005) [Global]	To discuss choice and acceptability of medical abortion from the perspective of both women and abortion providers.	n/a	review	Unless the costs of surgical and medical abortions are broadly similar, many women will feel they need to choose the cheaper option, which limits choice. Where the health service is covering the cost, or health insurance companies control treatment options, similarly, clinicians and managers will also tend towards the cheaper option.
(Bessett, Gorski et al. 2011) [United States]	To learn about women's experiences applying for subsidized insurance and to identify barriers to obtaining insurance or its use for abortion services.	Interviews with [n=39] women who met the eligibility requirements for subsidized insurance programs in Massachusetts.	Qualitative cross-sectional	More than half the women interviewed reported delaying their abortions while they tried to secure subsidized insurance; this caused considerable stress as the women tried to manage symptoms, often without disclosing the pregnancy, and worried about being able to afford a termination if the pregnancy continued too long. Delays can have severe consequences, including delaying care until the second trimester.
(Billings and Benson 2005) [Latin America and Caribbean]	To review results from 10 PAC operations research projects conducted in public sector hospitals in seven Latin American countries.	10 PAC operations research projects conducted in public sector hospitals in seven Latin American countries.	Review of 10 operational research studies	Patient fees and other out-of-pocket expenses are likely to play an important role in whether patients seek professional PAC services when needed. The high cost of services may be a barrier to obtaining clinical services. One of the shortcomings of many PAC cost studies has been a narrow focus on costs to the facility. Facility costs certainly are a key component of sustainable services, but patient fees and other out-of-pocket expenses are likely to play an

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				important role in whether patients seek professional PAC services when needed. As reorganizing services can substantially reduce opportunity costs to the facilities, in some cases administrators have passed these savings on to the patients by reducing fees. In the Peru-Callao study, when the director of the hospital was presented with data documenting the high cost of treatment with SC (average of US$119 per patient) and the potential for marked reductions with MVA provided on an outpatient basis, she cut patient fees in half for ambulatory patients (from approximately US$32 to $16) (Benson et al. 1998). Overall out-of-pocket expenses (including admission, treatment fees, medications and some supplies) declined from US$52.98 before to $37.40 after the intervention. At the time of the 2000 follow-up, clients' costs averaged $32.75. The hospital was recovering almost 98% of the full cost of providing PAC services at the 2000 follow-up compared with less than half (45%) prior to the intervention.
(Blanchard, Meadows et al. 2017) [United States]	To study women's experiences seeking and receiving second-trimester abortion care in two geographically and legislatively different settings to inform ways to improve abortion care access and services.	Women receiving second-trimester services in eight clinics in Iowa, Nebraska, New Jersey, and Pennsylvania.	Mixed methods	Most women reported traveling at least 1 hour to their appointment, with one woman traveling 5 hours. More than half of participants travelled up to 50 miles. Women reported challenges securing transport, childcare, and work leave. Interviewees reported paying between $300 and $1066 for services, with the mean cost of $722. Although 59.6% of women had insurance, over half of participants paid out-of-pocket. Women with insurance reported insufficient coverage, confidentiality issues, or complex processes and delays to obtain coverage. Most interviewees sought

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				financial support from partners, family, friends, and/or abortion funds.
(Bloomer and O'Dowd 2014) [Ireland]	This paper considers abortion tourism in Ireland, both north and south, and how the moral conservatism present in both jurisdictions has impacted on attitudes and access to abortion	Literature on women seeking abortion services in restricted settings.	Literature review and supplemental expert interviews	Women who cannot access abortion in Northern Ireland must travel elsewhere to obtain one and pay as private patients despite being UK taxpayers. The cost of this ranges from £600–£2000, including travel and accommodation. This cost creates a significant burden to women with low incomes, often leading them to borrow from backstreet lenders. The difficulties in obtaining funds can also lead to delays in obtaining an abortion, thereby increasing its cost. Over the last decade, the data indicates an overall decrease in those travelling to England and Wales. It was noted that 6% of respondents had obtained an abortion outside the UK, with anecdotal evidence suggesting that travel to EU countries was less costly than accessing abortion services in the UK.
(Brack, Rochat et al. 2017) [Colombia]	This study sought to identify the key barriers to legal abortion, and to explore the ways they may work separately and together to delay the receipt of high quality, legal abortion care.	Women who obtained a legal abortion in Bogotá (n=17).	Qualitative: in-depth interviews	Seven participants discovered during the process of obtaining an abortion that not only was abortion legal, but that health insurance companies were legally obligated to cover its cost. Through self-advocacy and the assistance of La Mesa, these seven were able to obtain full coverage, though they had their abortions later than they had desired. Study participants described the representatives of clandestine clinics as trying to lure them with prices cheaper than those charged at well-known, legal establishments. These representatives promised that the abortion would be both quick and easy.
(Brown and Jewell 1996) [United States]	To estimate directly the responsiveness of abortion demand to county-level variations	Abortion providers in Texas	Log-linear regressions using data that were obtained from health facilities on each	The average travel costs in Texas were: Overall (254 counties): US$ 14.59 Counties with providers (19): US$ 3.61 Counties without providers (235): US$ 15.48

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	in travel-cost component of the full cost of abortion services		abortion performed and data on the localities of these facilities	The average time costs in Texas were: Overall (254 counties): US$ 0.18 Counties with providers (19): US$ 0.22 Counties without providers (235): US$ 0.18
(Calkin 2019) [Global]	This article makes the case for a political geography of abortion that moves beyond a state-based framework to account for changing patterns of resistance and restriction on abortion.	Review of literature on policies and political action related to abortion.	Literature review	Women who must travel for abortion face numerous barriers, of which political and economic obstacles often loom the largest. Crossing borders for an abortion requires a woman to have a passport and visa to freely leave and enter another country; refugees, asylum seekers, or undocumented migrants often lack this documentation and the money required to obtain it. Crossing large distances for abortion also requires a woman to have substantial financial means, access to transport, access to childcare, and a social support network to facilitate the trip. At the highest point in 2001, eighteen women per day travelled from Ireland to England for abortion; as of 2016, that number had fallen to just under nine per day. This decrease has been attributed to the increase in access to illegal abortion pills through online pro-choice networks. The recognition that abortion pills were being widely accessed, despite the threat of a prison sentence for their use, was instrumental in pushing towards a more permissive approach to early abortions in the lead up to its 2018 abortion referendum.
(Campbell, Sahin-Hodoglugil et al. 2006) [Global]	To describe barriers to fertility regulation	n/a	Review	“The literature on a consumer’s ability to pay … is virtually nonexistent in the case of abortion”
(Cano and Foster 2016) [Canada]	This study aimed to document women's experiences seeking and obtaining abortion services while residing in Yukon Territory, identify financial and personal costs and explore avenues	Women who accessed abortion services while residing in Yukon (n=16).	Qualitative: in-depth semi-structured interviews	Transportation challenges are further amplified for women living in remote communities, where there are few or no public transportation options available to travel to Whitehorse. All of the procedures through Whitehorse General Hospital were

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	through which services could be improved.			covered by Yukon's territorial health insurance. Out-of-pocket expenses included taxi fares, intrauterine devices inserted on the day of the procedure, medications (methotrexate/misoprostol) for one woman and hotel and gas for the two participants traveling in from outside of Whitehorse who were later reimbursed after submitting receipts. Indirect costs included missed work, missed classes at school and childcare.
(Casas and Vivaldi 2014) [Chile]	To describe a study of the criminalisation of abortion as a human rights violation in Chile.	n/a	Review	Women who had abortions with trained physicians reported widely differing conditions and prices, ranging from several thousand dollars for a safe procedure to two hundred dollars for a less safe one. Doctors reported that price is based on weeks of pregnancy and as the weeks rise so does the price.
(Casas-Becerra 1997) [Chile]	To highlight the gender and poverty-related discrimination that poor women having abortions face in Chile, and how the law is used to undermine medical confidentiality .	Case review files	Review	The cost of an abortion ranged from US $50 to US $200. Prices depended on the method used, and on whether the provider felt sympathy for the woman. Identified two cases where two women had had an abortion from the same provider, but for very different prices.
(Chełstowska 2011) [Poland]	To describe the economic consequences of the stigmatisation and illegality of abortion and its almost complete removal from public health services in Poland since the late 1980s.	Polish women	Review	The cost of a surgical abortion (D&C) in 2006 ranged PLN1,500–4,000 PLN and the cost of medical abortion from PLN400–1,000. The cost of a surgical abortion exceeded the average monthly income of a Polish citizen. Historically, under state socialism, abortion was accessible and, compared to present prices, affordable.
(Chor, Garcia-Ricketts et al. 2018) [United States]	This study uses the abortion visit as an opportunity to identify women lacking well-woman care (WWC) and explores factors influencing their ability to obtain WWC after implementation of the Affordable Care Act.	Low-income women seeking abortion services (n=34).	Qualitative: purposive sampling; semi-structured interviews	Most women identified at least one structural barrier to engaging in WWC, centered mainly around three themes: insurance and cost, navigating providers and clinics, and geography and transportation. Many women experienced or perceived instability around insurance coverage. In the

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				2 years before participating in this study, 15 women (44%) had gained or switched insurance and 9 women (26%) had lost insurance. Accordingly, many women cited insurance disruptions as a barrier to WWC, whether owing to changes in employment, clerical errors, or "aging out" of parental coverage.
(Chunuan, Kosunvanna et al. 2012) [Thailand]	The purpose of this descriptive study of women from southern Thailand, who had undergone a recent abortion (spontaneous, therapeutic and unsafe), were to obtain data regarding: pregnancy history; number of abortions and cost of abortion related treatments; abortion complications, impacts and related health care services; reasons for having an unsafe abortion; and, circumstances related to an unsafe abortion.	Women that received abortion services from one of six government hospitals	Convenience sample and questionnaire	For most of the women, in both the unsafe abortion group and the spontaneous/therapeutic abortion group, this was their first abortion. Universal health care coverage was the primary payment option for both groups. The mean length of the hospital stay, among the subjects in the unsafe abortion group, was slightly longer than the mean length of the hospital stay among those in the spontaneous/therapeutic abortion group. The cost of health care treatment was found to be slightly higher among subjects in the unsafe abortion group compared to those in the spontaneous/therapeutic abortion group. This finding was not surprising given that, compared to spontaneous/therapeutic abortions, unsafe abortions often are followed by medical complications
(Coast and Murray 2016) [Zambia]	To analyse the details of pathways to care, barriers and delays, and the role of others in influencing these pathways.	Females aged 15-43 years seeking either safe abortion or PAC at University Teachig Hospital, Lusaka [n=112]	Qualitative cross-sectional	Financial costs of seeking an abortion played a role in the timing and complexity of trajectories, as well as the choice of abortion method and provider. The hospital served a large area and finding money for transport was a hurdle. To decrease unnecessary hospital use and encourage use of government primary care facilities in Lusaka, a referral from a satellite health centre reduces registration fee at the hospital from K80 (£11.60) to K10 (£1.20). For poorer women knowing how to navigate the public sector health system in this way made care

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				more affordable but it also added an additional step in their trajectory to the hospital. Illegal, unofficial provider payments are quite frequently expected and paid, and can introduce delays to care-seeking.
(Coast, Norris et al. 2018) [Global]	To present a new conceptual framework for studying trajectories to obtaining abortion-related care.	n/a	Review	In contexts where abortion is illegal, access to economic resources and emotional support are critical for accessing a medically supervised abortion in a clandestine clinic. Women may delay care in order to have sufficient funds to pay user fees. Disclosure can be influenced by the need for financial support for the abortion.
(Cockrill and Weitz 2010) [United States]	The primary purpose of this paper is to explore abortion patients' perspectives on abortion regulations.	Women seeking abortion services at three abortion facilities in the U.S (n=20).	Semi-structured interviews	Cost of the procedure ranged from $370 to $1,575. 6/20 traveled more than 60 miles for their abortion appointment(s) and 4/20 traveled more than 100 miles. The cost of travel depended on distance and ranged from $5 to $200. Of those who were traveling from out of town, 3/20 were required to stay overnight. Of these three, two stayed overnight because of the nature of the care they were receiving rather than state regulation. Although 10/20 had some type of public or private insurance, all women paid the full out-of-pocket cost of their abortion . Of the women who were insured, only two women attempted to get coverage for their abortion. The remaining women did not attempt to get coverage because they already suspected their insurance would deny them coverage or because they did not want their insurance provider, employer, or parents to know about their abortion.
(Cohen, Ortiz et al. 2005) [anonymized Latin American country]	To identify appropriate channels through which instructions of misoprostol use could be disseminated	Healthcare workers, people receiving care and women in the unnamed community	In-depth interviews and focus group discussions	Physicians were viewed as inappropriate for providing misoprostol, as they might promote more costly procedures. Care-

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				seekers tend not to use physicians due to costs. A respondent who sought a safe abortion noted: ''They give you another [drug] and sell it to you for the same price as Cytotec. That is to make you suffer for a while, and nothing else. They don't give you advice for what you want, so they are very, very bad sources of information.''
(Coles, Makino et al. 2010) [United States]	Examine the relationship between adolescent pregnancy intention and policies affecting abortion access: mandatory waiting periods, parental involvement laws, and Medicaid funding restrictions.	Data from the Pregnancy Risk Assessment Monitoring System (PRAMS) on women under 18 years of age seeking abortion services in 30 states.	Case-control	Those living in states with either Medicaid funding restrictions or mandatory waiting periods reported higher percentages of both unwanted and mistimed birth compared to minors living in states without these statutes. Subgroup analyses noted additional associations with unintended birth for black teens exposed to Medicaid funding restrictions and for white and Hispanic teens exposed to parental involvement laws. These findings may be explained by difficulties accessing abortion. Among minors who identified as black or Hispanic, who received Medicaid, or who had lower educational achievement, the risk of unintended birth was even higher than among the general adolescent population. Waiting periods that mandated multiple visits varied from other types of waiting periods, further supporting the view that it is the financial and time costs imposed by these statutes that impose may alter pregnancy outcome.
(Colman and Joyce 2011) [United States]	Examine the impact of the Women's Right to Know Act in Texas (disclosure, waiting period, and surgical center regulations) on number, timing, and cost of abortions and distance traveled.	Reported data for abortions performed in Texas.	Regression analysis	Charges for second-trimester abortions increased by more than $400 (39 percent) between 2001 and 2006.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Comendant 2005) [Moldova]	To present information on the current abortion law, policy and services in Moldova and describe a project whose aim is to improve the quality of abortion services, including the introduction of medical abortion through training of service providers and community education.	Abortion services in Moldova	Review	Abortions were performed free of charge 1955-1998. However, most women (67%) had to make unofficial payments to medical personnel. 1998 regulations stipulated that payment for abortion services in the public sector was required (37–65 lei). Abortion is not covered by health insurance, and the public sector price has officially been raised to 170–250 lei (about US$20), while the average income is 250 lei per month. In the private sector the price for an abortion ranges 300-900 lei (US$25–US$70). There are no officially approved categories of women for whom abortion fees are waived. Since 1994, to reduce the number of complications, the Ministerial Order said that all abortions should be performed in hospitals by obstetrician–gynaecologists. This centralisation of services and their relatively higher cost has reduced the accessibility of abortion. There are difficulties in the organisation of service delivery as most abortions are currently being provided on an inpatient basis, and the fees include payment for a hospital stay. The cost of a medical abortion, including the cost of the pills, is much higher than for vacuum aspiration. Thus, many women will not have access to this method, preferring the cheaper option.
(Cooper, Dickson et al. 2005) [South Africa]	To report whether a significant proportion of women seeking abortion in public sector services would be early enough in pregnancy to be eligible for medical abortion and to investigate the hypothetical acceptability of medical abortion among women, policymakers and	People (n=673) attending abortion services in 8 facilities across three provinces in South Africa	Cross sectional survey	81% of care-seekers spent approximately 1.25 USD to reach the clinic. The cost (in South African Rands) breakdown per area for travel to seek care was: Soweto (n=272) No cost (walk) - 13.2% <R5 - 2.6% R5-R10 - 70.2% R11-R20 - 12.9%

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	providers and whether women would attend for follow-up.			>R20 - 1.1% Cape Town (n=287) No cost (walk) - 17.4%, <R5 - 48.4% R5-R10 - 18.2% R11-R20 - 12.2% >R20 - 3.8% Philadelphia (n=114) No cost (walk) - 4.4% <R5 - 14.0% R5-R10 - 40.4% R11-R20 - 29.8% >R20 - 10.5% Total (n=673) No cost (walk) - 13.5% <R5 - 24.1% R5-R10 - 42.9% R11-R20 - 15.5% >R20 - 3.9%
(Creinin, Shore et al. 2005) [United States; India]	Evaluate relative differences in direct and total (direct and indirect) costs for medical abortion regimens mifepristone and misoprostol or misoprostol alone.	Modeled data with no specific population.	Modeled data and cost analysis	In the United States, the mifepristone–misoprostol regimen was more expensive, regardless of the cost variation for follow-up visits and suction aspiration procedures. The true direct cost difference between the two regimens ranged from US$38.35 to US$67.35 in Model 1 and from US$57.41 to US$71.41 in Model 2. When indirect costs are included, the differences shrink, ranging from US$6.63 to US$22.37 in Model 1 and from US$17.95 to US$31.95 in Model 2. Accounting for the higher efficacy, the mifepristone– misoprostol regimen significantly reduces the actual excess cost of the mifepristone by at least 73% in Model 1 and by 62% to 78% in Model 2. In India, under Model 1, the direct costs of the misoprostol-alone regimen were US$6.59

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				higher than the mifepristone– misoprostol regimen (increases by US$2.50 in Model 2). When including indirect cost estimates, this cost difference increases to US$10.64. Other factors besides cost also influence decisions related to treatment regimen. In countries where access to abortion providers is limited and waiting periods for appointments are long, the increased efficacy of the mifepristone– misoprostol regimen would outweigh its more prohibitive costs because of the decreased number of office visits required as compared with a regimen using misoprostol alone. In developing countries, transportation and time away from the home become very important factors when examining the differences between the two regimens.
(Crighton and Ebert 2002) [Europe; France; Germany]	To explore the impact of this controversial technology on abortion rates and practices in Europe, looking first at the EU region as a whole, then examining more closely the politics of RU 486 in France and Germany.	Abortion rates, policies, and practices for each nation state.	Policy analysis from published literature	Depending on how health care is funded, access to Mifegyne may vary as well with a woman's income and social class. For example, in France, where patients are required to stay in the hospital for three days for a surgical abortion, Mifegyne provides an attractive alternative administered on an out-patient basis. In addition, the procedure is fully covered by national health insurance. In the Netherlands, abortion carries no stigma, and the costs are covered by national insurance, so surgical options trump medical procedures in their cost-benefit analysis. The cost of medical abortions (MA) can exacerbate an underlying budgetary dilemma in the National Health Service (NHS): "If women live in an area where a lot of abortions are requested and the budget is tight, then they are often subjected to restrictions beyond those imposed by law." Unless a woman has private health

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				insurance or can pay out of pocket, she may confront NHS- imposed limits on her abortion choices.
(David and Baban 1996) [Romania]	Explore, through individual in-depth interviews, psychosocial antecedents and consequences of the Romanian pronatalist policies banning importation of contraception, prohibiting abortion, and imposing tax on childless couples.	Women seeking abortion services prior to the revolution (n=50).	Qualitative: open-ended interviews	Anxiety was also created by the lack of sufficient money to obtain an abortion. A large amount of money was necessary, usually the equivalent of 2-3 months' salary. Many couples relied on borrowing money from different persons or on selling goods from their home.
(Davey 2005) [United Kingdom]	To present results of a review of the sexual health situation in the UK and to outline the challenges remaining in order for the UK to meet ICPD goals by 2015.	UK residents	Review	In 2003, 80% of abortions in England and Wales were funded by the NHS (National Health Service) vs. 67% in 1994. The authors conclude that while women should have the right to choose and pay for an abortion privately, all women who want to have an abortion should be able to access abortion services funded by the NHS, and recommend that as a minimum, at least 90% of abortions should be paid for by the NHS.
Dawson 2016 [United Kingdom; United States; Russia; Australia; New Zealand; Canada]	To identify quality studies of abortion services to provide insight into how access to services can be improved in Australia.	United Kingdom (n=14), United States (n=7), Russia (n=2), Australia (n=2), New Zealand (n=3), Canada (n=1)	Systematic review	Interviews with American women accessing a MTOP telemedicine clinic explained that they selected it as it saved them money that they would have had to spend on travel. For some women obtaining a STOP in Australia was very expensive, particularly rural women who in one study said they had borrowed money to cover not only the abortion fee but pay for travel, accommodation and additional childcare costs.
(de Bruyn 2003) [Global]	Summarises the results of a literature review on the subject of unwanted pregnancy and induced abortion among women living with HIV/AIDS.	Women living with HIV/AIDS	Review	Cited studies. Zimbabwe - HIV-positive women may be ready to end childbearing, but often cannot put that decision into practice because they lack control over contraception and access to abortion, among other reasons due to the cost. Thailand, 3/30 women had abandoned

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				attempts to obtain a termination because of the costs involved.
(Dennis and Blanchard 2012) [United States]	To investigate how Medicaid staff in 17 states responded to inquiries about coverage for abortion in the few circumstances that qualify for federal Medicaid funding.	Medicaid staff [n=23] in 17 states.	Cross-sectional	When asked, respondents who did not have full information about the availability of abortion coverage, the process for obtaining it, or the associated costs, suggested one of three sources for further information: the physician providing the abortion (39%), the state Medicaid website (17%), or other Medicaid offices or staff (13%).
(Dennis, Manski et al. 2014) [United States]	To answer the following questions: 1) What do women know about the cost of abortion and the availability of Medicaid coverage for abortion? 2) Where do women obtain this information? and 3) What are women's experiences paying for care?	Low-income women over the age of 18 who had an abortion within the past two years within one of the four study states (n=98).	Qualitative study: semi-structured interview	Women believed that obtaining an abortion is expensive and that the procedure must be paid for out-of-pocket at considerable personal costs. Women's experiences paying for abortion care varied widely and were almost entirely dependent on their home state's policies regarding Medicaid coverage. Insured women residing in Massachusetts, New York, and Oregon largely described a straightforward payment process. Most women in these states who enrolled or were able to enroll in insurance at the time of their abortion reported that they would not have had the resources to pay for their care otherwise. Women living in Arizona and Florida, states where Medicaid coverage is largely not available, and women who were unable to access Medicaid coverage in Massachusetts, Oregon, or New York, turned to a number of different resources to pay for care, including drawing from their own resources and borrowing money. Some had savings, most had to wait for their paychecks, work additional hours, juggle bills, cut back on personal and household necessities (usually food), take out loans, use credit cards, and/or sell personal possessions to gather the necessary funds for their abortion.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Dennis, Manski et al. 2015) [United States]	Study explores low-income women's experiences accessing abortion in Massachusetts.	Low-income women who received abortion services in Massachusetts (n=27).	Qualitative: in-depth interviews	74% of women interviewed had public insurance at the time of their abortion. Participants who used their public insurance to cover their care described the process as easy and straightforward. Two insured women paid out of pocket because they feared a loss of confidentiality if they used their insurance. 33% of women paid out of pocket for their abortion care. Most commonly, uninsured women reported that they: 1) were in the lag period between applying for insurance coverage and being approved, 2) faced challenges navigating initial enrollment procedures and remained uninsured, or 3) had difficulty recertifying eligibility for insurance and therefore lost coverage. Uninsured participants often said they delayed their procedure while trying unsuccessfully to initiate or reinstate public insurance that would cover the procedure. The 33% of women who paid out of pocket for care reported that it was difficult to find the money they needed. Most of the low-income women in this study described having access to timely, conveniently located, affordable, and acceptable abortion care. Some Massachusetts policies likely contributed to this finding, including state health care reform, which lead to increases in the already high rate of insurance coverage in the state, and comprehensive abortion coverage in almost all public and subsidized insurance plans.
(Díaz-Olavarrieta, Cravioto et al. 2012) [Mexico]	To identify the perceptions and opinions of people who provide abortion services in Mexico City, three years after implementation of elective abortion legal reforms.	Key informants: clinic health providers [n=10], hospital health providers [n=9]	Cross-sectional qualitative	Participants identified the expenses incurred by women travelling from elsewhere in Mexico to Mexico City as an implication of the exceptionality of the federal District law.
(Diniz, d'Oliveira et al. 2012) [Brazil]	To examine equity in health and health care in Brazil, examining	Brazil	Review	Safe abortions are only provided in the private sector illegally; they are prohibitively

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	unjust disparities between women and men, and between women from different social strata, with a focus on services for contraception, abortion and pregnancy.			expensive for poorer women but affordable for those with a higher income.
(Dobie, Gober et al. 1998) [United States]	31 family planning clinic sites in rural Washington State were surveyed about their sponsorship, staffing, service provision and population coverage.	Family Planning clinics in rural Washington (n=31).	Cross-sectional survey	Only one clinic provided abortions onsite; the rest referred their clients elsewhere. Respondents for these clinics estimated that women seeking an abortion traveled from 20 to 200 miles each way to obtain an abortion, with an average oneway driving distance of 68 miles.
(Doran and Hornibrook 2014) [Australia]	Identify factors that New South Wales (NSW) rural women experience in relation to their ability to access an abortion service and follow-up care.	Rural clinics in NSW (n=7) and women who sought abortion services at those clinics (n=13).	Qualitative: Surveys and interviews	Only one women's health clinic provides financial support; between 2007 and 2012, 138 women were loaned money with an average individual loan of $450.00. Cost, transport/lack of public transport, distance, lack of services in local area and shortage of rural General practitioners were identified as factors that influenced access to an abortion and follow-up care. Expenses beyond the clinic fee included overnight accommodation, petrol/train/airfare costs, taking time off work (for woman and their support person) and childcare.
(Doran and Nancarrow 2015) [Multiple: USA, Canada, Australia, New Zealand, France, Norway, Sweden, Northern Ireland, Norway, UK]	To identify the factors that facilitate and hinder access to abortion services for women in developed countries in relation to first-trimester abortions.	n/a	Systematic Review	The direct and indirect costs of travel – including time away from work or studies; extended arrangements for child care; transport, accommodation and cost of meals; poor continuity of care and significant time away from home – were identified in four studies. The cost of abortion procedures was identified as a barrier in four studies. Almost 20% of Canadian women who accessed an abortion clinic reported that the fees were too high. In the USA, hospital-based abortions cost around six times that of non-hospital abortions and increase sharply beyond a

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				gestational age of 12 weeks. Almost 75% of women self-fund their abortions. Research undertaken in 15 USA states revealed that in only two states were 97% of submitted claims funded, and women with low incomes experienced significant challenges to access affordable and timely care. Women who qualify for Medicaid have delays in reimbursement, which sometimes prohibits them from accessing abortion. Delays in accessing resulted in an inability to access an abortion; later abortions for some women; and inability to access a medical abortion. In the USA in 2008, medical abortion at 10 weeks was reported to be more expensive than surgical abortion except in facilities with smaller caseloads. Another study found some women choose to travel for anonymity, lower fees or to access a surgical abortion which might not be available locally.
(Doran and Hornibrook 2016) [Australia]	Identify factors that women in rural New South Wales (NSW) experience in accessing abortion services and suggestions about how rural women could be better supported when seeking access to an abortion service.	Women who sought access to abortion while living in a rural part of NSW (n=13).	Qualitative: in-depth interviews	Logistics arrangements included managing expenses related to organising early morning departure, child care, borrowing a car, seeking finance, asking a support person to drive them to and from the clinic, overnight accommodation, petrol/train/airfare costs and taking time off work for the woman or the support person. Participants travelled 1–9 hours one way to reach a clinic and five women required overnight accommodation. Not all women mentioned problems with money but several did. Some women's partners paid the abortion fee, even if they were separated. Some women commented that the abortion cost, whilst expensive in the short term, was not as expensive as raising a child. Many women borrowed money to

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				help with petrol, abortion fees or accommodation.
(Dragoman and Davis 2008) [United States]	Synthesis of published literature and current practices for adolescent abortion care.	Literature on national abortion statistics and evidence for adolescents.	Literature review	The availability of affordable abortion services determines if a young woman can obtain an abortion at all and how quickly. Compared with adults, barriers to care may particularly affect adolescents with limited resources. Obtaining an abortion may require significant travel because most counties in the United States (more than 80%) have no abortion provider. In most states, abortion is not covered by state Medicaid programs and poor teens may have difficulty funding the cost of care. Delays experienced by adolescents lead to increased costs and risk, as later abortions are more technically difficult and expensive.
(Duggal 2004) [India]	Examination of the political economy of abortion care in India by reviewing cost and expenditure patterns for abortion care in India.	Literature/database review	Literature/database review	First trimester abortion is mostly available for Rs.500–1000 and second trimester abortion for Rs.2000–3000. Overall in the six states, the average charges for an induced abortion were Rs.615. This is equivalent to more than three weeks of average per capita income for all- India. The overall charges in the public sector averaged Rs.115 (or four days of per capita income) and in the private sector Rs.801 (or 30 days of per capita income). A 1987 study on health expenditures, which included abortion, found that the mean expenditure for an induced abortion was Rs.300, of which 41% went to the doctor and hospital and 36% for medicines and tonics. The share of abortion expenditure in total out-of- pocket household health expenditure was 0.21%. In two recent studies, the share of abortion in total out-of-pocket household health expenditure was 0.16% in 2000 and 0.28% in 2001, respectively. Analysis of expenditure data shows that women have to spend

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				substantial amounts to access both private and public abortion services. Public abortion services until recently were free of charge even though women reported out-of-pocket expenses (usually non-medical expenses like travel or prescription drugs). At present, abortion services in the public sector are free only if the woman or her husband accepts some form of contraception, usually sterilisation or an IUD, after the abortion.
(Duggal and Ramachandran 2004) [India]	To synthesize findings and reports from the Abortion Assessment Project – India	380 facilities in six states in India	Review of studies: policy reviews, multicentred facility surveys, 8 qualitative studies, community-based studies	Out of pocket cost of abortions in Maharashtra and Tamil Nadil were Rs. 1220 and Rs. 950 respectively.
(Dzuba, Winikoff et al. 2013) [Latin America and Caribbean)	Present evidence of medical abortions' (MA) contributions to reduced complications, describe strategies to enhance safe MA, and highlight existing barriers to access in Latin America and Caribbean (LAC), while examining MA's role in newly legal abortion services.	Women seeking abortion services in LAC	Descriptive analysis	The cost of one misoprostol pill, approximately US$0.75–$2.81 in the United States, can reach US$35 or even higher in LAC. In Brazil, misoprostol is limited to hospital use only and cannot be obtained in pharmacies, obstructing access to nearly 50% of South American women.
(Ely, Hales et al. 2017a) [United States]	Use a trauma-informed lens to explore abortion-related hardships in a previously understudied group: patients in the United States who received financial pledges from the National Network of Abortion Funds' (NNAF) Tiller Memorial Fund, to pay for an unaffordable abortion.	Patients in the US who received financial pledges from NNAF to pay for an abortion (n=3,999).	Cross-sectional descriptive analysis	Patients from states that do not use state Medicaid funds to exceed coverage of abortions (outside of instances of rape or incest) had a higher average reporting of hardships related to abortion and abortion care. This finding was also true for patients from states that restrict the private insurance coverage of abortion, with patients from these restrictive states experiencing a higher average number of hardship experiences.
(Ely, Hales et al. 2017b) [United States]	The aims of this paper are to discuss the results of a secondary data analysis of NNAF's Tiller	Patients in the US who received financial pledges from NNAF to pay for an abortion (n=3,999).	Exploratory, descriptive, secondary analysis	The average cost of the abortion that patients were seeking to fund was $2,247.64. The average abortion costs were

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	Memorial Fund cases that represent patients who received funding pledges to assist them with paying for an abortion.			highest for adolescents (11-13), costing $4,015.64 and costing $2,695.43 (14–15) and $2,696.37 (16–17). Married women's average costs were the highest at $2,605.99. Asian women reported the costliest procedures $3,613.44 resulting from procedures occurring at later stages of pregnancy relative to patients in other race categories. The average amount of funds the patients had to contribute was $535.02. The costs of abortions were highest for very young adolescents, suggesting that women in this group have significant difficulty gathering funds to pay for abortion procedures. Younger patients may not be fully employed, may not be comfortable asking parents or support persons for funding assistance, and they may also experience unique burdens, such as co-occurring psychosocial problems, which may increase delays in knowledge of the pregnancy and impact timing of abortions. The increased need for funding for second trimester procedures suggests that it may be becoming more difficult for women to gather the funding needed early enough to obtain the procedure in the first trimester.
(Ely, Hales et al. 2017c) [United States]	The study aims were to assess the origination of funding requests by geographic region, federal Medicaid requirement, and private insurance restrictions, and to analyze the distances travelled to receive services.	Patients in the US who received financial pledges from NNAF to pay for an abortion (n=3,999).	Secondary descriptive analyses	On average, an expected distance of 228.17 km, SD = 446.90 (141.78 miles, SD = 277.69) was traveled to access an abortion. Those with pledges in states that restrict private insurance companies from covering abortions travelled greater expectant distances compared to those in states that do not. Those in states that did not exceed federal requirements for Medicaid travelled lesser expectant distances than those in states that exceeded. Of the 3,156, a total of 986 persons travelled out of state for an abortion, and persons who travelled out of

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				state, on average, travelled nearly ten times the distance relative to persons who did not travel out of state for an abortion. Trimester was the most significant predictor of traveling out of state, with persons in their second trimester having a 3.40 times greater likelihood of traveling out of state for an abortion than first trimester pregnancies, and callers from states that did not exceed the federal Medicaid requirements a 2.62 times greater likelihood of travelling out of state relative to those from states that exceed the federal requirement.
(Ely, Hales et al. 2018) [United States, Republic of Ireland, Northern Ireland, Isle of Man]	To examine the experiences of abortion fund patients in the United States (USA) and Republic of Ireland (RI), Northern Ireland (NI) and Isle of Man (IM) to compare abortion fund patient experiences across these developed nations for the first time.	Select abortion fund patients within each country (n=6340 cases; 3995 from the USA and 2345 from the RI, NI and IM).	Cross-sectional descriptive analysis	National Network of Abortion Funds (NNAF) patients were contacting the fund approximately eight weeks further along in their pregnancies relative to Abortion Support Network (ASN) patients, which resulted in significant impact on the cost of abortion with US procedures costing over three times the amount. In a linear regression model where procedural costs were regressed on a binary variable, weeks pregnant explained 44% of the variation in procedural costs, while the datasets (representing organisation or country) explained 5% of the variation. While NNAF patients had a greater amount of funds to contribute to procedural costs, patients required a greater proportion of funding to have an abortion because the overall cost was three times greater. Conversely, while ASN patients had lesser funds to contribute, lower abortion costs allowed ASN patients to contribute to over half of the total costs. Results from the current study suggest that patient characteristics vary somewhat across countries, with characteristics of patients in the USA reflecting dire circumstances, including fewer resources

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				and higher costs to cope with when compared to those in the RI, NI and IM. This is contrary to our hypothesis that circumstances from the ASN patients would reflect greater difficulties, given that abortion is banned with fewer exceptions there.
(Esia-Donkon, Darteh et al. 2015) [Ghana]	Explore the pre and post experiences of young people (aged 12 to 24) who had their abortion three months prior to the study.	Young people (12-14) who received abortion services at the Planned Parenthood Association of Ghana Cape Coast clinic (n=21).	Qualitative: in-depth interviews	The respondents were aware of both public and private health facilities where abortion services are provided. Respondents chose the PPAG clinic because it is youth-friendly, the cost of abortion is comparatively cheaper, the location of the facility is convenient in that it does not attract many potential 'gatekeepers' and gossips, and the attitude of staff is youth-friendly, compassionate, and sympathetic. Comparing the cost at the PPAG Clinic to other facilities elsewhere, they indicated that the former was economical. The cost of aborting a pregnancy in its first trimester ranged between $30-$40 accordingly and approximately $175 for second trimester abortions. In most cases, the male partners or both partners contributed to pay for the abortion services, unless the partner was not in favor of the abortion. The Coordinator of the facility indicated that the facility usually provides free services to young people who do not have money to pay for the services received.
(Felkey and Lybecker 2014) [United States]	The analysis seeks to measure whether young women really are less careful in using contraception if abortions are less costly, both in the context of financial and opportunity costs, and explore the impact of direct and indirect abortion restrictions,	Data on women under the age of 25 seeking abortions.	Regression analysis	The results of this analysis indicate that legal restrictions on minors' access to abortion have increased pill use among young women. This is especially true among the youngest women and in the earlier years of this analysis. Restrictions on minors' access to abortion may have an impact that diminishes over time, thus the restrictions may be most applicable to the youngest

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				women and fades as they age. In the context of abortion provider availability, this restriction is shown to matter most for the youngest women in our sample, with a diminishing effect over time and as women age into adulthood. Women have fewer financial resources at younger ages, which may pre-vent them from traveling across state or county lines in order to find a provider.
(Felkey and Lybecker 2018) [United States]	Analysis of state abortion legislation and proxying how the cost of obtaining an abortion varies across states, then assessing the implications of legislative changes on women's contraceptive choices.	Data from the National Survey of Family Growth (NSFG) on women who are actively making an observable contraceptive choice (n = 7,070).	Regression analysis	Women making US$20,000 to US$59,999 a year are unaffected by both abortion restriction measures, meaning that their contraceptive behavior does not change as abortions become harder to obtain. This is a concern because these women may not be able to afford the additional travel costs associated with seeking an abortion, potentially resulting in an increase in unwanted births or illegal abortions. The poorest women (income < US$20,000/year) are affected in almost the same way as the total population of women. In addition, they are relatively less likely to use barrier and hormonal methods relative to no contraception. This means as abortion restrictions grow, there are some cases where they move toward less reliable forms of birth control. Finally, the richest women are rarely affected significantly.
(Finer, Frohwirth et al. 2006) [United States]	Examine the steps in the process of obtaining abortions and women's reported delays in order to help understand difficulties in accessing abortion services.	Women seeking abortion services (n=1,247). Location and facility details presented elsewhere (Finer, Frohwirth et al. 2005).	Mixed methods	Women who are financially disadvantaged also have difficulty obtaining early abortions. Lower-income women typically take more time to confirm a suspected pregnancy, which could relate to the cost of a home pregnancy test and the difficulty in getting a test from a clinic or a doctor. They also typically take several more days between deciding to have an abortion and actually doing so than their higher-income

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				counterparts. Poor women (67%) were also more likely to say that they would have preferred to have had the abortion earlier than women above 200% of poverty (50%). The need to take time to make arrangements is the most common reason for delay for the sample as a whole, and low-income women are more likely to have this problem. Similarly, women who had second- trimester abortions were more likely to have concerns about cost or about raising money. Half of second- trimester patients reported that it took them a long time to decide, while only 35% of first-trimester patients said so; this finding was of borderline statistical significance (p=.06). However, second-trimester patients were more likely to cite worries about cost as a reason for delay in deciding.
(Font-Ribera, Perez et al. 2009) [Spain]	The objective of this study was to describe the determinants of the voluntary pregnancy interruption (IVE) delay until the second trimester of pregnancy in the city of Barcelona, between 2004 and 2005.	Women who reside in the city of Barcelona who obtained abortions for physical or mental health issues between 2004 and 2005 (n=9,175).	Cross-sectional study	The time of gestation and the moment in which the IVE occurs is important because it determines the abortion method that can be used, the risk of complications and mortality, and economic cost of the intervention. After adjusting the rest of the independent variables it is observed that women with primary education or lower have a prevalence ratio of 1.8 to delay the IVE until the second trimester (confidence interval of 95% [IC95%]: 1.4-2.2) compared with women with university education.
(Foster, Jackson et al. 2008) [United States]	To examine and report on factors associated with abortion delay among a cross-section of patients at the San Francisco General Hospital Women's Options Center.	Women seeking elective abortion services at General Hospital Women's Options Center (n=398).	Secondary data analysis of a cross-sectional study	"difficulty with getting MediCal to pay for the abortion" was significantly associated with delay during the second step of the abortion process. Several factors may contribute to difficulty with getting MediCal to pay for the abortion including women's lack of knowledge about available coverage, difficulty negotiating the MediCal application process or difficulty locating an

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				abortion provider that accepts the MediCal payment. In the original analysis, results indicated that nearly a third of second-trimester women were still in the first trimester when they first called an abortion provider. This delay was associated with the following: having a prior second-trimester abortion, an initial referral to another clinic, an unsupportive partner, and difficulty financing an abortion.
(Foster and Kimport 2013) [United States]	To analyze data on women who sought and received an abortion at or after 20 weeks' gestation for reasons other than fetal anomaly or life endangerment	People who were seeking abortions after 20 weeks gestation across 16 sites (n=272) and people who presented for first trimester abortions (n=169)	Mixed methods – qualitative data from interviews and quantitative data for logistic regression	The average cost of a first-trimester abortion was 519 USD and later abortions 2,014 USD. "[the] financial part [slowed me down], because I could get there, but paying for it was the biggest problem." 21-year-old Black woman in California – 22 weeks gestation "I couldn't afford it. They told me it was going to be $650, [but] by the time I was able to raise the $650, they had to do a different procedure, and so the price went up. The price jumped to $1,850...and they don't take insurance." 28-year-old Asian woman – 21 weeks gestation Individual financial challenges also included costs associated with travel. People seeking first-trimester abortions spent an average of 18 USD in travel with a range of 0-400 USD. Women seeking later abortions spent an average 100 USD in travel with a range of 0-2,200 USD. The following are case studies:

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				"Angel had difficulty finding a clinic where she could obtain an abortion. After visiting one facility that could not help her, she found another, three hours away. As late as she was in her pregnancy, the cost of the procedure was daunting: $2,700. But as Angel said, “I was determined.” She paid $300 herself, borrowed $400 from her mother and received aid from three funds that help low-income women pay for their abortions. She had her abortion at 24 weeks." "Deciding to have an abortion was easy for Rose. Finding a clinic where she could obtain an abortion, however, was much more difficult. Rose called four clinics and visited another one before finding a clinic four and a half hours from her home that could perform her abortion at 20 weeks, for which she paid $1,750." "Lesley left her husband. After counseling from a private therapist and with the support of two friends, Lesley got an abortion at 20 weeks’ gestation. The procedure cost her $1,700.”
(Foster, LaRoche et al. 2017) [Canada]	To document women's experiences obtaining abortion care in New Brunswick (NB) before and after the Regulation 84-20 amendment; identify the economic and personal costs associated with obtaining abortion care; and examine the ways in which geography, age and language-minority status condition access to care.	New Brunswick residents who received abortion services (n=36).	Qualitative: semi-structured interviews	Women obtaining hospital abortions in New Brunswick are required to undergo multiple visits, a process that costs women time and money. Although the abortion services are “free” at the hospital, some patients had to pay for travel and overnight hotel costs in order to attend multiple appointments in cities away from home. Some women also mentioned childcare costs and lost wages. For women who obtained clinic-based abortion care in-province, the costs were even greater, ranging from CAD400 (US$300) to CAD1600 (US$1225), excluding

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				travel costs. Although Francophone women were unable to obtain abortion care in their preferred language, all of the Francophone participants described the overall inaccessibility of abortion care in New Brunswick as a more pressing issue and were more concerned about travel, cost and wait times than receiving French-language care. A small number of participants traveled outside of New Brunswick to obtain their abortion care. In addition to having to pay for both the costs of the procedure and the costs associated with travel, there seemed to be a lack of clarity about how the cost of the procedure was calculated, with prices up to $2000 (US$1535).
(Freeman, Coast et al. 2017) [Zambia]	To examine men's involvement in women's abortion seeking in Lusaka, Zambia.	Women [n=112] who had undergone induced abortion at the hospital or had received post-abortion care there following induced abortion.	Cross-sectional descriptive	Some men were instrumental in securing care following an unsafe incomplete abortion, including payment for travel and the costs of care. Very few of the men helping in such cases were told the purpose of the care they were supporting or that the woman had attempted abortion unsafely. However, it is unclear how much these men knew of what was happening or if they preferred not to know. When directly involved in women's abortion trajectories, men were most commonly providers of financial assistance for care seeking.
(French, Anthony et al. 2016) [United States]	To assess the association of clinician referral with decision-to-abortion time.	English-speaking women aged 19 years and older presenting for an abortion for all indications at the three abortion clinics in Nebraska [n=263]	Cross-sectional survey	Reasons for delay among Nebraska women who would have preferred to have their abortion earlier: worry about cost (9%); time to raise money to have the abortion (28%); difficulty taking time off work (13%); difficulty arranging for childcare (4%).
(Friedman, Saavedra-Avendaño et al. 2018) [Mexico]	To examine how a legislative discrepancy (legalized access in the city center vs. restricted access in the remainder of the	Data from Mexico City's public abortion program and census for 75 municipalities.	Case-control	Some of the barriers posed by local illegality in the context of proximate legal services include increased actual or perceived cost, a decreased level of knowledge about

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	muncipalities in the metropolitan area) affects access to public-sector abortion across the Mexico City Metropolitan Area.			abortion services and increased stigma. The legal abortion program (ILE) framework indicates that only women in the city center are eligible to receive care for free (though a sliding scale for payments is often used for a majority of women seeking care from out of state). Regardless, perceived cost may influence decision making for women considering travel into the city center. The legalization of abortion in only part of the Mexico City Metropolitan Area has created a situation of reduced access to public-sector abortion services for the approximately 55% of the population of women of reproductive age living outside of the city center. Socio-economic status is also a key determinant of abortion access, especially in determining who is able to cross a border to access care. Even within the ILE program, adolescents and women with lower levels of education are more likely to present for care past the legal limit.
(Gallo and Nghia 2007) [Vietnam]	To understand the determinants of delaying obtaining abortion until the second trimester.	Clients presenting for an abortion at 13–24 weeks of gestation in 5 health facilities in 3 provinces in Vietnam (n=60); abortion service providers (n=6)	Qualitative: semi-structured interviews	Despite sliding scale fees, about one-third of respondents recounted difficulties paying for the abortion. For example, a farmer related that the second-trimester abortion fee was equivalent to their annual savings. Some women described borrowing money to pay for the procedure or needing time to acquire enough money for the procedure.
(Ganatra and Hirve 2002) [India]	To explore adolescent women's access to abortion services, decision-making on abortion, determinants of provider choice and extent of morbidity experienced.	women who had undergone an induced abortion in three districts in Western Maharashtra in an 18-month reference period (1996–1998) [n=1717]	Mixed methods [interviewer-administered questionnaire, a qualitative in-depth time-line of sequence of events]	Cost considerations were the most commonly determinant of provider choice mentioned by adolescents (29.1%). Older women mentioned cost considerations significantly less frequently than the adolescent women (12.1%). The cost of the abortion depended on gestational age at which it was sought and the type of provider, but did not vary by age of the woman. The median costs that women

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				incurred for a first trimester abortion in the private sector were Rs. 490.8 (US$ 10.20: Rs. 65–2625 / US$ 1.40–54.70). Public sector abortions were cheaper but not free of cost; the median costs for a first trimester were Rs. 177.2 (US$3.70: nil to Rs. 550 /US$11.50). Second trimester abortion costs in the private sector averaged Rs. 1661.4 (US$34.60) and in the public sector Rs. 560.8 (US$11.70). Indian law requires a guardian's consent for young women below 18 years of age but some girls reported that private practitioners were willing to forego this requirement for a fee, between three to five times the normal rate.
(Ganatra, Manning et al. 2005) [India]	To understand how mifepristone and misprostol how they are being used, who is using them, how women access them or how providers, chemists, women and their partners perceive medical abortion.	A survey of 209 chemists, in the Indian states of Bihar and Jharkhand.	Cross-sectional descriptive survey	The belief that mifepristone was better was often due to its higher price, with cost being a proxy for quality. 8/9 chemists reported deciding on which drug to prescribe based on their estimate of the customer's ability to pay. The bottom line for most chemists was to ensure that no one went away from the shop without buying a medicine. 6/9 chemists said that when the prescription is for mifepristone and it is not in stock, they have no option but to turn the person away, as there are no other abortifacient drugs in that price range that can be substituted. While the price of mifepristone in India is less than in many other countries, a single tablet still costs 8–10 times more than any of the other preparations and even in absolute terms can prove a considerable barrier in these two states, both of which have a per capita income considerably lower than the national average. The fact that higher than necessary doses of mifepristone continue to be prescribed and sold increases costs and further reduces access and therefore demand.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Gerdts, Fuentes et al. 2016) [United States]	To evaluate the additional burdens experienced by Texas abortion patients whose nearest in-state clinic was one of more than half of facilities providing abortion that had closed after the introduction of House Bill 2 in 2013.	Texas-resident women seeking abortion services from ten facilities in Austin, Dallas, Fort Worth, Houston, and San Antonio. [n=398]	Survey	Out of pocket expenses >US$100 for 19.7% women whose nearest clinic in 2013 was open in 2014 vs. 31.9% of women whose nearest clinic in 2013 was closed in 2014 (p=0.04).
(Gerdts, DeZordo et al. 2016) [United Kingdom]	To better understand the experiences of non-resident women who travel to the United Kingdom (UK) seeking abortion services.	Non-UK residents seeking abortions at three British Pregnancy Advisory Service (BPAS) clinics (n=58).	Cross-sectional survey	Nearly all women in this study (97%) came to England for the express purpose of seeking an abortion. 75% travelled with a companion. The large majority of women travelled by airplane (95%) and stayed overnight (88%). Women paid an average of £631 (range: £20–£3000) for travel expenses, and an average of £210 (range: £0–£1000) for accommodation. More than half of women in this study found it 'difficult or very difficult' to cover the cost of travel.
(Gerdts, Raifman et al. 2017) [South Africa]	To investigate the reasons for attempting self-induction, methods used, complications, and sources of information about informal sector abortion, and test a recruitment method.	Women [n=41] who sought informal sector abortion services in Cape Town, South Africa using respondent driven sampling (RDS).	Cross-sectional descriptive survey	Cost of informal sector abortion (Rand) (n=41) Mean=163R; SD, range: 146.8 (0-450); distribution: <50R = 12; 50-100R = 8; 100-250R = 7; 300+R = 14; missing = 1. Two women believed the cost would be lower outside the formal health system—despite the fact that public sector facilities are required to offer services for free.
(Girard and Nowicka 2002) [Poland]	To present evidence from the Polish Tribunal on Abortion Rights	Testimonials of women who had managed to obtain an abortion, legally or illegally, and those who had not [n=7]	Qualitative	Illegal abortions cost between 2000 and 4000 PLN (US$500–1000). The average monthly Polish salary is 2000 PLN. The negative impact of the Act is therefore disproportionately greater on poorer women, and on those who do not live in large towns where services are more easily found. It takes women time to find the money and identify a willing provider. The fees for clandestine abortions were considered by the Tribunal judges to constitute a barrier in Poland.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Grindlay, Lane et al. 2013) [United States]	The purpose of this study was to evaluate patients' and providers' experiences with telemedicine provision of medical abortion.	Women receiving telemedicine (n=20) or in-person (n=5) medical abortion services from Planned Parenthood of Heartland clinics in Iowa.	Qualitative: in-depth interviews	One dominant factor that drove women to opt for the telemedicine visit was closer proximity, along with the associated considerations of reducing the time they had to take off from work or school, limiting costs associated with travel, and avoiding having to explain the reason for traveling to a more distant location, among others. No women in this study cited telemedicine or the greater access to abortion services that it facilitated as a factor in their decision about whether to have the abortion. Instead, women reported reasons such as financial insecurity, it being a bad time in life for a child, wanting to finish school, being too young, having completed their family, and not having a stable partner as their principal considerations.
(Gresh and Maharaj 2011) [South Africa]	To examine the acceptability of medical abortion among young people in Durban, South Africa. To investigate the potential demand for and applicability of the method among women in South Africa	Sexually active women at the University of Durban and under 30 years of age (n=20)	Qualitative in-depth interviews	Private consultation fees are a major financial barrier – with reports of people needing ZAR 1000 to access these. The study reports that paying an approximate ZAR 900 for medical abortion at private clinics is unaffordable.
(Grossman, Ellertson et al. 2004) [Global]	Review of protocols and existing evidence on follow-up care for abortion.	Global literature on follow-up visits for abortion care.	Literature review	Costs associated with this visit can be great. These include travel expenses, lost wages, child-care expenses, privacy and emotional burdens for women, and scheduling disruptions and the related opportunity costs caused by "no-shows" for the provider. With 87% of American counties lacking a single provider, approximately 25% of American women travel 50 miles or more for their abortions. Time spent traveling to and from the clinic, as well as in the waiting and examination rooms, may be taken away from work or school and may reduce earned income. These lost wages also may apply to

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				the woman's partner or another person who accompanies her to the visit. Women who attend a follow-up visit and have children must arrange child care on 2 separate occasions.
(Grossman, Baum et al. 2014) [United States]	To assess the change in abortion services after the first three provisions [of a restrictive law HB2] went into effect.	Licensed Texas abortion facilities (n=22)	Observational study	The findings suggest that most—but not all--women desiring an abortion overcame the barriers of distance and additional cost to obtain the service they needed, following the implementation of HB2.
(Guttmacher, Kapadia et al. 1998) [South Africa]	Article examines the policies that have regulated accessibility of abortion and assesses their impact on reproductive health.	South African policies.	Review of policies and related evidence	Prior to 1975, financially secure upper- and middle-class white women could fly to England to terminate an unwanted pregnancy if they could not procure adequate services privately in South Africa. In contrast, the relatively low-paying and insecure jobs available to black and colored women limited their ability to seek termination of an unwanted pregnancy. Besides the difficulty of financing a safe abortion, finding a trained doctor willing to perform an abortion was more difficult for women of color.
(Henshaw, Naji et al. 1994) [United Kingdom]	Estimate and compare the relative costs to the NHS of providing legal termination of pregnancy using medical abortion or vacuum aspiration; also to estimate and compare the relative financial costs incurred by women undergoing these procedures.	Women receiving legal abortion services at a Scottish teaching hospital (n=363).	Cost analysis	Medical abortion used 18 percent less of women's resources (213 pounds vs 259) when compared to vacuum aspiration.
(Henshaw 1995) [United States]	To provide information on the percentage of women who travel long distances to obtain abortion services, the availability of abortion providers for second trimester services, the need to make more than one trip to the abortion facility and the amount	Abortion providers in the United States (n= 1,525)	Cohort	8% of women having abortions in nonhospital facilities in 1992 traveled more than 100 miles for abortion services, and an additional 16% traveled 50–100 miles. The larger the facility, the higher the proportion of patients who travel long distances for services. If mandatory waiting periods are adopted by more states, travel to states

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	abortion providers charge for services. In addition, it presents a measure of antiabortion harassment.			without such restrictions will probably increase. Other women may choose a distant provider to take advantage of lower fees or to obtain services such as general anesthesia that may not be available from small local providers. Because most women go to the larger clinics with lower fees, the average patient paid about $296 for the abortion itself, not including other expenses such as travel, time missed from work and any additional medical services needed by a particular woman. The average amount paid in 1993 was 18% higher than the average amount paid in 1989. Women who live in large urban areas and have the necessary financial resources can usually obtain abortion services in a single visit without a long wait for an appointment. Many women who have unintended pregnancies, however, have a low income and lack health insurance that covers abortion services.
(Henshaw and Finer 2003) [United States]	This article documents the current status of abortion service accessibility in the United States, on the basis of data collected in a survey of all known abortion providers in the United States conducted in 2001–2002 by The Alan Guttmacher Institute (AGI)	Providers documented in the AGI Abortion Provider Survey (n=1,819).	Quantitative; survey	Respondents estimated that 8% of women having abortions in nonhospital facilities travel more than 100 miles to obtain this service, and that 16% travel 50–100 miles. In 2001, four states had legislation requiring most or all clients to receive specified in-person counseling at least 24 hours before the procedure is performed. Such requirements usually necessitate two trips to the abortion provider. On average, surveyed facilities charge $468 for a surgical abortion at 10 weeks LMP (last menstrual period). The lowest average charge ($364) is reported by specialized abortion clinics, and the highest average charge ($632) is reported by physicians' offices. At 16 weeks, the mean and median charges ($774 and $650, respectively) increase. At 20 weeks, the mean and median charges increase to

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				$1,179 and $1,042, respectively. In the second trimester, charges vary relatively little by type of provider, but the range remains wide, with some providers charging 2–5 times the average. In general, the mean amount paid by clients ($372) is lower than the mean amount charged by the typical provider, since larger providers (especially abortion clinics) tend to charge lower fees. However, clients obtaining an abortion at a doctor's office pay substantially more ($471). The average self-paying client's payment for an abortion at 10 weeks LMP has increased steadily over time—from $200 in 1983 to $319 in 1997, and to $372 in 2001. When cost of living inflation is taken into account, the amount changed little between 1983 and 1997, but increased by 9% ($30) from 1997 to 2001. When compared with the amounts paid for other medical care, the amount paid for abortion services fell from 1983 to 1997, and then increased by 5% ($17) between 1997 and 2001.
(Henshaw, Adewole et al. 2008) [Nigeria]	To better understand morbidity resulting from unsafe abortion and to better assess its current magnitude and characteristics.	Women seeking post-abortion care (PAC) or abortion services and their provider in 33 hospitals (n=2093).	Qualitative: structured questionnaires	The greatest expense, averaging nearly 11,000 naira per patient, was for women treated for serious complications of abortion attempts outside the hospital. This total included about 7,900 naira for the hospital, which usually included physician care, 1,200 naira for supplies and 1,900 naira for medications. In addition, before going to the hospital, these women had paid an average of about 2,900 naira for the abortion attempts that caused the complications. In all, pregnancy termination and treatment cost about 13,900 naira for this group. Women needing treatment of spontaneous abortion paid less than half this amount (5,100 naira). Least expensive was abortion

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				provided in the hospital for women who had made no prior attempts and those whose prior attempts had not resulted in serious complications (3,800 naira). Hospital care associated with abortion in the second trimester was much more costly than care associated with earlier abortions (with the exception of women who had serious complications from previous abortions). For women with complications of abortion attempts, the costs in private hospitals (5,000 naira) were lower than in other types of hospitals (10,300–16,200 naira): it is likely that public and mission hospitals were more costly because they receive patients with more severe complications and provide more comprehensive care.
(Htay, Sauvarin et al. 2003) [Myanmar]	Describes the process undertaken by the Department of Health (DOH) in Myanmar to address the issue of abortion complications, by integrating post-abortion care and contraceptive service delivery into existing health care services	Health-providers [n=285] and post-abortion women [n=170].	Cross-sectional descriptive survey	The cost of treatment was not a big factor in the decision to delay seeking care. Over 95% of women said that the cost of care was reasonable; two-thirds of those interviewed were charged under 6,000 kyat for inpatient care and medication, and on average they had spent 1,500 kyat prior to admission to hospital on transport and medication. An informal community support system exists for transport, and hospital staff keep a fund with donations for treatment of poor patients.
(Hulme-Chambers, Temple-Smith et al. 2018) [Australia]	To understand rural women's experiences in obtaining a medical termination of pregnancy (MToP) through a rural primary healthcare service in Victoria, Australia.	Women aged 16 years and over who attended clinic between February 2016 and 2017 for an appointment related to MToP. [n=18]	Qualitative [semi-structured interviews]	Although surgical termination was available close by in the neighbouring regional city, women's reasons for not using this service included cost, limited appointment availability, and avoiding protestors who picketed the facility. Women reported that the most important aspects of the MToP experience were the supportive services provided by the clinic staff, and the low cost of the MToP. Some women reported indirect costs associated with the process

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				including travel time or missing time from work or education.
(Hung 2010) [Hong Kong]	To describe the experience of teenage women in Hong Kong from deprived backgrounds who seek an abortion and the extent to which their access to legal services is constrained by age, income and class.	Young women [n=29] from deprived backgrounds in Hong Kong who had had an abortion, and key informants [n=4]	Qualitative cross-sectional descriptive	Among those who went to illegal abortion services, the cost of a legal abortion, the legal consequences for their sex partners of being identified, and the requirement of parental consent for public abortion services were key factors deterring them from using legal abortion services. The cost of abortion services was of great concern to all the respondents. Charges for an abortion ranged from a few hundred to more than tens of thousands of Hong Kong dollars. 5/29 respondents, either out of their own savings or with the financial support of family members, were able to afford the costs of private medical services. For the others, the first thing they had to do was to find the money needed for the abortion. Delaying abortion was not uncommon, caused by the time needed to find the money.
(Ilboudo, Greco et al. 2015) [Burkina Faso]	to study both costs and consequences of induced and spontaneous abortions and complications	women [n=305] whose pregnancy ended with either an induced or a spontaneous abortion in Ouagadougou.	Cross-sectional descriptive survey	Women with induced abortion paid much more money to obtain abortion and treatment of the resulting complications compared with women with spontaneous abortion: US$89 (44 252 CFA) vs US$56 (27 668 CFA). Women who had had an induced abortion paid significantly more for the abortion procedure and treatment of its complications than women with spontaneous abortion: US$89 (44 252 CFA) vs US$56 (27 668 CFA), respectively (P < 0.001). They paid one and a half times the amount paid by women with spontaneous abortion for ending their pregnancy, and on immediate treatment linked to the abortion procedure before hospitalization: US$56 (28 065 CFA) vs US$37 (18 413 CFA), respectively. Women with induced abortion

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				paid more than one and a half times the amount paid by women who had had a spontaneous abortion for treating complications resulting from their abortions: US$33 (16 187 CFA) vs US$19 (9255 CFA), respectively (P < 0.01). There was no evidence of a significant difference between induced and spontaneous abortion costs by type of facility. Women from low income households paid the highest amount of money for the abortion procedure and for subsequent treatment of its complications: US$105 (52 231 CFA).
(Izugbara and Ukwayi 2003) [Nigeria]	To document the characteristics and health conditions of the clientele of traditional birth attendants (TBAs) in southeastern Nigeria.	TBAs (n=13) and users of TBAs (n=147) in four rural communities.	Qualitative: interviews	32 participants included 'low charges' as a reason they used TBA services. 3 clients were 20 and lower, 9 clients were in the 21-30 age category, 10 were between 31-40, and 10 were in the 41 and older age category.
(Izugbara, Egesa et al. 2015) [Kenya]	How, in the context of Kenya's current abortion law as well as severe abortion stigma in the country, do ordinary women perceive and understand abortion safety? How do lay and public health discourses of abortion safety compare?"	A convenience sample of 50 women treated for complications of unsafe abortion at six purposively-selected public facilities in Kenya.	Qualitative cross-sectional descriptive	Pregnancy termination in hospital settings and by high-profile providers was considered very costly and often out of the reach of the poor. Women and young girls may not often have the resources to pay providers in these facilities to keep their abortions secret; women seek inexpensive but unsafe providers. Well-equipped facilities and providers were considered out of the financial reach of most abortion-seekers and thus expensive to use.
(Janiak, Kawachi et al. 2014) [United States]	Our study sought to enumerate abortion barriers specifically among a population of women seeking abortion care in the latter half of the second trimester, when abortion care is most expensive and difficult to obtain.	Data from Massachusetts referral program on women seeking second trimester abortion services (n=587).	Regression analysis of secondary data	Difficulty deciding whether to terminate the pregnancy, financial barriers and the woman not having realized she was pregnant until recently were the most common barriers. Though the sample was 89.7% insured at the time of referral to the program, some insured women experienced financial barriers to abortion, such as having private insurance that does not pay for abortion or

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				having experienced a lapse in Medicaid coverage earlier during the pregnancy.
(Jejeebhoy, Kalyanwala et al. 2010) [India]	To shed light on the experiences of unmarried young abortion-seekers aged 15–24, compare their experiences with those of their married counterparts, and explore the proximate factors leading to delays in them obtaining abortions into the second trimester.	A survey of abortion seekers and in-depth interviews with selected unmarried survey respondents [n=795 young women were surveyed: n= 549 unmarried, n=246 married]. In-depth interviews with n=26 randomly selected unmarried survey respondents. Sampled from facilities in two poorly developed neighbouring states in north India with weak health systems.	Cross sectional descriptive: survey and qualitative	The study was located in certified clinical settings of an NGO that charges a nominal fee (Rs 199 (US$4) for medical abortion, Rs 399 (US$9) for first trimester surgical abortion, Rs 799 (US$18) for second trimester surgical abortion). Its clinics are preferred to government clinics and other private health facilities by large numbers of poor women because they are reliable, confidential, of high quality and there are no hidden costs (e.g. drugs or tests).
(Jerman, Frohwirth et al. 2017) [United States]	To examine the breadth of barriers, beyond those related to individual state-level abortion restrictions, that women encounter and any associated consequences.	Patients seeking abortion services at six health facilities providing abortions in the states of Michigan and New Mexico [n=29]	Qualitative [in-depth interviews]	One respondent had been able to find an abortion provider that performed abortions past 20 weeks in a neighboring state, and had borrowed money to buy the plane ticket needed, but upon arriving, she had been turned away for being “too high risk.”
(Jewell and Brown 2000) [United States]	This paper applies a model of fertility control to estimate the responsiveness of teenage abortion rates to variations in the local availability of abortion providers,	Data from 254 counties in Texas on teenagers seeking abortion services.	Regression analysis of secondary data	The results indicate that counties with higher travel costs have lower teenage abortion rates: the coefficient sizes imply that a $1.00 increase in travel cost would decrease abortions per woman by 0.86% and per pregnancy by 0.67%, other factors constant. To the degree that abortion services are available at nonlicensed facilities within a county, these coefficients may overestimate the true impact of travel cost on abortion demand–as licensed providers become less available, teenage women may substitute toward having abortions at nonlicensed facilities.
(Johnston, Ved et al. 2003) [India]	To obtain information about where rural women seek care for abortion complications and about the quality of care they receive	Surveys of formal and informal organizations, institutions and key leaders in four selected villages in rural Uttar Pradesh. Community mapping exercises in four selected villages in rural Uttar Pradesh. 24 focus group discussions with	Mixed methods: Descriptive surveys, community mapping exercises, focus group discussions, and in-depth interviews	Women who experienced abortion complications generally first sought care from untrained or inadequately trained providers in their village. When their medical condition worsened, some women sought the services of providers who were more qualified but less affordable or less

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
		informants from specific population subgroups, including married women and men, and single female and male young adults. 88 in-depth interviews with 53 key informants who were married women that the interviewers identified as being particularly knowledgeable about abortion and post-abortion care issues in their village. In-depth interviews with 38 post-abortion care providers		conveniently located. Treatment for abortion complications was widely available in the villages studied, but as this treatment was largely inappropriate, it tended to exacerbate rather than alleviate complications, cause delays in patients' seeking appropriate care and increase the total expense associated with treatment by necessitating multiple visits to providers.
(Jones and Weitz 2009) [United States]	To review laws that directly target abortion providers.	United States	Legal review	Factors causing women to delay abortions until the second trimester include cost and access barriers, late detection of pregnancy, and difficulty deciding whether to continue the pregnancy. Low-income women and women of colour are more likely than are other women to have second-trimester abortions. The cost of abortion is an important factor in access to care because abortions increase in price with weeks of pregnancy and are therefore more expensive later in the second trimester. When associated expenses, such as transportation, overnight lodging (because later second-trimester abortions require more than one day to perform), and child care are added, the price of abortion in the later second trimester rises dramatically. Three quarters of women receiving outpatient abortions to pay for the procedure with their own funds. Women with limited financial resources can find themselves in a vicious cycle: by the time they have secured the money for an abortion performed at one gestational limit, their pregnancy has advanced into the next. Lack of financial support for abortion results

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				in delays that push the procedure into the second trimester.
(Jones, Ingerick et al. 2018) [united States]	To examine differences in abortion service delivery in Hostile, Middle-ground, and Supportive States.	All known abortion- providing facilities in the United States.	Cross-sectional descriptive.	After cost of living adjustments, a first-trimester surgical abortion was most expensive in middle-ground states ($470) and least expensive in supportive states ($402). On average, women paid $27 more for medication abortion at EMA-only facilities than at facilities that also offered surgical abortion. This pattern was consistent across the three policy climates, ranging from $9 more in hostile states to $35 more in supportive ones (after cost of living adjustments). The median charge for an abortion at 20 weeks gestation was $1,195 (data not shown). Clinics in hostile states charged the most, at $1,350 (adjusted for cost of living), and clinics in supportive states charged the least ($964); clinics in middle-ground states charged $1,158.
(Jones, Upadhyay et al. 2013) [United States]	To understand how women pay for abortions, including ancillary expenses, in the United States.	Abortion care patients aged 15 or older at six abortion providers located in major cities in Arkansas, California, Georgia, Illinois, New Jersey, and Texas. [n=639]	Cross-sectional descriptive.	On average, women paid $382 for their abortion. 21% of abortion patients had $0 out-of-pocket costs. When women with $0 out-of-pocket costs are excluded, the average amount paid was $485, and up to $3,500 or more. Second-trimester abortions cost more: $854 on average ($652 when those paying $0 are included) compared with $397 ($319, respectively) for first-trimester patients. It was somewhat or very difficult for 41% of respondents to pay for the procedure (52% among women not using health insurance). The majority of those with health insurance did not or could not use it to pay for the procedure; 23%. 59% of women who were not using insurance and who were paying fully out of pocket indicated they obtained money from others, most commonly (60%) the man involved in the pregnancy. Regardless of

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				whether the assistance came from an abortion fund, a male partner, or a family member, women's most common characterization of having to obtain money from others was to feel grateful. Substantial minorities of women who obtained money from abortion funds and family members characterized the experience as "lifesaving," although few women who obtained money from men indicated this response. A few women reported negative emotions such as "resentful," "humiliating," or "angry".
(Kacanek, Dennis et al. 2010) [United States]	To investigate the following questions: What are providers' experiences with Medicaid reimbursement for abortion in cases of rape, incest and life endangerment? What is the process for applying Medicaid reimbursement? What factors facilitate or hinder reimbursement?	Abortion providers in Florida, Idaho, Kansas, Kentucky, Mississippi, Pennsylvania, South Dakota, and Wyoming, where Medicaid funding is limited (n=25).	Qualitative: purposive interviews	The median costs were $450 for a medication abortion, $425 for a first trimester surgical abortion and $900 for a second-trimester abortion, but costs varied considerably. Respondents reported that the majority of patients pay for abortions out of pocket.
(Karasek, Roberts et al. 2016) [United States]	This study investigates the experiences of women seeking abortion and their perceptions of a 24-hour waiting period between clinic visits. Using abortion patient survey data, we describe the financial costs women incurred when accessing abortion, assess anticipated emotional response to a change in the law, and identify women who may be particularly affected by a 24-hour waiting period.	Women seeking abortion services at a health clinic in Tucson, Arizona (n=379)	Qualitative: survey	The mean length of time travelled was 58 minutes, and 10% of the population travelled more than 2 hours to reach the clinic. The mean travel time was nearly 30 minutes greater among the participants below the federal poverty level (FPL). Women's reports verified that a first trimester procedure at the clinic cost $450. More than one-half of participants reported having to miss work; Participants reported additional costs of transportation (33%), missed work (32%), staying overnight (4%), and childcare coverage (11%). Additional transportation and childcare costs were more likely to be forgoing payment for bills and food. Overall, 56% of women reported at least one reason that they were delayed from obtaining an earlier procedure, with

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				the most common reasons being the costs of the procedure (39%), not knowing they were pregnant (30%), and taking time off work (18%).
(Kinoti, Gaffikin et al. 2004) [sub-Saharan Africa]	To provide a basis for continued policy dialogue and reform to address the problem of death due to abortion complications among the East, Central and Southern Africa Health Community countries	Abortion complication patients and health providers at selected districts and tertiary care hospitals in three countries (Uganda, Malawi, Zambia)	Literature review Reviews of logbook data and interviews	For the majority (53%) of patients interviewed, their spouse or partner was paying for the abortion treatment services received. Relatives (22%) and the patient herself (16%) were the other two major categories of payees. Overall, relatives paid for services at a higher rate (32%) among adolescent patients (£20 year olds) than among patients above 21 years (17%). Differences in payment practices were significant (p=0.015) by facility type. While 62% of patients in non-tertiary centers said a spouse or partner was paying for their treatment services, this was the case for only 37% of patients interviewed from tertiary centers. On the contrary, more clients (26%) from tertiary centers paid for services themselves than patients from non-tertiary facilities (11%).
(Kishen and Stedman 2010) [Global]	Study examines evidence to suggest that the outcome of first-trimester abortions performed by suitably trained non-medical practitioners is comparable in terms of safety and efficacy to abortions performed by doctors.	Literature and data on national averages of costs to obtain an abortion.	Literature review	In Guatemala, where 37% of the population lives on US$2 a day or less, an abortion carried out by a midwife costs around US$38 in rural areas and US$128 in urban areas. In Uganda, where 85% of the population survives on US$1 day or less, the cost of an abortion obtained from a trained professional is around US$6–58, compared with US$6–18 for the services of an unskilled provider. Therefore, poor women who live close to trained mid-level health providers may still not access safe abortion care in many developing countries, as they are unable to afford their services.
(Lafaurie, Grossman et al. 2005) [Mexico,	To collect information about women's experiences using misoprostol or methotrexate plus	Women [n=49] who had used either vaginal misoprostol alone up to a maximum of ten weeks of pregnancy	Qualitative cross-sectional descriptive	In many settings, the cost of medical abortion with provider involvement, US$60–130, was less than for surgical abortion,

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
Colombia, Ecuador, Peru]	misoprostol under clinical supervision in Mexico, Colombia, Ecuador and Peru.	LMP or intramuscular methotrexate followed by misoprostol up to eight weeks LMP.		which was important for many of them. In contrast, the cost of the misoprostol tablets, purchased at a pharmacy rather than through a provider, was US$15–78, and differed by place of purchase.
(Lalley, Jelsema et al. 2001) [United States]	The purpose this study was to complete a cost effectiveness evaluation for women who received either PGE2 or misoprostol for a second trimester termination of pregnancy with either a living or dead fetus.	Medical records of women seeking abortion care services at Butterworth Hospital Grand Rapids, Michigan (n=78)	Cost comparison and analysis	Patients charged on average $548.21 for PGE2 and $298.86 for Misoprostol, for an average savings of $249.35.
(Le, Connolly et al. 2015) [South Africa]	To evaluate the likely costs of unintended pregnancy in South Africa using a deterministic modeling approach	Model estimates based on contraception prevalence and failure rates among women of reproductive age.	A decision analytic model to estimate costs of unintended pregnancies	The estimated cost per abortion was 3094 ZAR
(Leone, Coast et al. 2016) [Zambia]	To estimate the costs for women of seeking safe and unsafe abortion and to establish whether the burden of abortion care-seeking costs is equally distributed across the sample.	Women [n=112] receiving care for either safe abortion or post-abortion care at University Teaching Hospital [UTH], Lusaka	Cross-sectional descriptive survey	Women who sought a SA from UTH incurred the lowest costs (US$52.6) vs. PAC following an unsafe abortion (US$82.4). Of those women who sought PAC following an unsafe abortion, women who initiated a medical abortion unsafely incurred higher costs compared to women who used some other unsafe method (US$82.4 vs US$62.5). Women who sought PAC following a non-medical unsafe abortion incurred the highest relative miscellaneous costs. Irrespective of the type of abortion care sought, unofficial payments to health professionals represent a significant component of the costs that women have to pay. For women seeking a safe abortion at UTH, these payments represent 32% of the overall cost of abortion care-seeking. Whilst representing a lower proportion of costs (27%), the unofficial provider payments paid by women who initiated a medical abortion outside of the regulated sector were highest; this group of women also had

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				substantially higher costs related to the purchase of medicines. For both safe abortion and PAC after an unsafe non-medical abortion, costs increase with wealth.
(Limacher, Daniel et al. 2006) [Canada]	This study compares the costs of four options for early medical and surgical abortion in Ontario. Costs are considered from the perspectives of society, the health care system, and the patient.	Available data on abortion procedures in Ontario.	Cost analysis	The indifference price of mifepristone, at which the costs of mifepristone and methotrexate abortions would be identical, is $36.05 from the patient's perspective and $59.89 from the societal perspective. In our model, the medical options for early abortion compare favourably with the surgical options in terms of total cost to society, the health care system, and the patient.
(Lince-Deroche, Constant et al. 2015) [South Africa]	To assess women's costs of accessing second-trimester labor induction and dilation and evacuation (D&E) services at four public hospitals in Western Cape Province, South Africa.	Women seeking second trimester labor induction and D&E services at four public hospitals (n=194).	Cost analysis	Although offered for free in the public sector, women incurred costs while accessing second-trimester abortion services. The median total cost for obtaining a second-trimester abortion, considering all participants, was $21.23 (R144.00). The participants made multiple visits to facilities while seeking an abortion, resulting in repeated transport costs. Induction procedures required more visits and more time and travel than D&E procedures. Few women lost income or paid for childcare during their visits. About one quarter of the women reported having paid for a pregnancy test. Despite public sector guidelines suggesting that the pregnancy test should be done at the facility, many clinics and hospitals in South Africa informally require that women present with a positive pregnancy test result.
(Lince-Deroche, Fetters et al. 2017a) [South Africa]	To explore women's experiences accessing services and estimate costs incurred for first-trimester abortion at four public hospitals	Women requesting first-trimester abortion services at one of four public hospitals (n=1,167).	Observational cohort design	12.2% of all women who had a follow-up visit reported having missed work as a result of their abortion, and 5.4% indicated that they had lost income as a result of obtaining the procedure. The median travel time per

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	in KwaZulu-Natal Province, South Africa.			visit (round trip) for all women was 50 min [IQR 30–80]. Almost all women (97.2%) reported having to pay for transportation, and 59.6% reported paying for a pregnancy test. The median recurring cost per visit for all women was US$3.23 [IQR 1.57–4.54] (ZAR 46.48 [IQR 22.59–65.33]). Combining recurring, per visit, costs and once-off costs for each woman, the median total cost for the procedure, considering the entire study population, was US$9.99 [IQR 6.46–14.85] (ZAR 143.76 [IQR 92.96–213.69]). Despite appearing low, the cost incurred by women in this study may have proved challenging as the majority of the study population was unemployed and dependent on family members for financial support. In 2010, the average monthly income for an employed, black individual in South Africa was ZAR 2167 [roughly US$151.69 (US 2010)] [23]. Thus, even for many working South Africans, US$9.99 (ZAR 143.76) for an abortion may not be insignificant.
(Machungo, Zanconato et al. 1997) [Mozambique]	The purpose of the present study was to give a socio-economic profile of each of the three categories of women and to attempt to calculate the expenditure related to interventions necessary for the two abortion groups in terms of hospitals cost and individual cost.	Women who had an illegally induced abortion (IA) (n=103), women who had a legally induced abortion (LA) (n=103), and women attending antenatal care (AC) (n=100).	Mixed methods	At an individual level the cost of a legal intervention is consequently unfavourable in comparison with the cost of an illegal one. The average individual cost of intervention was 46 contos for the LA group and 14 contos for the IA group. If salaried days lost (due to abortion-related complications) are also included, the mean total individual cost amounted to 49 contos for the LA group and to 36 contos for the IA group.
(Manouana, Kadhel et al. 2013) [Guadeloupe]	To describe the typical profile, and to assess the motivations of women who underwent illegal abortion with misoprostol in Guadeloupe (French West Indies).	Women who consulted at the Department of Gynecology and Obstetrics at the University Hospital of Pointe-à-Pitre / Abymes after failure or complication of an illegal abortion with misoprostol [n=52]	Descriptive prospective study	The costs of procuring medical abortion drugs illegally are cheaper (32 cents per tablet) than the official cost for treatment in a medical institution (50-60 Euros, although this can be exempted if a women qualifies for complimentary care). The official medical expenses are an important barrier to care

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				for some women. Women who were migrants were more likely to self-use misoprostol because of a lack of access to social security.
(Marlow, Wamugi et al. 2014) [Kenya]	To understand the methods married women aged 24–49 and young, unmarried women aged ≤ 20 used to induce abortion, the providers they utilized and the social, economic and cultural norms that influenced women's access to safe abortion services in Bungoma and Trans Nzoia counties in western Kenya.	Focus groups [n=10] conducted in Trans Nzoia and Bungoma county with un/married and younger/older women in rural and urban settings.	Qualitative cross-sectional descriptive	The cost of an abortion ranges from KS 60 for quinine purchased at a pharmacy to 5,000 KSH (US$ 60) from a doctor, although costs were negotiable with individual doctors. Women in 6/10 groups considered the cost of abortion from public hospitals or private providers to be prohibitive, and used less expensive options, such as traditional drugs and herbs. Even where women knew about a potentially safe option for abortion, the cost was prohibitive and limited them to less expensive options. Most women in western Kenya earn less than 220 KSH (US$ 2.50) per day, so a procedure that costs 950–2,000 KSHs, is prohibitively expensive. Women and young women reported similar costs of abortion services in their communities and both sought less expensive options.
(Medoff 2015) [United States]	This paper addresses the gap in the literature by empirically examining two important public and social policy questions: Do restrictive state abortion laws increase the price charged by abortion providers? And, if so, does the increase in the price charged by abortion providers, as a result of complying with the restrictive state abortion laws, have a significant negative impact on abortion demand?	Data from the Guttmacher Institute.	Regression analysis of secondary data	The empirical results consistently show that abortion providers in states that fund Medicaid abortions have higher abortion prices most likely because they incur higher expenses from providing Medicaid abortions. The enforcement of two-visit laws and TRAP laws in a state is associated with an increase in the price charged by abortion providers presumably in order to cover the additional expenses of complying with these laws
(Messinger, Mahmud et al. 2017) [Bangladesh]	To investigate the knowledge, attitudes and practices regarding mHealth of both MR [menstrual regulation] clients and formal and	MY clients (n=24) and health service providers (n=24)	Qualitative	Although MR is provided free of charge, or at a nominal cost, through the public sector and various non-profits organizations, many women face barriers in accessing safe,

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	informal sexual and reproductive healthcare providers in urban and rural low-income settlements in Bangladesh.			affordable MR and post-MR care. 5/24 MR clients stated that obtaining health-related advice over the phone saved them the price of a medical visit and enabled them to avoid paying the cost of transportation to a clinic. Formal and informal providers have to bear the cost of their mobile phone credits in order to communicate with their clients.
(Moore, Dennis et al. 2018) [Zambia]	To compare the financial costs for women when they have an induced abortion at a facility, with costs for an induced abortion outside a facility, followed by care for abortion-related complications.	Household wealth data at one point in time (T1) and longitudinal qualitative data at two points in time (T1 and T2, three-four months later), in Lusaka and Kafue districts	Prospective quantitative and qualitative.	Younger patients were less likely to know the costs that were paid. Among women who knew what had been cumulatively spent in the process of obtaining an abortion, both on the procedure and on ancillary expenses, approximately one-third of the respondents had spent less than 300 ZMW (<USD 47); two-thirds had incurred expenses between 300 KWZ and 1000 ZMW (USD 47–155); and 2 patients incurred over 1000 ZMW in expenses (>USD 155). Women who had case for unsafe abortion (CUA) spent on average, 30% more than women who obtained a TOP. The average cost spent on a TOP for all services was 396 ZMW (USD 62) vs. CUA 520 ZMW (USD 81). About two-thirds of the costs had been incurred by T1, while for women who had experienced either a TOP or CUA, an additional one-third of the total costs was incurred between T1 and T2. Women who went to a public hospital for a TOP incurred expenses which, on average, were less than half (210 ZMW, USD 33) the expenses of women who went to a private clinic (463 ZMW, USD 74). CUA cost, on average, at the public hospital (542 ZMW, USD 84) than a private clinic (450 ZMW, USD 70). Women who sought either a TOP or CUA at a private clinic paid about the same (463–474 ZMW, USD 72–73). In some cases, other costs were opportunity costs

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				which were incurred as the news of the abortion spread and stigma was enacted on the woman in her social or professional life.
(Murtagh, Wells et al. 2018) [United States]	To document the experience of buying abortion pills from online vendors that do not require a prescription and to evaluate the active ingredient content of the pills received.	Websites [n=18] that sold mifepristone and misoprostol to purchasers in the United States.	Quantitative cross-sectional descriptive	The price for the 18 mifepristone–misoprostol products ranged from $110 to $360 (median $204.50), including shipping and fees; the products without mifepristone cost less.
(Murthy and Creinin 2003) [United States, UK, France, Sweden, India, China]	To review the costs of abortion services	Review	Review	In 1997, the cost of a first trimester non-hospital abortion under local anaesthesia ranged US$150 – 1535 (average US$316). Medical abortion using methotrexate regimens ranged US$100 – 1250 (average US$401). Average cost of a second trimester procedure (US$618), to over US$1100 at 20 weeks. The cost of medical abortion was often set higher than the cost of surgical abortion because of assumptions about the procedure and follow-up. Despite a price differential, many patients would choose to have a medical abortion; however, utilisation would drop if the price difference was > US$50.
(Mutua, Manderson et al. 2018) [Kenya]	To illustrate how the quality of PAC in healthcare facilities is impacted by law and government policy.	Patients [n=21] and providers [n=16] at 16 hospitals in three regions sampled purposively by regional area, level, and reported quality of care.	Qualitative cross-sectional	In smaller facilities patients were not referred for specialized surgical interventions due to the transfer costs. Patient referrals increase the out-of-pocket cost of treatment, particularly referral from public to private facilities. Lack of payment options for patients necessitated the use of brokers, who would assist patients to make payments at a fee. Patients were often required to make cash payments for procedures, restricting services to patients with a credit/debit card. The requirement that patients paid prior to each procedure restricted access to timely care. Inability to pay for services led to multiple referrals. In private facilities, providers reported that

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				patients often could not afford services at all. In addition to direct treatment costs, even in public facilities other indirect costs such as toiletries and bathing accessories increased out-of-pocket expenses.
(Mutungi, Wango et al. 1999) [Kenya]	To evaluate adolescents' behavior regarding induced abortion.	Adolescent girls and boys ages 10-19 years in rural and urban Kenya.	Cross-sectional survey	The amount paid to procure abortion reported ranged from KS 100 to KS 30,000 (US$2 to 500). The cost of abortion services was mostly paid by boyfriends for adolescent girls, and by parents for boys.
(Naghma e 2011) [Pakistan]	To study the cost of induced abortions (unsafe abortion) and treatment of the complications of such abortions.	Women admitted to four tertiary hospitals in Lahore for complications of unsafe abortion [n=100]	Cross-sectional survey	Average cost of abortion was Rs.1686 (US$ 28) (range Rs.500-7,000); average cost of treating complications was Rs. 4,197 (range Rs. 1600-45,000).
(Nickson, Smith et al. 2006) [Australia]	To investigate the extent and cost of travel undertaken by women accessing Victorian termination of pregnancy services.	Women receiving privately funded pregnancy termination services [n=1,244]	Multi-centre, cross-sectional observational study.	Women face substantial and immediate costs beyond the service fee, as well as the difficulties associated with poor continuity of care and significant time away from home.
(Ogu, Okonofua et al. 2012) [Nigeria]	Evaluation of an intervention to improve the quality of private sector provision of post-abortion care in northern Nigeria.	Private medical doctors [n=458] and nurses and midwives [n=839]	Cross-sectional survey	The cost of procedures ranged from zero cost to a maximum of Naira 10 000 (US $66.7) (mean, Naira 2488±1745, US $16.5±11.6). 570 procedures (22.3%) were carried out gratis. The procedures were most commonly paid for by husbands (43.7%), the women themselves (15.9%), parents (8.9%), other relatives (5.9%), and boyfriends (3.3%).
(Ordinioha and Brisibe 2008) [Nigeria]	To uncover the motivations and experiences of private medical practitioners of abortion services.	Private medical doctors [n=34]	Cross-sectional survey and in-depth interviews	Respondents charge an average 5, 000 naira for an 8-week pregnancy.
(Ouedraogo and Sundby 2014) [Burkina Faso]	To show how economic resources, social networks, social norms and education affect the risk of clandestine abortion.	Case studies [n=2] from health facilities in Ouagadougou.	Qualitative cross-sectional	A case bought Misoprostol for Fr5000, Fr7000 for ultrasound, Fr3000 for PAC and Fr2075 for a prescription.
(Palma Manríquez, Moreno Standen et al. 2018) [Chile]	To document the experience of clandestine medical abortion use among university students in Chile	30 students aged between 17-26 years who had had medical abortions and attended 10 universities in the Santiago Metropolitan Region	Qualitative in-depth interviews	Respondents reported the role of the seller in providing the right pills in the right quantity for an affordable price.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				A respondent reported the following interaction with a seller: "He said: 'I have 2 types of pills. One that costs $70,000 for 4 misotrol, and one that costs $ 90,000 which includes 6 mifepristone, which I think is the best dose to use. It's up to you'."
(Penfold, Wendot et al. 2018) [Kenya]	To explore the pathways, decision-making, experiences and preferences of women receiving safe abortion and post-abortion family planning (PAFP) at private clinics in western Kenya.	Women [n=22] who had received an abortion or post-abortion care service at one of nine clinics.	Qualitative cross-sectional	Cost of the service was a consideration, with some facilities having a reputation for being more affordable. For some women, cost was a low consideration relative to the need to get an abortion
(Perrin, Berthoud et al. 2011) [Switzerland]	To compare the Swiss Criminal Code about TOP with its implementation by cantons and health professionals, including the cost of a TOP.	Women [n=281] before or after termination of pregnancy	Cross-sectional descriptive	TOP ranged CHF400-3500; average cost CHF1360. Successful medical TOP (average cost 1076 CHF), surgical TOP with general anaesthesia (average cost 1490 CHF); unsuccessful medical TOP, followed by a surgical TOP with general anaesthesia (2312 CHF) (significant differences p = 0.002; ANOVA p = 0.02). Costs vary depending on the size of the health care institution: private doctors' office (400-1270CHF, average: 620 CHF); average-sized, non-university hospital (592-2550 CHF, average: 1247 CHF); university hospital (693-3500 CHF, average: 1529 CHF).
(Pheterson and Azize 2005) [Anguilla, Antigua, St Kitts, Sint Maarten]	To contribute to an improvement in abortion care in the region, we sought to identify practitioners who were qualified, informed and potentially influential	Interviews with physicians (n=26), of whom 16 provided abortion care	Qualitative in-depth interviews	On the costs of abortions, a physician and abortion provider reported: ''Women have come to me and said, 'Doctor, I want to have a termination but I cannot afford the $1400 Eastern Caribbean [=US$560]). What can I do?' And I've said, 'This is what you can do, you can go to the pharmacist, they can give you these tablets, and if you have any problem you come back and see me.''

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Pongsatha, Morakot et al. 2002) [Thailand]	To gather evidence on abortion among women and their partners	Women (n=103) with a history of self-managed misoprostol use attending Department of Obstetrics and Gynecology, Maharaj Nakom Chiang Mai Hospital	Qualitative in-depth interviews	The mean cost of misoprostol reported by women was 663.16 Baht – calculated from self-reports by 88 of the respondents who knew the costs.
(Potdar, Fetters et al. 2008) [Cambodia]	To describe the loss of productive time and income related to abortion care and care-seeking.	160 women seeking elective abortions or care for complications of abortion from a purposefully selected group of public and private clinics and hospitals.	Cross-sectional survey	The mean productive days lost increased as the number of visits to terminate the pregnancy increased. Average time spent seeking and receiving care for women who required only one visit was 2.3 days. Women who needed three medical or pharmacy visits seeking advice or medication used more than 1 month (33.5 days) of productive time. Women wage earners reported losing the least amount of time obtaining an abortion. Women in the informal sector reported the greatest amount of lost productive time. The mean cost of 2nd trimester services was much higher than the mean cost for women with first trimester pregnancies. Women who first sought care at the office of a private physician reported almost no loss of earnings. Women who first approached private midwives also reported minimal lost earnings, followed closely by the women who went to government facilities. Lost wages that began with care-seeking from pharmacists were substantially higher than amounts lost seeking care from all other types of providers.
(Prada, Bankole et al. 2015) [Nigeria]	To identify near miss events and the proportion due to unsafe abortion, and the characteristics of women with these events, delays in seeking care and the short-term socioeconomic and health impacts on women and their families.	women of childbearing age with maternal near-miss or at risk of maternal near-miss due to unsafe abortion	Cross-sectional survey	Cost of treating life threatening complications due to unsafe abortion was six times higher than the cost of all attempts to end the pregnancy. Women spent on average 12,586 Naira (US$8316) in all attempts to end the pregnancy; average cost of treating the severe unsafe abortion complications was 74,407 Naira (US$488). Boyfriends (six out of 11), and to a lesser

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				extent family members, were most commonly responsible for paying the cost of the abortion procedure. About half of the women did not know who bore the cost of treatment.
(Ramachandar and Pelto 2004) [India]	To examine women's decision-making processes, the types of facility they attended and the extent of post-abortion complications they experienced	Women [n=97] who had had abortions within the previous six months	Cross-sectional descriptive qualitative	Fee for a first trimester abortion ranged Rs.800–1000 (US$20). The typical woman wage labourer in the district earned Rs.1000–1200 per month. The cost was much higher if the pregnancy was advanced or if the woman was unmarried. Unqualified and unsafe abortion providers were cheaper at Rs.200–300 (US$6) for first trimester abortion. Abortion costs of well-equipped and qualified providers was a serious challenge to family resources; the majority of women (and their husbands) were willing to pay the costs because of the lower risk of post-abortion complications. Unmarried women are particularly vulnerable to dangerous abortions from unqualified providers because of their concerns about cost and secrecy, the tendency to delay seeking services and the unwillingness of qualified providers to help them. The perception of poor quality of care in government PHCs and hospitals was a major reason why most women chose private practitioners if they could afford the costs.
(Roberts, Gould et al. 2014) [United States]	To describe payment for abortion care before new restrictions among a sample of women receiving first and second trimester abortions.	English- and Spanish-speaking women aged 15 and older, with no known fetal anomalies or demise, presenting for abortion care at one of 30 facilities throughout the United States between January 2008 and December 2010 and meeting specific gestational age criteria.	Interviews and regression analysis	Median price of a first trimester abortion $490 ($225-$750, mean $497). No significant differences in prices of first trimester medication versus aspiration abortions. Median price between 14 and less than 20 weeks $750 ($490-$1,500, mean $860). Median price at or after 20 weeks $1,750 ($946-$6,008, mean $1,874). Median out-of-pocket costs when private insurance or Medicaid paid were $18 and $0. Median out-of-pocket cost for women

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				for whom insurance or Medicaid did not pay was $575. For more than half, out-of-pocket costs were equivalent to more than one-third of monthly personal income; closer to two thirds among those receiving later abortions. More than half reported cost as a reason for delay in obtaining an abortion.
(Rossier 2007) [Burkina Faso]	To examine the choice of confidants with whom young women share their abortion secret, the probability of leaks and the extent of gossip that exists in a rural and urban social environment.	Key informants [n=13], male and female	Qualitative cross-sectional descriptive	The cost may range from a few thousand CFA francs for traditional potions or abortifacients of varying effectiveness, tens of thousands for an injection by a health worker, and up to 200,000 CFA francs for a curettage in hygienic conditions. The monthly wage for a maid or caretaker is 20,000–40,000 CFA francs; an abortion using a medically safe method (even in unhygienic conditions) is beyond the reach of the poorest population groups. In villages, where the main source of income is the sale of agricultural produce, individuals have little ready cash. Abortionists – even those using medically safe methods – charge no more than 10,000 CFA francs. In most cases, the young women will ask older relatives or the partner for money using a fabricated excuse.
(Schiavon, Collado et al. 2010) [Mexico]	To know whether factors [fear of staff attitudes, ignorance about the law, lack of information on where to access services, fear of breaches in confidentiality, burdensome requirements] were driving women in Mexico City to continue seeking private abortion services despite the availability of low-cost, safe, legal abortion services in the public sector.	Health providers working in lower middle-class neighbourhoods with small community health facilities [n=135 private sector physicians]	Descriptive	Fees charged ranged from a minimum of US$35 to a maximum of US$1,109and varied depending on the method and the clinic. D&C was most expensive ($35-$1,109), MVA ($35-$887) and medical abortion ($37-$443). The cost of a private abortion was high and the use of D&C, ultrasound and general anaesthesia, along with keeping women in the clinic overnight, contributed to this.
(Schuster 2010) [Cameroon]	To examine the histories of four young women who became	Young women [n=4] who became pregnant and had an abortion in the	Cross-sectional descriptive qualitative	Costs are highly dependent on the provider, gestational age and type of abortion.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	pregnant and had an abortion in the Anglophone region of the Cameroon Grassfields.	Anglophone region of the Cameroon Grassfields.		
(Sethna and Doull 2007) [Canada]	A pilot study of a questionnaire aimed at tracking the abortion journeys of individual women to a Canadian abortion clinic	Women [n=1022] attended Toronto Morgentaler Clinic, a private non-profit abortion clinic	Pilot study to test a questionnaire	Approximately 90% of women spent less than 50 CAD on transportation to and from the clinic, 20% spent nothing. The majority of women had no accommodation expenses, however, those that did predominantly paid more than 100 CAD. Expenses varied significantly, including one respondent who spend 4445.05 CAD for travel and hotel accommodation. Expenses increased depending on child care needs, if people accompanied, loss of wages.
(Sethna and Doull 2013) [Canada]	To analyse the travel women undertake to access abortion services at freestanding clinics.	Women [n=1186] seeking abortion care at 17 freestanding abortion clinics.	Cross-sectional survey and mapping	Women's travel costs ranged from “nothing” (15.6%) to more than $100 (CDN) (5.4%). Some women (38%) incurred other expenses ranging from less than $10 (CDN) (9.5%) to more than $100 (CDN) (3.1%). Costs were often doubled as the majority of women reported travelling to the clinic with someone (73.1%). Although abortion is supposedly a funded, medically necessary procedure, 22.1% of women reported that they paid for their own abortions. Of these women, 19% paid for the abortion procedure and for travel to the clinic, likely supplementary expenses such as administrative fees, medication or follow-up contraception rather than for the abortion procedure itself. The 25.3% of women who reported paying more than $300 likely paid for the abortion procedure itself. Whether or not these women would later be reimbursed by their provincial government health care plans for the abortion procedure is unknown.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Shankar, Black et al. 2017) [Australia]	To examine access and equity to induced abortion services in Australia, including factors associated with presenting beyond nine weeks gestation.	Survey of 2,326 women aged 16+ years attending for an abortion at 14 Dr Marie clinics.	Cross-sectional descriptive survey	Abortion costs are substantial, increase at later gestations, and are a financial strain for many women. Under 1% reported an abortion free of cost, and of this group, nearly half cited an external organisation as their source of financial assistance. 97.6% had Medicare coverage, however 5.0% did not use or were unsure about using it to subsidise costs. Among women who used Medicare, the reported median upfront cost of a medical abortion was $560 vs. $470 for a surgical abortion at ≤9 weeks, however the final out-of-pocket direct costs for the patient are the same. Without the Medicare rebate or PBS reimbursement for the cost of the medicine, the median costs for both medical and surgical abortions at ≤nine weeks roughly doubled. As women progressed beyond the first trimester, the cost of the surgical procedure rose at key gestational intervals, whilst the value of the Medicare rebate remained constant. For women who used the rebate, the median out-of-pocket costs for surgical procedures at 13-19 weeks and beyond 19 weeks were three ($1,500) and 16 times ($7,700) greater than the median out-of-pocket costs within the first trimester ($470). About 41% reported indirect costs related to travel and accommodation, GP referrals and medical tests, childcare and lost wages. The median cost for these additional expenses was $150. Women who had difficulty paying (AdjOR: 1.5, 95%CI 1.2-1.9) were more likely to present ≥9 weeks.
(Singh 2010) [Global]	To review the scientific evidence on the consequences of unsafe abortion, highlight gaps in the evidence base, suggest areas where future research efforts are	Women who had unsafe abortions.	Review	Unsafe abortion has a number of significant consequences that are much less widely recognized: economic consequences, the immediate costs of providing medical care for abortion-related complications, the costs

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	needed, and speculate on the future situation regarding consequences and evidence over the next 5–10 years.			of medical care for longer-term health consequences, lost productivity to the country, the impact on families and the community, and the social consequences that affect women and families.
(Sjostrand, Quist et al. 1995) [Kenya]	To analyze the socioeconomic and reproductive background characteristics of women with incomplete abortions and assess post-abortion health consequences and financial implications for the women and the hospital.	Women seeking help for incomplete abortions at Kenyatta National Hospital.	Cross-sectional survey	Cost of unsafe abortion procedures averaged 470 Kenyan shillings (range 0 to 3000). Total average cost of treating unsafe abortions was 348 KS compared to 87 KS who were treated for spontaneous incomplete abortions.
(Sjostrom, Kopp Kallner et al. 2016)) [Sweden]	To calculate the cost-effectiveness of early medical abortion performed by nurse-midwifes in comparison to physicians in a high resource setting where ultrasound dating is part of the protocol.	Women attending an outpatient clinic of a university hospital in Sweden	Modelling	Comparison of cost of a patient's time for non-complicated care: cost standard (Euro14); cost intervention (Euro10).
(Sommer 2010) [Late Imperial China]	A historiography of abortion in Late Imperial China	8 legal case studies in historical documents of abortions	Legal case studies	"Cost of abortion in eight legal cases, with place and year: 1) 3 taels of 70-percent cash (= 1.5 shi of husked rice); Jin'gui county, Jiangsu, 1773 2) 1,500-4,500 cash; Yongbei subprefecture, Yunnan, 1774 3) 1,000 cash; Yanghu county, Jiangsu, 1781 4) 4,100 cash; Cangwu county, Guangxi, 1788 5) 4.5 shi of unhusked rice (= 2.25 shi of husked rice); Lingling county, Hunan, 1800 6) 2,000 cash; Gao'an county, Jiangxi, 1802 7) 5 taels of silver; Guzhou subprefecture, Guizhou, 1815 8) 5 taels of silver; Yuqing county, Guizhou, 1842"
(Souza, Diniz et al. 2010) [Brazil]	To analyze the trajectory of women that performed a	Women hospitalized for post-abortion care in a public hospital in Salvador [n=17]	Qualitative cross-sectional	Respondents reported borrowing money to abort, and spending relatively substantial

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	provoked abortion related to a clandestine procedure.			amounts of money to procure unsafe abortions.
(Sundaram, Vlassoff et al. 2013) [Uganda]	To measure the costs of unsafe abortion and post-abortion care to Ugandan women and their households.	Ugandan women [n=1,338] who had been admitted to one of 27 health facilities for treatment of complications of abortion were interviewed while at the facility. Two to three months later, follow-up interviews completed with n=517 women.	Prospective survey	Respondents who likely had had an unsafe abortion had paid an average of 59,600 shillings (US$23) in out-of-pocket expenses for the procedure, for the treatment of complications prior to arriving at the facility, or both. In addition, on average, women paid 41,800 shillings (US$16) in out-of-pocket costs for treatment of post-abortion complications. At follow-up, women reported having paid an additional 26,700 shillings (US$10) for medical expenses incurred between the first and second interviews. The average total out-of-pocket expenditure per woman was 128,000 shillings (US$49). The amount paid to obtain an unsafe abortion was higher among women who were younger than 20 (68,100 shillings), childless (77,000), unmarried (73,300), attending school (94,500), residing in urban areas (71,500) or in the wealthiest group (81,900 shillings) than among women in the respective reference groups. Expenses women incurred for post-abortion care were higher among women who had spent two or more nights in the health facility (58,900 shillings) than among women with shorter stays (28,900–29,500). Facility and provider characteristics were also strongly associated with the level of expenses incurred. Women who had received post-abortion care at private or nonprofit facilities incurred higher expenses than did women treated at public facilities (153,000 vs. 32,300 shillings), and women who were treated by doctors paid more than did women who received care from providers other than doctors or nursemidwives (46,900 vs. 30,200). Women who did not have any children incurred

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				higher post-abortion care expenses than did women with three or more children (46,800 vs. 37,700). No subgroup differences were observed at the follow-up interviews for post-abortion care expenses.
(Svanemyr and Sundby 2007) Côte d'Ivoire	To analyse how illegally induced abortion is understood in terms of social processes.	Women seeking care for abortion complications and key informants	Qualitative cross-sectional	D&C abortions could be obtained at hospitals and clinics for between US$ 30-70.
(Thapa, Poudel et al. 2004) [Nepal]	To assess and evaluate the safety, acceptability, and effectiveness of MVA services.	Women seeking abortion services at the largest national maternity hospital in Kathmandu [n=765]	Cross-sectional comparative	The basic fee per patient (excluding other related costs, if any) is Rs 645, representing approximately five days' wages for a female labourer in the Kathmandu Valley. In addition, ultrasound is used in about a quarter of MVA cases (Rs 300).
(Tousaw, La et al. 2017) [Thailand]	To document the experiences of women with unwanted pregnancies who accessed the SARP in order to inform programme improvement and expansion. [SARP = Safe Abortion Referral Programme]	Migrants of Burmese ethnicity to Thailand	Cross-sectional qualitative descriptive	Undocumented migrant women stated that without the SARP they would not have been able to access a safe abortion because of both the financial and legal implications of seeking and obtaining care.
(Upadhyay, Johns et al. 2016) [United States]	To examine whether the 2011 Ohio law change from an evidence-based regimen to the FDA regimen (as approved in 2000) was associated with the need for additional intervention following medication abortion. Additionally, to examine the number of follow-up visits, continuing pregnancy rate, experience of side effects, proportion of medication abortions (versus other abortion procedures), and average patient charges for medication abortion.	Medication abortion patients from 1 year prior to the law's implementation (January 2010–January 2011) to 3 years post implementation (February 2011–October 2014) at four abortion-providing health care facilities in Ohio.	Pre/post-observational study with no control group that was not exposed to the law	The average patient charge increased from US$426 in 2010 to US$551 in 2014, representing a 16% increase after adjusting for inflation in medical prices." [p.1] " "The average patient charge for medication abortion rose from US$426 to US$551 between 2010 and 2014, representing a 29% increase in nominal dollars and a 16% increase after adjusting for inflation in medical prices
(Upadhyay, Johns et al. 2017) [United States]	To examine the association between distance traveled for an abortion and site of post-abortion care among low-income women.	Claims data from California's Medicaid programme (2011-12) [n=39,747 abortions]	retrospective cohort study	Costs were consistently higher when subsequent care occurred at an Emergency Department rather than the abortion site (median cost $941 vs. $536, P<.001).

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Upadhyay, Cartwright et al. 2018) [United States]	To assess medication abortion access among California's public university students.	California's public university students.	Modelling	The average out-of-pocket cost of medication abortion at the facilities closest to campus was $604.
(Van Bebber, Phillips et al. 2006) [United States]	To determine total patient costs for medication abortion	Women [n=212] seeking abortion services at a convenience sample of 5 health care practices.	Descriptive cross-sectional survey	The mean total cost for medication abortion was $351 ($0–1,140). Average charge $306 paid by women themselves for the procedure. Three quarters of total costs were direct medical costs and almost one quarter was time away from work and other activities. Although nearly three quarters of the women were insured, only 1% used insurance to cover their abortion—many (44%) did not know if their insurance covered abortion.
(Visaria, Barua et al. 2008) [India]	To understand gynaecologists' perspectives on medical abortion and chemists' marketing strategies and drug distribution.	Gynaecologists and chemists	Qualitative interviews	Total cost of medical abortion estimated to be Rp1,200 (inclusive of 3 ultrasounds); mifepristone tablet (Rp325-930); Misoprostol table (Rp31-60).
(Vlassoff, Walker et al. 2009) [Bolivia, Brazil, Ecuador, El Salvador, Mexico, Peru, Egypt, Ghana, Kenya, Malawi, Nigeria, South Africa, Tanzania, Uganda]	To estimate health care system costs of unsafe abortion in Africa and Latin America.			The average cost of post-abortion care per patient, based on all samples from 20 studies, was $86 (2006 US$); costs ranged from $2 to $390. The average cost per patient for treating low-severity complications was $72, while the average cost for samples of women with all types of complication was $111. Costs varied little by region, ranging from $83 in Africa to $94 in Latin America; the average for Sub-Saharan Africa was $89. Even though the cost per patient in U.S. dollars was highest in Latin America, after conversion to international dollars, the average costs in Sub-Saharan Africa and in Africa as a whole were substantially higher ($228 and $213 vs. $161). This demonstrates that in relation to patients' purchasing power, abortion complications are considerably more expensive to treat in Africa than in Latin America.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Vlassoff, Fetters et al. 2012) [Ethiopia]	To address the knowledge gap that exists in costing unsafe abortion in Ethiopia, estimates were derived of the cost to the health system of providing post-abortion care (PAC).	14 health facilities in Ethiopia.	Cost analysis	The average direct cost per client, across 5 types of abortion complications, was US $36.21. This total includes the cost of drugs, supplies, material, personnel time, out-of-pocket expenses.
(Vlassoff, Mugisha et al. 2014) [Uganda]	To fill a gap in knowledge in the cost of unsafe abortion, this article presents estimates based on the research conducted in 2010 of the cost to the Ugandan health system of providing post-abortion care (PAC).	39 health facilities in Uganda	Cost analysis	The average annual PAC cost per client, across five types of abortion complications, was $131. This total includes the cost of drugs, supplies, material, personnel time, out-of-pocket expenses, and direct non-medical costs in the form of overhead and capital costs.
(Weitz and Cockrill 2010) [United States]	To understand abortion care in relation to providers of women's health care	Pregnant people seeking abortions across three clinics in two states in the U.S. Heartland	Qualitative interviews	In the case study of one respondent [pseudonym Cheryl]: "At the time of the interview, she had already been billed $11,000 for the hospital care for the mass while she was trying to locate an abortion provider. She was acutely aware of the increasing costs related to her refusal: ''I spent probably seventy- five, eighty-five dollars just on medicine for vomiting and pain that I never would have had to have.'' In the end Cheryl's expenses totaled over $40,000; Cheryl has no insurance."
(Whittaker 2002) [Thailand]	To examine the effects of the current laws through the experiences of women who have undergone illegal abortions.	Women of reproductive age	Qualitative	Most rural women cannot afford or have difficulty accessing safe private abortion services. Women's risks are stratified along economic lines.
(Wilder 2000) [Israel]	This study uses data from the 1974-75 Israel Fertility Survey and the 1987-88 Study of Fertility and Family Formation to examine the changing determinants of abortion among Jewish women in Israel.	Women of reproductive age in Israel	Regression analysis	In cases where government agencies do not cover the costs of the procedure, the woman pays the equivalent of US$250-400, depending on the hospital, for the procedure and associated care. Abortion is widely available in Israel, and 95% of Israeli women have access to moderately priced abortion.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Winikoff, Hassoun et al. 2011) [United States, France]	To examine the commercial, political, regulatory, and legislative history of the introduction of mifepristone / misoprostol in France and the United States.	n/a	Review	In the United States, a large majority of women (74%) pay for their abortions with their own money or with funds they obtain from their partners, family or others. Most abortion costs are paid out-of-pocket. The insurance situation in the United States has important implications for the use and accessibility of mifepristone. On the one hand, because few women use insurance to cover the procedure, insurance companies exert little influence over practice patterns or standards of care compared to other surgical or reproductive health procedures; clinics and providers have been free to develop innovative service models for provision of the service that ultimately may have reduced the overall cost of the procedure. On the other hand, the price of the procedure has a wide range. The adjusted cost of providing medical abortion care varies significantly depending upon the practice model used (from $252 to $460 per abortion, median $351). Consequently, the method may be more or less accessible or a more or less attractive alternative to surgical abortion depending upon the practice and pricing model in place.
(Wu, Maru et al. 2017) [Nepal]	To review abortion care in Nepal 15 years after it was legalized.	n/a	Review	The landmark 2009 Supreme Court decision in Lakshmi Dhikta v. Nepal centered on a poor, rural woman who was forced to give birth to her sixth child due to her inability to afford the required fees for an abortion (approximately US$20). In the past, government policies mandated a small fee—ranging from 800 to 1200 Nepali rupees (US$8 to 12)—for abortion. This cost did not include pain medications, antibiotics, gloves, or syringes. Abortion was purposely separated from the package of free

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				maternal care services, out of concern that inclusion may promote abortion as a method of contraception. While the landmark 2009 Supreme Court decision established the legal framework for the government to mandate free and accessible abortion services in the public sector, there was no policy to implement safe abortion services until the passage of the Safe Abortion Service Guidelines of 2016. Under these guidelines, all government facilities should provide free abortion services. However, the provider reimbursement scheme outlined in the guidelines is less profitable for providers than it was when women paid out of pocket.
(Yavangi, Sohrabi et al. 2013) [Iran]	To calculate total and out of pocket inpatient costs for seven pregnancy complications including preeclampsia, intrauterine growth restriction (IUGR), abortion, ante-partum hemorrhage, preterm delivery, premature rupture of membranes and post-dated pregnancy	Teaching hospitals in Tehran (n=2)	Mixed methods: descriptive analysis and analysis of variance test	Patients receiving treatment for abortion complications had a mean expenditure of 370.52 USD. They paid 148.77 USD out of pocket.
(Zamberlin, Romero et al. 2012) [Latin America]	To summarize the findings of a literature review on women's experiences with medical abortion in Latin American countries where voluntary abortion is illegal	Studies on women's experiences with medical abortion in Latin American countries where voluntary abortion is illegal	Literature review	Prices vary across country contexts and are often unaffordable: women report borrowing money from friends and relatives, asking for their salary in advance, working overtime or selling valuable objects. The internet was a frequent source of access and where men's involvement existed it was frequently via economic contributions.

Appendix H. Summary of studies reporting micro-economic impacts

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Ahmed, Islam et al. 1999) [Bangladesh]	To find out where women go for induced abortion in rural Bangladesh today, their contraceptive practice prior to and after getting pregnant, their reasons for choosing abortion, who makes the decision for abortion, what complications they develop and where they go for treatment for these	Women seeking abortion services	Mixed methods using semi-structured questionnaire	Money was obtained by borrowing from relatives and selling jewelry. The woman and her family are now living in extreme poverty
(Aiken, Johnson et al. 2018)[Ireland]	(1) to examine the factors affecting whether women in Ireland choose to access abortion by travelling or by using online telemedicine; and (2) to explore their experiences in accessing care through each pathway	Women (n=38) identified through three organisations: Women on Web, Abortion Support Network, For Reproductive Rights Against Oppression, Sexism and Austerity. Criteria: aged over 18, had an abortion within 8 years of study, lived in Ireland at time of abortion, had travelled or used telemedicine to access abortion care.	Qualitative in-depth interviews	One respondent (aged 35) who took out a loan to afford to travel to receive abortion care in England commented: "If you're feeling desperate and your support system is non-existent, you do very desperate things. There was this forum online talking about having a hot bath and drinking a bottle of vodka, or going in there with a long, sharp instrument. I tried the hot bath. And there's a fitness class that's on a mini trampoline, and people told me that if you go on that within the first 6 to 8weeks, you miscarry. So, I tried that religiously for 2weeks, but it didn't help. It was just pure desperation"
(Alouini, Uzan et al. 2002) [France]	To determine whether women undergoing repeat	Women who had undergone two	Survey of women and interviews	Guilt, depression and psychological distress were found in 21 patients out of 30 after the second abortion. Patients undergoing repeat abortions

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	abortions are exposed to risk factors which might be amenable to preventative measures, and the methods employed by carers in these cases	abortion up to 1997 (n=30) and interviews with the care team	with the care team	request psychological help, but the medical manpower available is well below what is required to meet their needs.
(Anandhi 2007) [India]	To contextualize the decision to abort in terms of local cultural practices, women's employment in newly emerging peri-urban informal sector, and new forms of encoding masculinities in four villages in northern Tamil Nadu where the fertility rate is rapidly declining.	Women aged between 45-65 and 25-45 who live in the study villages that are marked by high incidence of abortion and industrial estates for pharmaceutical companies	Qualitative: FGDs with women in-depth interviews with key informants	Women's decision to abort is often a process of accommodating the pressures of cultural values and beliefs. Women's decision to abort seems to be linked to a vector of factors like childcare as their exclusive responsibility, marital conflicts, son preference and belief in astrology and local religion. Since women do not have control over these social conditions, their "choice" of abortion is basically to deal with these situations. The logic of family limitation through abortion as promoted by the state population policy might be influencing women's consciousness on abortion. But how women arrive at the decision to abort is not based on the received notions of family planning or birth control, but on the basis of local, social and cultural conditions and relations that define their lives. In the case of young unmarried working women, as the study shows, what they attempt to do by means of abortion is to negotiate the harsh realities of work and the increasing control over their sexuality at the workplace and at home through their sense of reproductive entitlement. While abortion by unmarried girls may signify subtle sexual and reproductive strategies or even a "counter hegemonic morality" to the existing social conditions, it also simultaneously indexes women's lack of control over the oppressive work conditions and social norms. Given this interlocked nature of labor rights and reproductive rights, it is important to seek labor rights such as the right to equal wages, enabling work conditions and right to unionization, as part of seeking reproductive rights.
(Aniteye and Mayhew 2011) [Ghana]	To explore and understand the reasons why women terminate their pregnancies and their experiences of seeking services in order to know what and how to reform services to reduce unsafe abortion.	Women admitted to the hospitals with incomplete abortions (n=131)	Semi-structured hospital-based survey	When asked what their partners' reaction to the pregnancy was, more than half of respondents said their partners did not like the pregnancy. The 67 women who said their partners were not happy with the pregnancy were asked whether they knew the reasons for their partners' reaction. Almost half of these respondents said their partners feared the reaction of the girls' parents and other socio-cultural problems. One-third mentioned financial constraints, 12% said it was to avoid disrupting the girls' educational or career opportunities and 6% said their partners doubted their paternity. The 53 respondents who reported their partners were happy with the pregnancy were asked the reasons why they terminated their pregnancy despite this. Fifteen percent said they aborted because they were not yet ready to have a child or they were nursing another child.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				Other reasons given were similar to those cited for the partners not wanting the pregnancy: financial constraints, academic/career pursuits, and a range of socio-cultural issues like not being married to the man responsible for the pregnancy, not ready to be second wives, unstable marriages and having different religious inclinations from partners. The great majority of respondents were young and single presenting a typical pattern, found in other studies, of younger women wanting to delay childbearing until they are married or have furthered their education.
(Appiah-Agyekum, Sorkpor et al. 2015)[Ghana]	To explore the factors that are likely to influence abortion decisions among University students in Ghana and their knowledge and perceptions on abortion.	Randomly sampled students of the University of Ghana (n=142)	Qualitative: FGDs	Evidence from this study suggests that the main factor considered by students in their decision to abort is the likely effect of the pregnancy and the birth of the child on their education. Pregnant students, together with their partners or parents, weigh the prospects and the investments and sacrifices that have been made in their education with the impending termination or delay in education as a result of the pregnancy. Specifically, students consider the length of time left to complete school, their desire or prospects for further education, and the adverse effect of the pregnancy and the newborn child on their studies in their decisions to abort. Consistent with the findings of Hubbard, the present study showed that students with good academic grades are more likely to abort to stay in school than poor performing students who had little academic prospects. Students with scholarships or under sponsorships, as well as those with funding difficulties, are also more likely to abort to avoid the effects the pregnancy may have on the length and completion of their education and their funding opportunities. Additionally, students who have other options of continuing their course, including opportunities to convert to part-time, off-campus distance students, or even deferring the course for the duration of the pregnancy, are also less likely to have an abortion because of their education.
(Austin and Harper 2018) [United States]	To conduct a systematic review of TRAP (Targeted Regulation of Abortion) laws and their impact on abortion trends and women's health	Women exposed to TRAP policy	Systematic review	TRAP laws may not need to close clinics to have an impact on health and other outcomes: some laws may instead increase service costs or decrease availability of appointment slots, both of which could increase the time it takes for a woman to obtain an abortion. An increase in gestational age at presentation may limit the number of providers willing to perform an abortion (particularly if the pregnancy has entered the second trimester) and increase out-of-pocket costs to patients. While women with adequate resources are generally able to obtain an abortion with minimal difficulty, regardless of local policies, access-oriented barriers to abortion may introduce special challenges to low-income, young and/ or rural women, as these women may be less able to manage increases in cost and distance.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Asplin, Wessel et al. 2014)[Sweden]	To explore what women who have had a pregnancy termination due to a detected fetal malformation perceive as being important in their encounters with caregivers	Pregnant women with fetal malformation attended four clinics specializing in ultrasound in the Stockholm area of Sweden	Semi-structured interviews	A respondent describes the impact that cost had on seeking psychological support: "I wanted a more professional psychological help and phoned a therapist, but the high cost, 1200 Swedish crowns per hour was not feasible in the circumstances of me sick-listed and [having] no insurance coverage because a fetus does not count as a legal person before gestational week 22"
(Bailey, Bruno et al. 2001) [Brazil]	To determine social and behavioral consequences of pregnancy and how these differed according to the pregnancy outcome (live birth or abortion) 1 year after the event.	A cohort of pregnant teens who sought prenatal care at the Adolescent Clinic (n=367), and a cohort of girls of the same age who attended the same hospital but who were admitted through the emergency services with complications from abortion (n=196)	Cohort analytic	Induced abortion patients were the most likely to be enrolled in school (68%). About two-thirds of the girls whose pregnancies were intended and those who miscarried had already left school before the first interview. The primary reason for leaving school as stated by all groups, except the girls with induced abortions who quit school to work, was their pregnancy or their marriage (39% among the adolescents with intended and unintended pregnancies). Others stated that they simply did not like school (25% overall). Induced abortion patients were the most likely to be working (33%)." Employment status did not change for any group but school enrollment dropped from more than half of the teens enrolled at baseline to only 31% at 1 year. The vast majority of these girls dropped out; a few may have finished the equivalent of high school. The largest percentage of school attendees at 1 year was among the induced abortion patients. Compared with adolescents whose pregnancies were intended (the reference group), the probability that girls with induced abortions would be in school at one year was 6.9 times as great, girls with spontaneous abortions were five times as likely to be enrolled, and adolescents whose pregnancies were unintended were three times as likely to be in school. Age was inversely associated with school enrollment (the odds of being in school decreased as age increased). Adolescents enrolled in school at baseline increased their odds of staying in school almost six-fold. However, the likelihood of being in school decreased by half if the adolescent had a sister who also had experienced a pregnancy during adolescence.
(Baum, White et al. 2016) [United States]	To explore qualitatively the experiences of women who were most affected by restrict abortion laws in Texas: those who had to travel farther to reach a facility and those desiring medication abortion	Women recruited from ten abortion clinics across Texas. The purposive sample included women who obtained or strongly preferred medication	Qualitative, in-depth interviews	Women who completed the in-depth interviews not only spoke about the types of costs associated with attending multiple visits, including lost wages for themselves and their support network, and paying for child care, gas or public transportation, but also how poverty often compounded the barriers they faced. This led some to consider not having the abortion, and one woman ultimately decided to continue her pregnancy at least in part because of the obstacles she encountered.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
		abortion or traveled ≥50 miles one way to the clinic. (n=20)		
(Baxerres, Boko et al. 2018) [Benin and Burkina Faso]	To document the means women use to obtain abortions in the capital cities of Benin and Burkina Faso To learn whether or not use of misoprostol has become an alternative to other methods of abortion and the implications for future practice	Women in Cotonou (n=21) and in Ouagadougou (n=13), including 5 secondary school students	Qualitative in-depth interviews	The requirement of a prescription to access misoprostol in Benin often leads to purchasing through informal sellers such as the Adjegounlè drugs market in Dantokpá international market.
Berer 2000 [Global]	To examine the changes in policy and health service provision required to make abortions safe	Literature review with multiple populations	Literature review	In Bangladesh, women tend to wait until complications become severe before seeking help, increasing both the cost and complexity of treatment. Furthermore, women attending untrained providers have been found to make more visits for care and spend more overall than women attending trained providers in the first place.
(Bessett, Gorski et al. 2011) [United States]	To learn about women's experiences applying for subsidized insurance and to identify barriers to obtaining insurance or its use for abortion services	English-speaking women who met the eligibility requirements for subsidized insurance programs in Massachusetts: Women whose household income is less than 300% FPL, who are uninsured, who are American citizens or have been permanent residents for more than 5 years, and who are	Systematic, qualitative interviews with women	A 19-year-old who first contacted the funds at 23 weeks' gestation, described "timing out" of an in-state surgical abortion when she was unable to become enrolled right away; nor would MassHealth cover abortion care provided by out-of-state providers. She ultimately completed her pregnancy, intending to give the baby up for adoption, but explained that she was very disappointed by MassHealth. Delays also limited women's ability to obtain medication abortion. As medication abortion is typically provided through the 63rd day after the woman's last menstrual period, several women reported considerable anxiety that they might not obtain insurance in time. Although at least one woman was able to obtain and use Commonwealth Care for a medication abortion in a timely way, the approaching deadline prompted abortion funds to provide grants to at least two desperate women. Both women were later deemed eligible for MassHealth, suggesting that the costs for abortion should have been covered by insurance. A third woman, aged 18, reported being so fearful of "surgical abortion" that she ultimately decided to continue her pregnancy after her struggles with MassHealth put her past the limit for medication abortion. She first applied for insurance at 6 weeks' gestation; by the time of follow-up 37 days later, she was still unsure if she had been approved for MassHealth. The delays caused by attempts to enroll in subsidized

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
		Massachusetts residents (n=39)		insurance had a disproportionate impact on women who sought medication abortion, forcing them to pay out of pocket or placing their preferred method for termination out of reach.
(Biggs, Ralph et al. 2018) [United States]	To assess women's interest in and support for three alternative models of MA provision: (1) advance provision with a prescription from a clinician in case of future need, and nonprescription (2) OTC access from a pharmacy and (3) online access, using a representative sample of United States women	A national, probability-based representative sample of United States women ages 18–49 (n=7022)	Online survey	Perceived advantages of alternative forms of medication abortion provision reported for advance provision, over the counter and online access included: could be less expensive (35% advance provision, 34% OTC access, 32% online access). Perceived disadvantages included: could be more expensive (16% advance provision, 20% OTC access, 18% online access).
(Billings and Benson 2005) [Latin America and Caribbean]	To review results from 10 major PAC operations research projects conducted in public sector hospitals in seven Latin American countries, completed and published 1991-2002	Review of operations research, that is, studies designed to measure the effectiveness of an intervention in achieving service delivery outcomes	Review paper	Long waits before and after treatment are often a major source of PAC patient dissatisfaction. Switching to MVA and reorganizing services can contribute to shorter average lengths of stay for clients.
(Bloomer and O'Dowd 2014) [Ireland]	To consider abortion tourism in Ireland, both north and south, and how the moral conservatism present in both jurisdictions has impacted on attitudes and access to abortion	Women seeking abortion serves in restricted setting, i.e. Ireland	Mixed methods	The moral conservatism in the Republic of Ireland and Northern Ireland is apparent in the role of religious and political institutions. Both fail to acknowledge the repeated evidence of the public and professional support for abortion law reform and the evidence of the continuance of abortion tourism. Their comments on abortion demonstrate that they fail to grasp the complex set of circumstances women find themselves in when faced with a crisis pregnancy. In denying women their agency, these comments reinforce perceived traditional feminine roles as fertile, caring and inevitable mothers, in effect forcing them into 'reproductive labor.'
(Brack, Rochat et al. 2017)[Colombia]	To identify the key barriers to legal abortion, and to explore the ways they may work separately and together to delay the receipt of high quality, legal abortion care	Women who had obtained a legal abortion in Bogotá, Colombia (n=17). Eligible for inclusion if aged 18 or older, had	Qualitative: In-depth interviews with women	Women experienced other logistic barriers. Fifteen of the 17 women had to take time off from work or school to obtain their abortion, and nine had to arrange for child care, all of which delayed the abortion.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
		obtained an abortion in the past 12 months and exhibited verbal proficiency in Spanish		
(Brown and Jewell 1996) [United States]	To estimate directly the responsiveness of abortion demand to county-level variations in travel-cost component of the full cost of abortion services	Abortion providers in Texas	Log-linear regressions using data that were obtained from health facilities on each abortion performed and data on the localities of these facilities	Through their modelling they estimated that raising the cost of travel for abortion care by 1 USD would decrease abortions per number of women by 1.31 percent and abortions per pregnancy by 0.97 percent.
(Chibber, Biggs et al. 2014) [United States]	To examine how partners figure in women's abortion decisions, and identifies factors associated with identifying partner as a reason (PAR) for abortion	Women recruited from 30 U.S. abortion facilities where no facility nearby offered care at a later gestational age of pregnancy. Study eligibility included being pregnant, English or Spanish speaking, 15 years or older, not having any known fetal anomalies or demise, and belonging to one of three groups: 1) Women just over the facility's gestational age limit and denied an abortion (n=231), 2)	Mixed methods using prospective longitudinal survey and in-depth interviews	One man involved as a partner in a pregnancy report wanting to go back and finish school to make enough money to raise a child.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
		women just under the limit and who received an abortion (n= 452), and 3) women receiving a first trimester procedure (n = 273)		
(Chunuan, Kosunvanna et al. 2012) [Thailand]	To obtain data regarding: pregnancy history; number of abortions and cost of abortion related treatments; abortion complications, impacts and related health care services; reasons for having an unsafe abortion; and, circumstances related to an unsafe abortion from women who had undergone a recent abortion (spontaneous, therapeutic and unsafe)	Thai females, of any age, who: were able to speak, write and understand Thai; had experienced an abortion, regardless of chronological age, gestational age or type; and admitted to one of the study site hospitals.	Structured self-report questionnaire	Being a student in an educational program was one of the most frequently stated social reasons for undergoing an unsafe abortion.
(Cockrill and Weitz 2010) [United States]	To explore abortion patients' perspectives on state regulations, including mandating waiting periods and the provision of state-authored information, and prohibiting private and public insurance coverage for abortion	Abortion patients	Qualitative: Semi-structured interviews	The reasons for choosing abortion among the women in our sample were diverse, but for most they matched the general categories identified in recent research that having a child would interfere with a woman's education, work or ability to care for dependents.
(Cooper, Dickson et al. 2005) [South Africa]	To report whether a significant proportion of women seeking abortion in public sector services would be early enough in pregnancy to be eligible for medical abortion and to investigate the hypothetical acceptability	People (n=673) attending abortion services in 8 facilities across three provinces in South Africa	Cross sectional survey	Financial concerns were the second most cited reason among rural women for delaying seeking abortion related care. 20% of women cited financial reasons.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	of medical abortion among women, policymakers and providers and whether women would attend for follow-up.			
(Cunningham, Lindo et al. 2017) [United States]	To document the effects of abortion-clinic closures on clinic access, abortions, and births using variation generated by a law that shuttered nearly half of Texas' clinics	Women of reproductive age and children	Regression analysis	The distance the average Texas woman had to travel to reach an abortion clinic increased from 21 miles in the quarter prior to House Bill 2 to 44 miles in the quarter immediately after. Women who had to travel more than 100 miles (one-way) to reach a clinic increased from 5% to 15%, with the largest increases in travel distances occurring in the central-western region of Texas. Travel distance to the nearest clinic was unchanged for women whose nearest abortion clinic was already located in a major city because at least one clinic remained open in these cities.
(David and Baban 1996)[Romania]	To explore the psychosocial antecedents and consequences of the Romanian pronatalist policies banning importation of contraception, prohibiting abortion, and imposing tax on childless couples	Women, aged between 18 and 55 years in 1998, the year before the December 1989 revolution (n=50)	Qualitative: in-depth interviews	While the reality of the unwanted pregnancy was usually a stressful moment for most women, the decision to abort was made relatively quickly, seldom involving ethical concerns. Many women indicated that their motivation was determined by socioeconomic conditions that would not allow them to have additional children within their standard of living. The most frequent socio- economic reasons mentioned were the lack of adequate housing and the chronic shortage of food. Four women said that a child would interfere with their studies or their profession; another four said that they did not want to be a single parent. There was fear that the pregnancy would be discovered, especially in cases of women working in a factory where compulsory gynecological examinations took place at least every 3 months.
(Dennis, Manski et al. 2014) [United States]	To answer: 1) What do women know about the cost of abortion and the availability of Medicaid coverage for abortion? 2) Where do women obtain this information? and 3) What are women's experiences paying for care?	Women seeking abortion care in study states: 1) was age 18 or older, 2) had an abortion within the past two years, 3) resided in one of the four study states at the time of the abortion, and 4) was low- income, which we defined as meeting the	Qualitative: in-depth interviews with low income women who had abortions	Policies regarding Medicaid coverage of abortion affect the lives of women and their families in numerous ways. Restrictive coverage policies appear to force women to take measures to raise money for an abortion that may put their health and wellbeing at risk, promote short and longer-term financial instability, and increase the difficulty of implementing an abortion decision, thereby interfering with women's reproductive life plans. Restrictive Medicaid coverage policies also appear to have ripple effects on children, partners, and parents of women seeking abortion services. We believe that a nationally representative study is needed to test our emergent hypothesis that low-income abortion clients in states without Medicaid coverage of abortion experience significantly more emotional and financial harm than clients in states where coverage is available. More research is needed to quantify the extent of emotional and financial duress placed on women and their families, and how this duress affects individuals and families over time.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
		Medicaid income qualifications of the state where she had the abortion (n=98)		
Diniz 2012 [Brazil]	To address equity in health and health care in Brazil, examining unjust disparities between women and men, and between women from different social strata, with a focus on services for contraception, abortion and pregnancy	Review paper from Brazil	Review paper	Safe abortions are only provided in the private sector illegally; they are prohibitively expensive for poorer women but affordable for those with a higher income. Women with lower income tend to use more affordable methods, such as misoprostol (again, illegally, from the black market), turning to public services for treatment when there are problems. In 2008, there were 215,000 hospitalizations in SUS for complications of abortion (or miscarriage), especially from hemorrhage and infection.
(Doran and Nancarrow 2015) [United States]	To identify factors, from a systematic literature review, that facilitate and hinder access to abortion services for women in developed countries in relation to first-trimester abortions, from the perspective of both the woman and the service provider	Multiple populations within systematic review	Systematic review	85% of women said that they would be willing to pay for an earlier abortion
(Dragoman and Davis 2008) [United States]	To synthesize published literature and current practices for adolescent abortion care	Adolescents aged 19 years and younger	Descriptive analysis of current evidence and practice	Adolescents faced with an unintended pregnancy give several reasons for their decision to have an abortion; these reasons are similar across diverse groups of young women. Adolescents feel unprepared for motherhood both psychologically and financially and are concerned that childbearing will adversely affect educational attainment, career opportunities, and personal relationships with their partners and family members. Observational research supports these concerns by demonstrating better educational outcomes among adolescents choosing abortion compared with those continuing pregnancy. One study found that those undergoing abortion were more likely to complete high school than those who carried their pregnancies to term. Another 25-year longitudinal study found that those adolescents undergoing abortion achieved higher levels of education than those carrying to term, even after adjustment for family, social, and baseline educational differences. The availability of affordable abortion services determines if a young woman can obtain an abortion at all and how quickly. Compared with adults, barriers to care may particularly affect

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				adolescents with limited resources. Obtaining an abortion may require significant travel because most counties in the United States (more than 80%) have no abortion provider. In most states, abortion is not covered by state Medicaid programs and poor teens may have difficulty funding the cost of care. Delays experienced by adolescents lead to increased costs and risk, as later abortions are more technically difficult and expensive.
(Ely, Hales et al. 2017a)[United States]	To explore abortion-related hardships in a previously understudied group: patients in the United States who received financial pledges from the National Network of Abortion Funds' (NNAF) Tiller Memorial Fund, to pay for an unaffordable abortion	National sample of US patients who received a financial assistance pledge to help cover abortion procedural costs (n=3,999)	Descriptive, exploratory, cross- sectional analysis of administrative health care data of patients	A total of 19 categories of hardship emerged. On average, persons in the sample experienced 2.29 hardships (SD 1.13), with a range from 0 to 7 hardships. Out of the total sample of 3,999 cases, 82.8% (N 3,311) experienced at least one hardship. The most frequently occurring hardships involved having multiple children, defined as two or more (N 1,511; 37.8%); currently being on some form of public assistance (e.g. food assistance) (N 1,482; 37.1%); traveling distances greater than 50 miles to obtain an abortion procedure (N 1,151; 28.8%); not being on birth control (N 967; 24.2%); or having birth control failure (N 893; 22.3%); currently unemployed and seeking employment (N 785; 19.6%); and having unstable or partial housing (N 747; 18.7%). These findings are consistent with other studies, and the authors make linkages to the broader economic hardships faced by this population. Some of the less-researched hardships identified in this study are problems with employment/current unemployment, marginal housing or homelessness, and medical problems. These results are, however, similar with findings suggesting that unemployment, partner unemployment, problems paying for housing and problems paying for life necessities were common in abortion patients and people with a recent history of abortion. A modest proportion of the patients from the sample also experienced a variety of medical conditions, including obesity, and preexisting mental health and substance use diagnoses, which is consistent with studies suggesting a link between unplanned pregnancy and obesity, existing mental health problems, and substance use, in adults and adolescents.
(Ely, Hales et al. 2018)[United States, Republic of Ireland, Northern Ireland, Isle of Man]	To examine the experiences of abortion fund patients in the USA and Republic of Ireland, Northern Ireland and Isle of Man to compare abortion fund patient experiences across these developed nations for the first time	Abortion fund cases for Republic of Ireland, Northern Ireland, and Isle of Man combined 6340 cases (n=3995 from the USA and 2345 from the RI, NI and IM)	Cross-sectional descriptive analysis	There is evidence that factors related to patients' access to abortion are similar across these countries, which include similarities in the number of children that patients have. These findings demonstrate the commonality of the parenting conundrum faced by economically vulnerable patients who are trying to gather the resources to access abortion across all of these nations. These patients are typically already parents, which suggests that they are already devoting resources to rearing existing children, which is consistent with other research from Biggs, Gould and Foster (2013) indicating that patients seek abortion so they can focus on other children. Additional results suggest that fund recipients are faced with a dearth of

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				available resources, despite the help offered by the funds. Even with abortion fund assistance, these patients had notable resource deficits when trying to access abortion services.
(Erfani 2011)[Iran]	To provide direct estimates of abortion levels in Tehran for both all women and selected subgroups: estimate the abortion rate and the proportion of known pregnancies that end in abortion for the population of married women in Tehran, to examine variations by women's demographic and socioeconomic characteristics, and to assess reported reasons for having an abortion and the contraceptive method used at the time of conception	Women seeking abortion in Tehran, married women aged 15-49 (n=2,934)	Cross-sectional survey	Twenty-one percent of abortions performed in the five years preceding the survey were undertaken for a socioeconomic reasons: 19% for economic difficulty and 3% for a spousal relationship problem (divorce, separation or a partner's drug addiction.) Fifteen percent of respondents who knew another woman who had had an abortion in the previous year said the main reason for them undergoing the procedure was a socioeconomic issue.
(Esia-Donkon, Darteh et al. 2015) [Ghana]	To explore the pre and post experiences of young people (aged 12 to 24) who had their abortion three months prior to the study	Young people (aged 12 to 24) who had their abortion three months prior to the study	Qualitative: pre/post in-depth interviews	Reasons given for young females' decision to abort abortion are consistent with literature. Principally, inability to care for the babies owing to household poverty, fear of dropping out of school, societal/community stigma and shame were mentioned.
(Font-Ribera, Perez et al. 2009) [Spain]	To describe the determinants of the IVE [voluntary pregnancy interruption] delay until the second trimester of pregnancy in the city of Barcelona, between 2004 and 2005	Women who reside in the city of Barcelona who obtained abortions for physical or mental health issues between 2004 and 2005 (n=9.175)	Cross-sectional study	Women with an unfavorable socioeconomic position take more time in learning that they are pregnant. In Catalunya, the pregnancy test is not covered by the National Health System (SNS) and its price is between 10 and 20 euros. In Spain, there is no uniform criteria that determines what kind of IVE is financed by the SNS, and in practice, public centers conduct some of IVEs that result from fetal malformation, while those conducted because of women's health are conducted in private centers.
(Foster and Kimport 2013) [United States]	To analyze data on women who sought and received an abortion at or after 20 weeks' gestation for reasons other	People who were seeking abortions after 20 weeks gestation across 16 sites (n=272)	Mixed methods – qualitative data from interviews and quantitative	Gives the case study of Amber [a pseudonym] whose gestational age meant that she had to seek 600 USD from an abortion fund, 600 USD from her ex-boyfriend and 300 USD of her own money to obtain abortion related care. This occurred after contacting three clinics to find a provider of care.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	than fetal anomaly or life endangerment	and people who presented for first trimester abortions (n=169)	data for logistic regression	
(Foster, LaRoche et al. 2017)[Canada]	To document women's experiences obtaining abortion care in New Brunswick before and after the Regulation 84-20 amendment (Regulation 84-20 has historically restricted funded abortion care to procedures deemed medically necessary by two physicians and performed in a hospital by an obstetrician-gynecologist); identify the economic and personal costs associated with obtaining abortion care; and examine the ways in which geography, age and language-minority status condition access to care	New Brunswick residents who obtained abortions (n=33)	Qualitative: semi-structured in-depth interviews	One respondent decided to have an abortion because she was not in a financial position to care for another child.
(Fuentes, Lebenkoff et al. 2016) [United States]	To describe women's experiences seeking abortion care shortly after clinics closed and document pregnancy outcomes of women affected by these closures	Women who sought abortion care at Texas clinics that were no longer providing services and Texas resident women seeking abortion in Albuquerque, New Mexico. (n=23)	Qualitative: in-depth interviews	Most women, especially those in West Texas and the Lower Rio Grande Valley (LRGV), spent more money and time than they would have before HB2 to obtain an abortion after their local clinics closed. Women also described being uncomfortable, lonely and feeling sick while traveling far from home. Women also reported that they needed to ask for more help than they would have if there had been a local provider, and in the process, they had to reveal their abortion decision to people they might not have told otherwise. Some discussed needing to borrow a vehicle or ask someone to drive them to their appointments, and others mentioned that they had to borrow money from friends to help pay for the abortion and travel costs. A few women compromised their desire for privacy in order to make arrangements to obtain an abortion. After being turned away from closed clinics or having appointments canceled most women who had to arrange transportation or could not take time off of work on the day of the next available appointment were delayed even further. Two women who wanted an abortion did not obtain one despite attempting to schedule an

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				appointment. Insufficient information, time and money led these women to the decision to carry their pregnancies to term.
(Gallo and Nghia 2007) [Vietnam]	To understand the determinants of delaying obtaining abortion until the second trimester	Clients presenting for an abortion at 13–24 weeks of gestation (n=60)	Qualitative: semi-structured interviews	Respondents described factors that delayed their accessing or receiving adequate abortion services. Four women described difficulties in obtaining leave from an employer or taking time off from agricultural labor that had prevented them from obtaining health care earlier. Women might have hesitated in making a decision because of a conflict between wanting to continue the pregnancy and their economic or educational situations. About half of the women identified inadequate resources as the primary factor for ending their pregnancy. Fifteen women specifically described negative consequences to their educational or employment opportunities from having a child at the present time. Other respondents described constraints on employment opportunities from childbearing. Women might have been initially ambivalent about the pregnancy as a result of discordant demands from cultural mores, economic realities, or educational aspirations, and this ambivalence could have delayed their decision to seek an abortion.
(Hendrickson, Fetters et al. 2016) [Zambia]	To examine sales practices, knowledge, and behavior of pharmacy workers regarding medical abortion in 2009 and 2011 in Zambia, where hostile and stigmatizing attitudes still result in high rates of unsafe abortion.	Pharmacy workers at government-certified pharmacies in the intervention areas (76 pharmacies in November 2009 and 80 in November 2011)	Descriptive cross-sectional design	In 2009, 35 (46%) clients left pharmacies with more information or with the opportunity to purchase medical abortion drugs; however, in 2011, this proportion was higher with 53 (66%) mystery clients reporting this (P = 0.0110).
(Hu and Schlosser 2010) [India]	To study the impact of prenatal sex selection on the well-being of girls by analyzing changes in children's nutritional status and mortality during the years since the diffusion of sex selective abortion in India.	Households in India	Econometric analysis of national survey data	An increase in the practice of sex-selective abortion appears to be associated with a reduction in the incidence of malnutrition among surviving girls. This negative association is stronger for girls born in rural households and at higher birth parities. We find no evidence that sex-selective abortion leads to selection of girls into families of higher SES. We do find some evidence of a larger reduction in family size for girls than for boys and we also find some suggestive evidence of better treatment of girls as reflected in breastfeeding duration. On the other hand, sex-selective abortions do not appear to be associated with a reduction in excess female child mortality. We estimate the model using our main sample (the last two children born within 3 years prior to each survey round) as well as for samples stratified by rural/urban residence and parity (i.e., the same samples used for the nutritional analysis). There is a disadvantage for girls in breastfeeding duration that widens with age. For example, girls are one

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				percentage point less likely than boys to be breastfed for at least 12 months, about 4 percentage points less likely to be breastfed for at least 18 months and almost 6 percentage points less likely to be breastfed for at least 24 months. Girls' disadvantage in breastfeeding duration is larger in rural areas and in parities higher than one.
(Ilboudo, Greco et al. 2015) [Burkina Faso]	To study both costs and consequences of induced and spontaneous abortions and complications	Women whose pregnancy ended with either an induced or a spontaneous abortion (n=305)	Cross-sectional study that collected cost data from the patient perspective	The average expenditure associated with abortion represented 15% of the GDP per capita for women with induced abortion and 9% of the GDP per capita for those with spontaneous abortion. Additionally, 12% percent of the sample of women incurred subsequent economic consequences, as expressed by their need to resort to measures such as reducing expenses on essential needs or using their entire savings, etc., to pay for their hospitalization. Compared with women with spontaneous abortion, women who had had an induced abortion seemed to have faced unaffordable abortions costs with a higher proportion of these women bearing the economic consequences associated with catastrophic health care payments (16% vs 11%). Moreover, the statistical difference between women with induced abortion and those with spontaneous abortion as to unaffordability of costs associated with abortions seems to suggest that access to abortion and/or post-abortion care may have impoverished much more women with induced abortion compared with women with spontaneous abortion.
(Jerman, Frohwirth et al. 2017) [United States]	To examine the breadth of barriers, beyond those related to individual state-level abortion restrictions, that such women encounter and any associated consequences	Patients seeking abortion services (n=29)	Qualitative / in-depth interviews	Participants described 15 barriers they encountered while traveling to obtain care. We grouped like barriers into five groups: travel-related logistical issues, system navigation issues, limited clinic options, financial issues, and state or clinic restrictions. Barriers to obtaining abortion reported by women who traveled to receive services, and number of women (n=29) reporting each, by barrier group: Making arrangements after appointment was scheduled (e.g., for transportation, accommodations, child care and work schedule changes) = 27; Financial issues (including below sub-groups) = 25; Need to raise money for procedure and related costs (e.g., travel, logistics) = 20; Lack of insurance coverage = 13 ; Difference in procedure costs between clinics = 8
(Jewell and Brown 2000) [United States]	To estimate the responsiveness of teenage abortion rates to variations in the local availability of abortion providers using a model of fertility control.	Teenage girls in Texas	Analysis of abortion survey data analyzed through logistic regression	The coefficients on poverty are statistically significant and negative, implying that higher poverty rates are associated with lower teenage abortion rates. The poverty measure could be correlated with eligibility for income assistance programs, and teenagers who are eligible for income assistance have lower opportunity costs of giving birth. Counties with a higher proportion of high-school educated residents also have higher teenage abortion rates, reflecting higher opportunity costs associated with having a child while

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				enrolled in high school. Female employment conditions have no statistically significant effect on abortions per woman, but counties with higher percentages of females employed have lower abortion rates per pregnancy. This result is unexpected, because better employment conditions raise the opportunity cost of children and, therefore, should increase rates of abortions. Counties with higher proportions of married households have lower abortion rates per woman but higher abortion rates per pregnancy. The difference in coefficient signs could indicate that teenagers from married households are less likely to become pregnant, although they are more likely to abort if a pregnancy occurs. The religious affiliation measures are statistically insignificant, with the exception that counties with higher proportions of Catholics have lower rates of abortion per pregnancy. More urbanized counties and those with higher percentages of white residents are shown to have lower abortion rates. The coefficient sign on family planning clinics indicates that counties with relatively more clinics tend to have higher abortion rates; however, this coefficient is only statistically significant for abortions per woman. This result may reflect a supply response to household preferences for children: family planning clinics tend to locate where there are higher pregnancy rates
(Jones and Weitz 2009) [United States]	Unclear objective: To address a set of laws targeting abortion providers, which have a significant capacity to reduce access to and quality of abortion care in the United States	Legal review for whole United States	Review paper	The second type of regulation unnecessarily requires abortions to be performed in ASC facilities set up for more sophisticated and intrusive surgical procedures. These costly requirements may force many providers to stop offering services or to raise their prices to levels prohibitive for some women seeking care. The costs and burdens stemming from the imposition of ASC requirements have hindered or prevented physicians in some states from providing abortions. For pregnant women, the corresponding effect of the laws and physicians' response to them has been to hinder (and possibly preclude) timely access to safe and legal abortion services.
(Jones and Finer 2012)[United States]	To examine the characteristics of women having abortions at 13 weeks or later	A national sample of 9493 women obtaining abortions in 2008	Regression analyses. Data analyses of the 2008 Abortion Patient Survey	1/3 of people relied on health insurance to pay for their abortions. Women using health insurance were twice as likely to have an abortion at 16+ weeks than those paying out of pocket and women in poverty were more likely to have later abortions than women who are poor.
(Jones and Jerman 2017) [United States]	To determine which characteristics and circumstances were associated with obtaining very early and second-trimester abortions	8380 non-hospital abortion patients from the 2014 Abortion Patient Survey	Regression analyses	45% of patients paid out of pocket for care, and Medicaid was the second most common method of payment. 14% of women used private insurance, 13% used financial assistance, which refers to discounts provided by clinics or subsidies available at some facilities.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Jones, Ingerick et al. 2018) [United States]	To determine which characteristics are associated with prior abortion	8380 non-hospital abortion patients from the 2014 Abortion Patient Survey	Regression analyses	The odds of having a prior abortion were higher for those who paid for the procedure using public or private health insurance (OR: 1.47; 95% CI: 1.29–1.69) / received financial assistance (OR: 1.32; 95% CI: 1.15–1.52), compared to patients who paid for the abortion out of pocket.
(Kiley, Yee et al. 2010) [United States]	To (1) describe risk factors for obtaining a second trimester abortion and (2) to further elucidate associations between several risk factors and delayed requests for abortion among women presenting to a high-volume family planning clinic in the Midwest	English-speaking women aged 18 years and old presenting for surgical abortion for all indications except fetal malformation, in a Chicago based clinic.	A patient survey with regression analyses	Of women aged 18-21, 64.4% had to pay out-of-pocket for their procedures.
(Lane, Jok et al. 1998)[Egypt]	To examine the economics of abortion safety in Egypt.	Egyptian women who sought to terminate their pregnancies (n=18)	Qualitative	Abortions categorized as being the “most safe” in the study were primarily available to upper class women, who had biomedical abortions performed by their own private gynecologists. Women in the study overwhelmingly preferred biomedical abortions, which they considered ``cleaner.” Almost universally the reason that women gave for using indigenous methods was that they could not afford biomedical abortions.
(Lee-Rife 2010) [India]	To examine the complex interplay between reproductive experiences and women’s empowerment	Women in Madhya Pradesh, India (n=2,435)	Logistic regression using household based probability survey	In the model with multiple reproductive events, the association between abortion successes and violence remains statistically significant after controlling for initial empowerment conditions, it loses its significance in the model including only abortion. This is probably attributable to the significant negative relationship between mistimed pregnancies and violence. This underscores the importance of examining multiple reproductive events simultaneously to better reflect the influences on women’s empowerment.
(Leone, Coast et al. 2016) [Zambia]	To estimate the costs for women of seeking safe and unsafe abortion and to establish whether the burden of abortion care-seeking costs is equally distributed across the sample	Women receiving care for either safe abortion or post-abortion care at University Teaching Hospital, Lusaka	Cross-sectional survey	We considered women and their household’s financial (e.g. having to find someone to cover work, or selling assets) coping mechanism in response to care seeking. However few women discussed these, possibly because the average duration of the stay was 3.5 h for SA vs 4.5 for PAC and if they stayed overnight the average number of nights was 0.77 (0.68 for SA vs 0.88 for PAC) which meant they could get on with their life more easily (e.g. less need to look for extra childcare). On average, women missed around 2.2 days of either school or work (2 for SA vs 4.8 for PAC) which includes time to get to and from UTH and time spent at UTH as well as time spent ill due to an unsafe abortion.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Lince-Deroche, Fetters et al. 2017a)[South Africa]	To explore women's experiences accessing services and estimate costs incurred for first-trimester abortion at four public hospitals in KwaZulu-Natal Province, South Africa	Women seeking abortion care: women were eligible if they were 18–49 years old, reporting 12 weeks' gestation or less based on their last menstrual period, and presenting at the facility to request an abortion (n=1,167)	Observational, cohort design and aimed to assess and compare clinical and acceptability outcomes	Women's reasons for choosing to have an abortion were varied. Over half (58.9%) said that they could not afford to have a(nother) child because either they or their partner were “not working.” Almost a quarter of the women (23.7%) said that they could not manage a child while studying, and many cited not being “ready” for or not wanting (more) children (43.4%). Public assistance for child support is available but is widely seen as insufficient. Ninety-one women (12.2%) who had a follow-up visit reported having missed work as a result of their abortion, and 5.4% of all women indicated that they had lost income as a result of obtaining the procedure. The median travel time per visit (round trip) for all women was 50 min [IQR 30–80]. Almost all women (97.2%) reported having to pay for transportation, and 59.6% reported paying for a pregnancy test. Among women who had a follow-up visit (n=780), 95.3% reported having to buy sanitary pads or pain medication. A few women (2.7%) also reported that they had paid for additional items such as food/drink, other doctor's visits and other supplies. Women who reported that their primary source of income was employment, or a grant were also more likely to present early. In contrast, women coming from households that never experienced food insecurity were less likely to present early for an abortion. Interestingly, having a long travel time to the facility or having to pay out-of-pocket for a pregnancy test was not significantly associated with presenting late.
(Machungo, Zanconato et al. 1997) [Mozambique]	To compare socio-economic characteristics of women with illegally induced abortion (IA), legally induced abortion (LA), and women attending antenatal care (AC) by use of a case referent design	IA women (n = 103) were recruited at the emergency ward at the department of gynecology, Maputo Central Hospital, LA women (n = 103) at the out-patient gynecology ward of the same hospital and AC women (n = 100) at a peripheral antenatal care clinic	Qualitative interviews and cost data	The profile of the IA and the LA patients, respectively, differed in various aspects. The IA patients were significantly younger and less likely to be in a stable relationship. The IA patients were also at a disadvantage as far as schooling, habitation and household size are concerned, and had employment with low wages.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Margo, McCloskey et al. 2016) [United States]	To examine the impact of state policies along with other barriers when they seek abortion care	Women in South Carolina	Qualitative	The greatest logistical barriers occurred as women prepared for their abortion appointments. They described the financial burden of paying for the abortion, arranging transportation and negotiating time off work for the appointment and aftercare. Though the interviewer asked participants about child-care arrangements, they did not consider this aspect of preparation to be a major challenge. The majority of women reported difficulty paying out of pocket for the abortion. Many described making adjustments to assemble the funds, including putting off other payments, such as a car loan; refraining from "extras," such as meals in restaurants; and dipping into a "Christmas gift fund." Multiple women said the abortion expense was a temporary setback or onetime expense, in contrast to the long-term financial commitment of raising a child. For some women, the fee required their whole paycheck, meaning they would be "short" or "tight" on money for a few weeks. Others said they could afford to make the payment, but "just barely." Several participants noted that they had had less money in general lately because of lost wages resulting from pregnancy-related symptoms. Some women borrowed from or were given money by friends, family or the man involved in the pregnancy.
(Molland 2016)[Norway]	To estimate the benefits of increasing abortion access to teenagers in Oslo	Women in Oslo	Analysis of national data using a difference in difference approach and others	There is compelling evidence that the expansion of abortion access in Oslo for cohorts born after 1950 led to a relative reduction in teenage fertility rates. Access to abortion as a teenager reduces the likelihood of becoming a teenage mother. The coefficient of −0.03 implies that abortion access reduces the probability by 3 percentage points. This is a substantial effect, given that the baseline teenage fertility rate is about 18%. Abortion access also causes these women to postpone when they have their first child by almost a half year and reduces the total number of children before age 20 by about 0.03. Interestingly, there is no evidence of a negative effect of teenage abortion access on completed fertility; if anything completed family size is slightly higher among women who had abortion access. These findings imply that abortion access causes women to postpone fertility rather than reduce it. This is consistent with the fact that the abortion access is at a sufficiently young age that a lack of access does not prevent most women from attaining their desired family size. The effect on the probability of remaining childless is small and statistically insignificant using the rest of Norway as a control. Using Bergen as the control county, I find a positive effect of abortion access as a teenager on the probability of remaining childless. This finding is consistent with the idea that abortion access allows women who have a desired family size of zero to attain that goal. I do not find any effect on the likelihood of finishing high school or on years of education, but I do find a positive effect on obtaining a college

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				degree that is about 1.8% and statistically significant at the 5% level. This is substantial as the baseline probability of achieving a college degree is only 24%. I find a smaller positive effect (also significant at the 5% level) on obtaining an advanced degree of about 0.8 of a percentage point. Given that only about 3% of these cohorts obtain a higher degree, this is a large effect, but the confidence interval is quite large. I conclude that abortion access led to increases in educational investments for these women. There is no evidence for any effect on high school graduation. However, children of mothers who had access to abortion are about 2% more likely to take the academic track rather than the vocational track. I see little evidence for a positive effect of maternal abortion availability on education of their children in terms of having some college.
(Moore, Dennis et al. 2018) [Zambia]	To compare the financial costs for women when they have an induced abortion at a facility, with costs for an induced abortion outside a facility, followed by care for abortion-related complications	Women seeking care at two public hospitals and two private clinics, one each in Lusaka and in Kafue districts in Zambia. The data were collected from women (n = 38) obtaining a legal termination of pregnancy (TOP), or care for unsafe abortions (CUA).	Mixed methods: household wealth data at one point in time (T1) and longitudinal qualitative data at two points in time (T1 and T2, three-four months later), in Lusaka and Kafue districts, between 2014 and 2015.	Identifying the source of funds women use to pay for abortion-related care enriches our understanding of the financial consequences for women of having to spend that money on abortion-related care. Women having TOPs differed in how they paid for their abortions depending on their education level. More educated women paid for the abortion with their personal funds whereas less educated women relied on families or partners to raise the funds. When men denied paternity or responsibility, the woman was left with fewer options to pay for the abortion and manage any complications that arose. It was more common among women getting TOP (compared to those who had CUA) for her, the husband, a relative, or a friend, to borrow money or sell items to provide funds to pay for the abortion. When funds were harder to come by, women in all wealth categories were more likely to have an unsafe abortion. Women who obtained CUA tended to be one to three people removed from the money that was used to pay for their abortion. (One person removed would mean that the woman had to ask for help from someone who lent her the money; three people removed would mean that she asked someone who asked someone who asked someone else and that third person provided the assistance.) In our sample, younger, less educated women experiencing post-abortion complications were most likely to be furthest from the money source; money for their abortion-related expenses came from family members borrowing money on their behalf. School-going girls often used money previously allocated for food or school-related expenses provided by their families to cover the abortion-related costs. In contrast, older women found ways to access money themselves, or borrowed directly from family. Delays in raising the funds increased the cost as well as the risk of the procedure. Women expressed frustration and anxiety about the duration of time it took them to raise the money.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Mutua, Manderson et al. 2018) [Kenya]	To illustrate how the quality of PAC in healthcare facilities is impacted by law and government policy	Patients (n=21) and health providers (n=16)	Cross-sectional study with in-depth interviews	Women were aware of service disruptions, and they often presented to public facilities only when their conditions were too grave for further self-management and when they could not afford private facilities. Emergency care was significantly impeded by the unavailability of the right service providers for certain procedures, especially doctors, and during the night, weekends or public holidays. These capacity gaps were also evident in the number of patients who required multiple evacuations, often leading to longer hospital stays and increased the cost of care to both the patients and the healthcare system.
(Mutungi, Wango et al. 1999) [Kenya]	To evaluate the adolescents' behavior regarding induced abortion	Adolescent girls and boys ages 10-19 (n=1820 adolescent, 1048 school girls, 580 school boys, and 192 post abortion patients)	Cross-sectional prospective study	More than 70% of the girls who aborted lost school-time ranging from a few days to more than one year, and three (6.4%) of the boys' girlfriends and two (1.1%) of the post-abortion girls actually discontinued school.
(Mutungi, Wango et al. 1999) [Kenya]	To evaluate the adolescents' behavior regarding induced abortion	Adolescent girls and boys ages 10-19 (n=1820 adolescent, 1048 school girls, 580 school boys, and 192 post abortion patients)	Cross-sectional prospective study	More than 70% of the girls who aborted lost school-time ranging from a few days to more than one year, and three (6.4%) of the boys' girlfriends and two (1.1%) of the post-abortion girls actually discontinued school.
(Prada, Bankole et al. 2015) [Nigeria]	To identify near miss events (using WHO criteria) and the proportion due to unsafe abortion among women of childbearing age in eight large secondary and tertiary hospitals across the six geo-political zones. To explore the characteristics of women with these events, delays in seeking care and the short-term socioeconomic and health impacts on women and their families.	Women of childbearing age with maternal near-miss or at risk of maternal near-miss due to unsafe abortion (n=137 maternal near miss cases, 12 interviews with those due to unsafe abortion)	Cross-sectional hospital-based study	Women were asked whether they or anyone in their household lost any income during the time they were hospitalized. Four women responded that they lost between 4,000 and 65,000 Naira (US$26-$426), whereas nine reported that someone else from their household had lost between 6,000 and 100,000 Naira (US$39-$656). Since the minimum monthly salary in Nigeria was 18,000 Naira at the time the study was conducted (US$118)17, these costs represent a huge amount of money for these women and their households.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Robson, Kelly et al. 2009) [United Kingdon]	To determine the acceptability, efficacy and costs of medical termination of pregnancy (MTOP) compared with surgical termination of pregnancy (STOP) at less than 14 weeks' gestation, and to understand women's decision-making processes and experiences when accessing the termination service.	Women accepted for termination of pregnancy (TOP) under the relevant Acts of Parliament with pregnancies < 14 weeks' gestation on the day of abortion. (n= 1877 women, 349 in the randomized arms and 1528 in the preference arms)	Randomized preference trial	There were no differences in time taken to return to work between groups (medical termination of pregnancy and surgical termination of pregnancy); around 90% had returned to work and normal activity by 2 weeks.
(Sanders, Conway et al. 2016) [United States]	To examine the impact of the increase from a 24-hour mandatory waiting period to a 72-hour waiting period on the proportion of women who obtain an abortion	Women attending three family planning clinics in Utah	Assessment of data from an abortion information consultation	One half of women negatively impacted by the increase in mandatory waiting to 72 hours reported that they had to take extra time off work. 47% reported loss of wages, 18% excess childcare costs, 30% increased transport costs and 27% in additional expenditures and lost wages by a family member or friend.
(Shankar, Black et al. 2017) [Australia]	To examine access and equity to induced abortion services in Australia, including factors associated with presenting beyond nine weeks gestation	Women aged 16+ years attending for an abortion at 14 Dr Marie clinics (n=2,326)	Cross-sectional survey	About 22.5% reported experiencing trouble with financial costs as a challenge in accessing the service. Separately, one in three (34.0%) women reported that they found it difficult/very difficult to pay for the abortion. Just over two-thirds of survey respondents (68.1%) obtained financial assistance from one or more sources to help pay for the abortion. The husband/partner/ man involved in the pregnancy was the most commonly cited source (80.0%) of help, followed by a family member (16.0%). About 64.0% answered the question on having to forego regular payments to cover abortion costs. Among them, just over a third (35.1%) had to forego one or more payments, most often for bills (71.2%), followed by food and groceries (35.5%). " [p.312] "About 16.0% of respondents were undergoing an abortion after 9 weeks, and therefore no longer eligible for the medical option. In a multivariate model (Table 2) adjusted for age, country of birth and educational status, we found that women who had to travel four or more hours (OR: 3.0, 95%CI 1.2-7.3), who had no knowledge of the medical option (OR: 2.1, 95%CI 1.4-3.1), and who experienced difficulties in financing the abortion (OR: 1.5, 95%CI 1.2-1.9) had significantly higher odds of presenting later than nine weeks gestation. Also, women who identified as Aboriginal and/or Torres Strait Islander (OR: 2.1, 95%CI 1.2-3.4) and who

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				received a government pension as main income (OR: 1.5, 95%CI 1.0-2.1) had higher odds of later presentation.
(Singh 2010) [Global]	To review the scientific evidence on the consequences of unsafe abortion, highlight gaps in the evidence base, suggest areas where future research efforts are needed, and speculate on the future situation regarding consequences and evidence over the next 5–10 years.	Women who obtained unsafe abortions	Literature review	There are types of economic costs that have not been studied because of the difficulty in collecting data to document these costs. The cost of medical care for longer-term consequences of unsafe abortion, which include chronic reproductive tract infections and infertility, has not been rigorously studied so far. In part, this is because estimates of the numbers of women who will experience these consequences are themselves difficult to make; an additional factor is the difficulty of estimating the medical costs needed to treat these serious long-term health consequences because the use of the necessary medical technology has been so infrequent. Another aspect of the economic cost of unsafe abortion for which documentation is relatively weak is the impact on women, families and households. The steps that women take to obtain an unsafe abortion, to seek medical care for complications (including intermediate care before reaching the hospital, transportation and out-of-pocket expenses while in a facility), and costs after obtaining post-abortion treatment (for example for drugs or supplies) are themselves costly, and these are out of pocket expenses that the household incurs. Loss of productive time because of the health complications can also be an important consequence for the household. Again, this is difficult to quantify given the disagreement on approximating the monetary value of women's labor and time, particularly for women who are not earning an income. Efforts for a more standardized approach to estimate the cost of post-abortion care found a need for more attention to be directed to finding ways, specific to each country context, for following up post-abortion patients. Such efforts are important given that out-of-pocket expenses and lost productivity do not end with the patient's discharge from a hospital or health facility, and a follow-up interview is essential for measuring these aspects of the economic impact of the unsafe abortion. This pilot project produced model questionnaires and a study design that are available for adaptation and use by others. The next step is to apply these at the national level, which is underway in Uganda.
(Sjostrand, Quist et al. 1995) [Kenya]	To analyze socioeconomic and reproductive background characteristics of women with incomplete abortions and assess post-abortion health consequences and	Women seeking help for incomplete abortions (n=281, 91 spontaneous abortions, 152	Interviews	Total salary loss due to treatment for unsafe abortions was 195 KS compared to 175 KS for spontaneous incomplete abortions

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	financial implications for the women and the hospital.	suspected induced abortions, 28 admittedly induced abortions)		
(Sowmini 2013) [India]	To examine reasons why girls who seek abortions are always at higher risk for delay in care seeking	Unmarried young people (10-24 years of age) seeking abortion care at the study clinic (n=34)	Cross-sectional descriptive study	Financial problems were another reason for delay. One respondent reported the pregnancy progressing to the second trimester by the time they had raised funds for the abortion which was a pregnancy resulting from rape
(Sundaram, Vlassoff et al. 2013) [Uganda]	To measure the costs of unsafe abortion and post-abortion care to Ugandan women and their households, examining micro-level costs in three ways: women's out-of-pocket expenditures for abortion and treatment of post-abortion complications, the impact of the complications and associated expenses on the children in the household (if any) and on the productivity of women and other family members, and the households' economic responses to the consequences of unsafe abortion: sales of assets, incurrence of debt, and changes in income and consumption	Ugandan women who had been admitted to one of 27 health facilities for treatment of complications (n=1,338)	Prospective hospital-based survey	Social and economic outcomes: At the first interview, 60% of the 666 women who had children reported that their children were eating less, were unable to attend school or both as a result of the abortion. In addition, 73% of the women who likely had had an induced abortion stated that they or someone else in their household were already experiencing some loss of productivity. During the follow-up interviews, 34% of the 420 women who likely had had an induced abortion reported that they had experienced an economic impact from their abortion complications. Most of our independent variables were associated with one or more negative consequences. Overall, higher proportions of women who had more serious complications (i.e., had spent a night or more in a health facility) than those with less serious complications reported having experienced negative consequences—their children had suffered, they or someone in their household had lost productive employment or their economic circumstances had deteriorated. The proportion of women who reported that their children had suffered negative consequence declined with increasing age, from 92% among teenage respondents to 62% among 20–29-year-olds and 51% among older women. Women with one or two living children were more likely than women of higher parity to report that their children had been negatively affected (69% vs. 49%); however, those with at least one child were more likely than childless women to have suffered some loss of productivity (76–77% vs. 66%). The proportion of women who reported that they, their children, or someone in their household had suffered negative consequences was consistently higher among married women than among unmarried women. Women who were not attending school were more likely than those who were to report loss of productivity (75% vs 64%). Those with no more than a primary education were more likely than better-educated women to report lost productivity (77% vs. 70%). Negative consequences for children: The odds that a woman's

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				children had already experienced negative consequences—had had less food than usual, had missed school or both—at the time she was being treated for abortion complications were higher among women who had spent a night or more at a health facility than among women who had not had an overnight stay (odds ratios, 1.6–1.8). The likelihood of negative consequences was substantially lower among children of women aged 20 or older than among those of teenage respondents (0.2 for both older age-groups), and lower among children of women with at least three living offspring than among those of lower-parity women (0.4). Children of married women had more than twice the odds of having suffered negative consequences than did children of unmarried women (2.2). Finally, and not unexpectedly, children of women in the two wealthiest groups were less likely than those of the poorest respondents to have had any negative consequences as a result of their mother's post-abortion complications (0.4–0.5). •Loss of productivity. Only two characteristics were associated with the respondent or other household members having experienced reduced productivity (inability to work, to earn or both) because of the respondent's abortion-related morbidity. The odds of productivity loss among women who had spent one or more nights in a health facility (and hence probably had relatively severe complications) were more than twice those of women who had been treated as outpatients (odds ratios, 2.2–2.4). In addition, loss of productivity was more common in households of married women than in those of unmarried women (1.6). Deterioration in economic circumstances: Among women who were re-interviewed 2–3 months after receiving post-abortion care, two characteristics were associated with deterioration in their economic circumstances—that is, with whether they and their family had lost economic assets, incurred debt, lowered their consumption, or had to work more or give up their jobs in response to their illness. Women who had spent one night at the health facility had higher odds of experiencing economic deterioration than did women who had not had an overnight stay (odds ratio, 2.8) and women who had incurred higher post-abortion care expenses (i.e., those in the highest three quintiles) were more likely than those with lower expenses to have seen their economic circumstances worsen (1.6).
(Upadhyay, Weitz et al. 2014) [United States]	To describe the characteristics associated with being turned away because of provider gestational age limit, and the	Women recruited in the Turnaway Study by 30 abortion providers across the US	Descriptive statistics through open and closed ended surveys	36.5% of first trimester patients and 58.3% of turnaways experienced delays from travel and procedure costs. 37.8% of first trimester patients and 48.1% of turnaways reported delays due to insurance problems. The most commonly cited reason for a delay was "money" or "finances".

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	efforts women make to obtain an abortion			Of the 21.6% of turnaways who considered having an abortion, 85.4% reported travel and procedure costs as a reason for not obtaining one.
(Upadhyay, Biggs et al. 2015) [United States]	To investigate whether abortion enables women to achieve personal life goals	Women seeking abortion services (n=757)	Regression analysis and qualitative methods	The 757 participants in this analysis reported a total of 1,304 one-year plans. The most common one-year plans were related to education (21.3 %), employment (18.9 %), other (16.3 %), and change in residence (10.4 %). Most goals (80 %) were aspirational, defined as a positive plan for the next year. First Trimesters (women who presented in the first trimester and received abortions) and Near-Limits (women who presented up to 2 weeks under the limit and received abortions) were over 6 times as likely as Parenting Turnaways (women with children who presented up to 3 weeks over the facility's gestational age limit and were turned away) to report aspirational one-year plans [Adjusted Odds Ratio (AOR) = 6.37 and 6.56 respectively, $p < 0.001$ for both]. Among all plans in which achievement was measurable (n = 1,024, 87 %), Near-Limits (45.6 %, AOR = 1.91, $p = 0.003$) and Non-Parenting Turnaways (47.9 %, AOR = 2.09, $p = 0.026$) were more likely to have both an aspirational plan and to have achieved it than Parenting Turnaways (30.4 %). Conclusions: These findings suggest that ensuring women can have a wanted abortion enables them to maintain a positive future outlook and achieve their aspirational life plans.
(Upadhyay, Johns et al. 2018)[United States]	To assess the incidence of abortion-related emergency department (ED) visits in the United States (U.S.): Estimated the proportion of visits that were abortion-related and described the characteristics of patients making these visits, the diagnoses and subsequent treatments received by these patients, the sociodemographic and hospital characteristics associated with the incidents and observation care only (defined as receiving no treatments), and the rate of major incidents for all abortion patients in the U.S.	Women seeking emergency care for abortion related issues (n=27,941)	Retrospective observational study	Women using Medicaid had higher odds of major incidents than those not using Medicaid and lower odds of observation care. In this context, insurance type may be a proxy for socioeconomic status, as women requiring Medicaid are low income and as a result, face a multitude of barriers to accessing health care and are known to have poorer health status, including multiple chronic conditions, than women with private insurance. Women who were self-pay were less likely to have major incidents and more likely to receive observation care only, suggesting that patients without healthcare coverage may not have been given treatments to reduce patient costs.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Valente 2014) [Nepal]	To assess the impact of providing accessible abortions on pregnancy decisions and sex-selection	Combined fertility histories using quantitative data	Difference-in-difference	The decreased cost of a first-trimester abortion might impact the decision to have a gender-blind abortion by women categorized as near-indifferent between perceived foetus sex.
(Vlassoff, Walker et al. 2009) [Global]	To estimate the health system costs of post-abortion care in Africa and Latin America	PAC patients	Cost estimation	The indirect economic costs of unsafe abortion—those borne by households, by sectors outside the health care system and by the wider economy— are also essentially unmeasured.
(Wiebe and Janssen 2000) [Canada]	To compare the loss of ability to work in 62 women having medical and 69 having surgical abortions	Women seeking abortion services (n=62 women having medical and 69 having surgical abortions)	Prospective cohort questionnaire study	Outcomes included the number of days lost from work outside the home and inside the home before and after the abortion appointment. The mean total loss from work inside the home was 10.1 days for the surgical group and 5.3 days for the medical group ($P < .05$). The mean total loss from work outside the home was not significant at 4.0 days for the surgical group and 2.5 days for the medical group.
(Zamberlin, Romero et al. 2012) [Latin America]	To summarize the findings of a literature review on women's experiences with medical abortion in Latin American countries where voluntary abortion is illegal	Studies on women's experiences with medical abortion in Latin American countries where voluntary abortion is illegal	Literature review	Difficulty in accessing misoprostol related to regulations and government control over sales create differing levels of obstacles, with stricter controls pushing women towards the black market where prices are higher. In settings where prescriptions are required, strategies for accessing including obtaining a prescription from a non-ObGyn specialist or asking a man or older woman to obtain a prescription under the pretense that it is for their use.

Appendix I. Summary of studies reporting micro-economic benefits/value

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Ahmed, Islam et al. 1999) [Bangladesh]	To find out where women go for induced abortion in rural Bangladesh today, their contraceptive practice prior to and after getting pregnant, their reasons for choosing abortion, who makes the decision for abortion, what complications they develop, and where they go for treatment for these complications	All women seeking abortion-related care at six health facilities (two rural hospitals and four static clinics) in two rural sub-districts of Bangladesh in 1996-1997 (n=143)	Semi-structured questionnaire with interviews	Twenty-two of the women (15.4%) said they were too poor to support another child.
(Aiken, Johnson et al. 2018) [Ireland]	(1) to examine the factors affecting whether women in Ireland choose to access abortion by travelling or by using online telemedicine; and (2) to explore their experiences in accessing care through each pathway	Women (n=38) identified through three organisations: Women on Web, Abortion Support Network, For Reproductive Rights Against Oppression, Sexism and Austerity. Criteria: aged over 18, had an abortion within 8 years of study, lived in Ireland at time of abortion, had travelled or used telemedicine to access abortion care.	Qualitative in-depth interviews	Telemedicine was considered a method to mitigate the negatives of travelling for abortion care in Ireland. A respondent (age 40, 5 children) explained: “I didn’t consider travelling at all. I don’t really get why people travel when the pill is available online. Travel just seemed very invasive and unnecessary and the pill just seems like such a sensible option.”
(Aiken, Guthrie et al. 2018) [United Kingdom]	To examine reasons for seeking abortion services outside the formal healthcare system in Great Britain,	Women resident in England, Scotland, and Wales who requested at-home medication abortion	Mixed methods	"I have restrictions that could jeopardise my safety here. The pregnancy is a result of adultery. I do not want to defy certain family members and bring shame on them knowing that I depend on them. This would put my life at risk and mean that I would have to flee with no job and no skills. This [abortion] is beyond doubt the safest options for me," (p. 6). "I'm in a

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	where abortion is legally available	through online telemedicine initiative Women on Web in 2016-2017 (n=519)		controlling relationship, he watches my every move, I'm so scared he will find out, I believe he's trying to trap me and will hurt me. I can't breathe. If he finds out, he wouldn't let me go ahead, then I will be trapped forever. I cannot live my life like this," (p.6).
(Aiken, Gomperts et al. 2017) [Ireland]	To examine the characteristics and experiences of women in Ireland and Northern Ireland seeking at-home medical termination of pregnancy (TOP) using online telemedicine	Women who requested at-home medical TOP through online telemedicine initiative Women on Web from 2010-2015 (n=5,650). Women who completed TOP in 2010-2012 (n=1,023)	Logistic regression and content analysis of women's evaluations	Among the 3,500 women for whom information was available on their reasons for termination, 62.1% said they cannot cope with a child at this point in their life, and 43.5% said they have no money to raise a child. "'You gave me another chance to continue my personal battle as a single mother to create a good quality of life for my child, working hard in three jobs to make ends meet and create opportunities and potential for her future,'" (p.1212). The experiences of women in Ireland and Northern Ireland with few economic and social resources suggest a grave inequity in their ability to access safe TOP. Women noted their inability to afford travel abroad, to take time away from children and work, to arrange travel without their families' knowledge, or to travel at all due to migrant status. For some women the need to travel would have caused long delays in accessing care, and for others, it would have rendered care completely impossible. Online telemedicine goes at least part of the way towards resolving this disparity in reproductive health and rights. As one woman explained: 'There is no way I could have afforded to travel to England, pay for the procedure, stay in a hotel, and have someone there to support me," (p. 1212).
(Akin, Kocoglu et al. 2005) [Turkey]	To show that early medical abortion could be introduced safely in Turkey to improve women's access to services	Women between the ages of 18 and 49 who had an intrauterine pregnancy up to 56 days LMP, lived or worked within one hour of study site, willing to return for at least one follow-up visit and no known allergies to mifepristone or misoprostol (n=470)	Descriptive clinical study	Women opted for home use of misoprostol rather than clinic use since transportation was a problem (7.6%). Among women preferring surgical abortion, 48% said the most important reason for this preference was that it takes a short time. Seven in ten surgical abortion patients said that one of the best features of surgical abortion is that it is done quickly. Among medical abortion patients, 62% reported no surgery as one of the best features, and 25% reported being at home as one of the best features.
(Almond, Edlund et al. 2013) [Canada]	To potentially cast light on the role of culture in sex selection among South and East Asian immigrants in Canada	Canadian residents who participated in the 2001 and 2006 censuses	Analysis of census microdata	High and rising sex ratios lead one to ask what causes parents to prefer sons to daughters. One argument emphasizes socioeconomic and institutional factors. Absent couples' ability to save or to rely on national pensions, the poor count heavily on children for old-age support, a task that under patriarchal norms falls on sons. In India, high and rising dowry

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				payments are argued to place families with daughters at a disadvantage, and families may depend on males for physical protection. In both India and China, however, sex ratios are highest in the richest areas, and for India a strong education gradient is evident, with better-educated parents favoring sons more extensively. These observations cast doubt on sex selection being the result of economic necessity alone.
(Alouini, Uzan et al. 2002) [France]	To determine whether women undergoing repeat abortions are exposed to risk factors that might be amenable to preventative measures and the methods employed by carers in these cases	30 women who had undergone two abortions prior to or in 1997 at the Family Planning Centre of Hospital Jean Verdier in Bondy, France. The care team: two gynaecologists, two marital counsellors, two nurses and a senior nursing officer	Evaluation using a questionnaire for women and interviews with the care team	These immigrants are generally economically successful and transplanted into a developed country in which many of the commonly invoked motives for selecting sons (poverty, old-age support, one-child policy) are rendered irrelevant.
(Altshuler, Ojanen-Goldsmith et al. 2017) [United States]	To compare women's needs and preferences in abortion to those in birth To examine ways in which women's needs and preferences in abortion care differ from intrapartum care	Women who had individually experienced both birth and abortion (n=20)	Semi-structured intensive interviews and a validated Individual Level Abortion Stigma scale (ILAS) assessment	Women value determining the outcome of their pregnancy and being respected as decision-makers by providers.
(Aniteye and Mayhew 2011) [Ghana]	To explore and understand the reasons why women terminate their pregnancies and their experiences of seeking services in order to know what and how to reform services to reduce unsafe abortion	Ghanaian women who had been admitted with complications from induced abortion (n=131)	Semi-structured hospital-based survey	Almost all respondents said their pregnancies were unplanned and two-thirds said their pregnancy was unwanted. When asked for what reason the pregnancy was unwanted, economic reasons (25%) were the second largest reason. Almost one-third of respondents, however, said they did want their pregnancy. Of these, 34% said that they had aborted because of economic problems. Among the 67 women who said their partners were unhappy with the pregnancy, one third said their partners mentioned financial constraints, and 12% said it was to avoid disrupting the girls' educational or career opportunities. The 53 respondents who reported their partners were happy with the pregnancy were asked the reasons why they terminated their pregnancy despite this. Fifteen percent said they aborted because they were not ready to have a child or were

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				nursing another child. Other reasons given included financial constraints, academic/career pursuits, and a range of socio-cultural issues like not ready to be second wives and unstable marriages.
(Appiah-Agyekum, Sorkpor et al. 2015) [Ghana]	To explore factors that are likely to influence abortion decisions among university students in Ghana To explores university students' knowledge and perceptions on abortion	Randomly sampled students at the University of Ghana (n=142)	Focus group discussions	Economic considerations appear to be the fourth most important consideration of the students. Interestingly, the availability of financial support from their partner, friends, or family during the term of the pregnancy and after the birth of the baby appears to be of much concern to the students. Additionally, the indirect costs of the pregnancy and childbirth including how the pregnancy and the birth of the baby is going to affect their income and spending levels, sources of income, cost of living, standard of living, economic activities engaged in, as well as other opportunity costs of the pregnancy, have an influence on their decisions. Apart from that, emphasis was also placed on the direct costs of the pregnancy and childbirth, such as the costs of healthcare and medication, feeding, clothing, and housing. Evidence from this study suggests that the economic circumstances of both partners and, to an extent, the families of both partners are key in decisions to abort.
(Bailey, Bruno et al. 2001) [Brazil]	To determine social and behavioral consequences of pregnancy and how these differed according to the pregnancy outcome (live birth or abortion) one year after the event	Pregnant teens who sought prenatal care at the Adolescent Clinic, and a cohort of girls of the same age who attended the same hospital but were admitted to emergency services with complications from abortion (total n=418)	Cohort studies	Adolescents who had induced abortions were 6.87 times likelier (C.I. 2.95-16.01) to be a student one year after the baseline than adolescents with intended pregnancies (reference group).
(Banerjee and Andersen 2012) [India]	To understand the pathways through which unsafe abortion leads to post-abortion complications and to describe the experiences of women seeking care for post-	Women of reproductive age who were seeking care for post-abortion complications between August and December 2007 at one of 10 hospitals	Analysis of data from structured and provider-friendly patient registers A semi-structured questionnaire for conducting a detailed	When asked why they had chosen to terminate the pregnancy, nearly three quarters of respondents indicated they did not want another child at this time (73%). Other common reasons included inability to afford another child (8%), husband not wanting another child (7%) or health problems (5%).

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	abortion complications in Madhya Pradesh		interview with participating women	
(Bélanger and Flynn 2009) [Cuba]	To explore why abortion persists as a widespread form of fertility control in Cuba despite the country's stable low fertility and high contraceptive-use rates	Patients presenting for an appointment a large obstetrics hospital in one of the municipalities of Havana Men who were accompanying their partners	Small-scale qualitative study using a series of in-depth interviews	Respondents' decisions to terminate a pregnancy were often influenced by their poor economic circumstances. Carrying through with an unplanned pregnancy was not considered to be a viable option. Many lived in a multigenerational household within a small residence, and commonly reported a lack of physical space and privacy as a key factor in their decision to obtain the abortion. Bearing and rearing an "extra" (unplanned) child in light of their financial circumstances made no sense to them. In some instances, participants expressed regret about having to terminate the pregnancy and indicated a desire to have a larger family if they were living under better circumstances. Despite often wanting to have a family, the impracticality of having a child under their current circumstances rendered abortion the logical decision.
(Belton and Whittaker 2007) [Thailand]	To examine the need for provision of reproductive services to displaced Burmese migrant workers along the border with Thailand	Burmese women with post-abortion complications (n=43). Burmese lay midwives from urban and rural areas (n=15). Male partners of women with post-abortion complications (n=10). Health workers (n=20). Community members	Ethnographic study including a retrospective review of medical records, directed group discussions, semi-structured interviews, and informal conversations	Many Burmese migrant women are in Thailand to earn money. Hence, concerns about earning capacity, debts, the need to send remittances, the costs of raising a child and threats of sacking and deportation by bosses if pregnant were common reasons given by women having abortions. Some women spoke of the pressure they received from their families to abort because of their economic situation. Women's right to work for equal pay, right to work during a pregnancy or any notions of maternity leave is non-existent for Burmese workers in Thailand. As most women interviewed did not have a work permit, they were a particularly vulnerable population.
(Bennett 2001) [Indonesia]	To examine the experience of premarital pregnancy and induced abortion among young, single women in Lombok, Eastern Indonesia	Single women and their families, and health care providers in Mataram, the capital city of Lombok, between August 1996 and February 1998	Ethnography	Marriage prospects, abandonment by their partner, single motherhood, early cessation of education, and an interrupted income or career were clearly undesirable options. For single women who lacked the choice of marriage, only abortion allowed them to maintain their status as 'good women' and to avoid compromising their futures.
(Biggs, Ralph et al. 2018) [United States]	To understand the support for and interest in various alternative provision models for medical abortion among a diverse group of	A U.S. national, probability-based representative sample of women ages 18–49 online	Multivariable analyses	For advance provision, OTC and online access, women reported 'could be less expensive' as a potential advantage (35%, 34% and 32%, respectively). For advance provision, OTC and online access, women reported 'could be more expensive' as a potential disadvantage (16%, 20% and 18%, respectively).

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	women, including women who may prefer not to access or have limited access to facility-based abortion care			
(Brack, Rochat et al. 2017) [Colombia]	To identify the key barriers to legal abortion, and to explore the ways they may work separately and together to delay the receipt of high quality, legal abortion care	Women who had obtained a legal abortion in Bogotá, Colombia in the last 12 months; were aged 18 or older; and exhibited verbal proficiency in Spanish (n=17)	In-depth interviews	One participant, a 39-year-old single mother, said that her partner had ended their relationship when she told him she was pregnant. She could not financially support a second child without the help of a partner and was very upset to be ending the unexpected pregnancy. Another participant said she was not emotionally or economically ready for a baby, but because she physically was able to give birth, she struggled with the decision to terminate. The women whose abortion had been paid for by their health insurance company said issues with the company had delayed their abortion. Health insurance representatives abruptly hung up when participants mentioned abortion, did not return their phone calls or told women that abortion was not covered. Inconsistent instructions from the companies regarding necessary authorizations further delayed these women from getting approval and obtaining a timely abortion. Some women were delayed by as much as two months. Insurance companies acted as a barrier to timely access to legal, safe abortion care, even though they are legally obligated to authorize the procedure. Religious sentiments appeared to underlie the behavior of company representatives.
(Broen, Moum et al. 2005) [Norway]	Aims: (1) To identify the most important reasons for having an induced abortion (2) To study the relationship between the reasons for abortion and emotional distress 6 months and 2 years after the abortion (3) to identify the most important predictors for emotional distress	80 women who had induced abortions at the Department of Gynaecology of the Buskerud Hospital, Norway	Semi-structured interviews and questionnaires	Negative feelings towards abortions were statistically significantly associated with women who sought abortions for financial reasons.
(Chae, Desai et al. 2017) [global]	To present the reasons women give for obtaining induced	Three types of data sources from 14 countries: (1) official	Descriptive quantitative survey data	In six of the 13 countries for data existed on the main reason for abortion, the most commonly reported reason for having an abortion was socioeconomic concerns, cited by a plurality of women (ranging from 27%

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	abortions in 14 countries	statistics; (2) population-based surveys of reproductive-age women (15–49 years); and (3) facility-based data collected from abortion patients		to 40%). In five countries, limiting childbearing was the most frequently reported reason, ranging from 20% in Nepal to 64% in Azerbaijan. In Belgium, the most frequently cited reasons were partner-related (23%) and socioeconomic concerns (23%), and in Kyrgyz Republic, risk to maternal health was commonly reported (44%).
(Chibber, Biggs et al. 2014) [United States]	To examine how partners figure in women's abortion decisions, and to identify factors associated with identifying partner as a reason (PAR) for abortion	Pregnant women aged 15 years or older recruited from 30 U.S. abortion facilities (January 2008-December 2010), where no facility nearby offered care at a later gestational age of pregnancy. Participants were English or Spanish speaking, no known fetal anomalies or demise, and belonged to one of the following three groups: 1) Women just over the facility's gestational age limit and denied an abortion (n=231); 2) women just under the limit and who received an abortion (n=452); and 3) women receiving a first trimester procedure (n=273)	Mixed methods study using in-depth interviews and baseline data from the on going Turnaway Study, a prospective longitudinal study	Twenty-six percent of women said that their partner was unable or unwilling to support them in having a baby. Reasons for feeling this way included the following: partner was not financially able to provide for a child; and partner did not support the woman in raising their existing children and was therefore unlikely to support her with a new baby. Thirty-nine percent of women identifying lack of partner support in having a baby also emphasized their own financial inability to raise a child at the time.
(Chunuan, Kosunvanna et al. 2012) [Thailand]	To obtain data from women from southern Thailand who had	Thai females, of any age, who: were able to speak, write and	Descriptive study involving a questionnaire	Unsurprisingly, a higher proportion of younger women, compared to older women, identified socio-economic problems as reasons for an abortion.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	undergone a recent abortion (spontaneous, therapeutic and unsafe) regarding: pregnancy history; number of abortions and cost of abortion related treatments; abortion complications, impacts and related health care services; reasons for having an unsafe abortion; and, circumstances related to an unsafe abortion	understand Thai; had experienced an abortion, regardless of chronological age, gestational age or type; and were admitted to one of the study site hospitals		Most likely this was because younger women do not have the same social or economic resources available to older women.
(Cockrill and Weitz 2010) [United States]	To explore abortion patients' perspectives on abortion regulations (e.g., mandating waiting periods, mandating the provision of state-authored information, prohibiting private and public insurance coverage for abortion)	Abortion patients at the only three high-volume abortion facilities in two states in the U.S. South and Midwest (n=20)	Qualitative study using semi-structured interviews with patients and providers	The reasons for choosing abortion among the women in our sample were diverse, but for most they matched the general categories identified in recent research '...that she could not afford a baby now..."
(Dennis, Manski et al. 2014) [United States]	To answer the following questions: 1) What do women know about the cost of abortion and the availability of Medicaid coverage for abortion? 2) Where do women obtain this information? 3) What are women's	Low-income women, defined as meeting the Medicaid income qualifications of the state where they had the abortion, aged 18 years or older who had an abortion within the past two years and who resided in one of the four study states at the time of the abortion	Two similarly-focused studies using in-depth interviews	When full coverage of abortion in the Medicaid program is available, there is little to no need for women or others in their lives to make financial sacrifices, and there is rarely a scramble for money that provokes feelings of indignity or delays abortion care. More work is needed to determine if the findings about the benefits of available abortion coverage hold true across the few states where this coverage is available and if there are other unidentified benefits.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	experiences paying for care?			
(Díaz-Olavarrieta, Cravioto et al. 2012) [Mexico]	To identify the perceptions and opinions of people who provide abortion services in Mexico City, three years after implementation of elective abortion legal reforms	19 health workers assigned to the legal abortion programs at a clinic and a hospital in Mexico's Federal District	In-depth interviews	The majority of the participants considered that the services influence the reduction of maternal mortality rates that result from poor abortion practices, and facilitate access to services mainly to poor women.
(Fergusson, Boden et al. 2007) [New Zealand]	To examine the extent to which young women who had an abortion prior to age 21 showed advantaged outcomes when compared with women who became pregnant but did not seek an abortion	A birth cohort of young women in New Zealand studied to the age of 25 years (n=492)	25-year longitudinal study with interviews at ages 15, 16, 18 and 21 about their pregnancy and abortion experience since the previous assessment	Prior to adjustment for confounding factors, compared with women who had become pregnant but had not had an abortion, those who had had an abortion had relatively advantaged outcomes on most measures of educational achievement, income, avoidance of welfare dependence and partnership relationships. At first sight, these findings may suggest benefits of abortion. However, subsequent analyses suggested that the differences were largely explained by the fact that those who had sought abortion were a more socially and educationally advantaged group prior to pregnancy. When due allowance was made for pre-pregnancy factors, only the educational differences between pregnant women seeking and not seeking abortion remained statistically significant. Furthermore, educational outcomes were similar among those who had had an abortion and those who had not become pregnant. Our results clearly suggest that having an abortion mitigated the educational disadvantage associated with early pregnancy. For the women in our sample, perhaps the choice to have an abortion allowed greater freedom to pursue educational goals. At the same time, similar advantages did not extend to the areas of income, welfare dependence and partnership outcomes.
(Fernandez Lopez, Carrillo Navarro et al. 2010) [Spain]	To: (a) know the prevalence of abortions in the immigrant population of an urban center of primary care health in the state of Murcia; (b) know the personal attitude before this population's abortions; and (c) analyze this population's	Women at a primary care center in San Andreas State of Murcia (n=230)	Descriptive traverse study	The fundamental reasons for which the women aborted are the lack of financial means, the pressure to which they are subjected by their partner or their family to abort, and in the third place because pregnancy and maternity constitute an inconvenience for their personal projects. The lack of financial means is related to their social instability, sometimes in an irregular situation, job instability, fear of losing their job due to the fact of being pregnant, fear of not having enough means to care for the children, or not being able to fulfill the commitment acquired sometimes to send money to their countries of origin, according to data coinciding with other studies.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	socio-economic and religious characteristics and to value their possible relationship with the abortion			In fact, 30% of the women surveyed live alone or with children, without a partner or other supportive family members. It is a reality that in Spain there are no adequate social benefits for maternity protection in terms of working hours, maternity leave, enough subsidized day care centers, aid for families with children, etc. Seventy percent of respondents who have aborted believe that they would not do it again and the reasons given are greater stability in their social, economic and family situation and having suffered the consequences of abortion. Twenty-seven percent would abort again and of the reasons given the first is social instability. The authors believe that immigrant women see their maternity determined according to socioeconomic patterns linked to their labor and social status of 'labor' subject to demands of temporality and precariousness.
(Finer, Frohwirth et al. 2005) [United States]	To understand women's reasons for having abortions among women who have already made the decision to have an abortion	Survey: women arriving for a pregnancy termination (in English and Spanish) In-depth interviews: all abortion patients had a chance to participate; recruitment was not based on social or demographic characteristics; was limited to fluent English speakers	Structured survey and in-depth interviews	Among the survey respondents, the two most common reasons for having an abortion were “having a baby would dramatically change my life” (74%) and “I can’t afford a baby now” (73%). The most common sub-reason given was that the woman could not afford a baby now because she was unmarried (42%). Thirty-eight percent indicated that having a baby would interfere with their education, and the same proportion said it would interfere with their employment. In a related vein, 34% said they could not afford a child because they were students or were planning to study. In the in-depth interviews, the three most frequently stated reasons were the same as in the structured survey: the dramatic impact a baby would have on the women’s lives or the lives of their other children (32 of 38 respondents), financial concerns (28/38), and their current relationship or fear of single motherhood (21/38). Roughly equal proportions of women in both the 1987 and 2004 surveys indicated that a baby would dramatically change their lives, that they could not afford a baby now, that they did not want to be a single mother or had problems with their relationship, and that they were not ready for a child or another child. On the other hand, smaller proportions of women in 2004 than in 1987 said that having a baby would interfere with their job or career (38% vs. 50%). In both 1987 and 2004, unreadiness for a child or another child and inability to afford a baby were each mentioned by about one-quarter of women as their most important reason for having an abortion. In contrast, the proportions reporting fear of single motherhood or relationship problems, and reporting that a child would interfere with school or career, both declined. Among women who gave at least two reasons, the most common pairs of reasons were inability to afford a baby and interference with school or work; inability to afford a baby and fear of single motherhood or relationship problems; and inability to afford a baby and

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				having completed childbearing or having other people dependent on them.
(Flory, Manouana et al. 2014) [Guadalupe]	To analyze, in the Guadeloupian context, the characteristics of underage people who ask for an abortion	Minor patients who have had an abortion	Descriptive, retrospective study reviewing medical records and interviewing the psychologist	Continuation of studies was the most frequently cited motive for the decision of abortion. A pregnancy and a child clearly appear as a brake on this objective of training. It is now recognized that the evolution of the statute woman's social status leads her to delay the age of motherhood, in favor of continuing education. The second reason most often found was the young age. Indeed, some of our patients felt they were too young to become mothers.
(Foster and Kimport 2013) [United States]	To analyze data on women who sought and received an abortion at or after 20 weeks' gestation for reasons other than fetal anomaly or life endangerment	People who were seeking abortions after 20 weeks gestation across 16 sites (n=272) and people who presented for first trimester abortions (n=169)	Mixed methods – qualitative data from interviews and quantitative data for logistic regression	Provides the following case study of Angel [a pseudonym] in Maryland, who they describe as representing 47% of the sample: "At the time of her abortion, she had a 10-month-old daughter, whom she cared for full-time while she looked for paid employment. Her husband had recently been incarcerated, leaving her with no household income. As Angel explained, her daughter was her top priority. When she realized she was pregnant, at 22 weeks, her principal concern was for her daughter. Angel's experience of being a new mother interfered with her ability to detect her pregnancy and, moreover, convinced her that having another child was a bad idea. She believed that having another child would compromise the care she could give her infant daughter: "I knew I couldn't continue with [the pregnancy]. My daughter isn't even a year." Deciding to have the abortion was very easy for Angel.
(Ganatra and Hirve 2002) [India]	To explore adolescent women's access to abortion services, decision-making on abortion, determinants of provider choice and extent of morbidity experienced.	Women (primarily those currently married) who had undergone an induced abortion in the study area in an 18-month reference period during 1996–1998	Questionnaires and a qualitative in-depth time-line of sequence of events	Adolescent married women mentioned their previous child being too young as the most common reason for having an abortion, while the adult women cited not wanting any more children. A small number of adolescent abortions were to delay a first birth; all 14 women who aborted their pregnancies for this reason were either employed, studying in college or doing a vocational training course.
(Gibb, Donaldson et al. 1998) [United Kingdom]	To measure women's preferences and strength of preferences (expressed in terms of willingness-to-pay) for medical abortion versus surgical vacuum aspiration	Women prior to having, and following, termination of early pregnancy (n=50) at a gynaecology out-patient clinic in Aberdeen Royal Hospitals NHS Trust	Willingness to pay technique	Thus, 48 participants gave a total willingness to pay (WTP) value of £4,211. The median WTP value (with 25th and 75th percentiles) was £50 (£26, £100), whilst the mean WTP (with 95% confidence interval) was £87 (£44, £130). Of the women who preferred the medical method, the total value given was £3,530, the median value for this group being £50 (£30, £100) whilst the mean was £103 (£43, £163). Of those preferring the surgical method the total value given was £681, the median value for this group being £50 (£5, £100), whilst the mean was £48 (£29, £67). The amounts given for each group are similar. There are, however, a minority of women

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
		between August 1993 and February 1994		who gave higher values for the medical method, and thus for those women their preference for that method was more intense. The results of the regression analysis reveal that the rating of the importance of choice and social class grouping are the best predictors of WTP. It seems that those with a greater ability to pay do not have systematically different preferences from those with less ability to pay. In general, values offered at follow up for both medical and surgical methods are similar, as well as similar to the valuations for the pre-termination preferences.
(Gresh and Maharaj 2011) [South Africa]	To examine the acceptability of medical abortion among young people in Durban, South Africa. To investigate the potential demand for and applicability of the method among women in South Africa	Sexually active women at the University of Durban and under 30 years of age (n=20)	Qualitative in-depth interviews	Medical abortion presents the opportunity to save hugely in financial and time resources for medical staff.
(Gruber, Levine et al. 1997) [United States]	To examine the impact of increased abortion availability on the average living standards of children through a selection effect	States with early adoption of abortion access vs. states with later adoption of access	''Differences-indifferences'' strategy to estimate the effect of abortion legalization on average living circumstances	The most important change in government fertility policy over the past 30 years was the legalization of abortion under the Roe v. Wade decision. The change had a significant effect on the living circumstances of the cohorts who were born after legalization. Subsequent cohorts were less likely to be in single-parent households, and as a result less likely to live in poverty, and less likely to receive welfare. In addition, these cohorts experienced lower infant mortality. In particular, for the marginal child not born due to increased abortion access, the odds of living in a single-parent family would have been roughly 60% higher, the odds of living in poverty nearly 50% higher, the odds of welfare receipt 45% higher, and the odds of dying as an infant 40% higher. Perhaps more importantly, these findings may also have implications for the lifelong prospects of the average child born after legalization. The children not born due to abortion availability would have grown up in adverse living circumstances that other studies have shown may be detrimental to later prospects. Of course, this conclusion is complicated by the fact that we cannot necessarily apply the effects on the average child of living in poverty (for example) to the effects on the marginal child who would live in poverty if their pregnancy were not terminated. However, as these cohorts age, researchers will be able to directly observe outcomes such as educational attainment, income, and family structure. The evidence strongly suggests

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				that abortion is used by women to avoid bearing children who would grow up in adverse circumstances.
(Howie, Henshaw et al. 1997) [United Kingdom]	To describe and compare health outcomes two years after medical abortion or vacuum aspiration.	140 women who participated in a randomized study in the Grapian Region, Scotland.	Structured interviews	90% of women in the medical groups of the randomized study and 86% in the surgical groups would be willing to pay for their method – a median of 311 GBP (range 40-500 GBP). This was considered proxy for importance of method choice.
(Hulme-Chambers, Temple-Smith et al. 2018) [Australia]	To understand better rural women's experiences in obtaining a medical termination of pregnancy (MToP) through a rural primary healthcare service in Victoria, Australia	Women aged 16 years and over who attended the clinic between February 2016 and 2017 for an appointment related to MToP	Semi-structured interviews	Women's reasons for choosing MToP in preference to surgical termination varied greatly but the most common responses highlighted the convenience and flexibility of MToP and the ability to time it around work and life commitments; the less invasive nature of the process; and that the clinic was the closest location providing MToP outside of urban areas.
(Hussey 2011) [United States]	To determine if women's Temporary Assistance for Needy Families (TANF) participation may magnify the cues that state policy choices, the accessibility of abortion providers, and public attitudes send to all women about abortion	All respondents had borne at least one child; the sample disproportionately captured unmarried women, women of color, urban women, and those of low socioeconomic status because the study sampled from hospitals where large numbers of single mothers delivered	Probit regression	In pro-choice states, new TANF recipients are estimated to be statistically significantly more likely to resolve a pregnancy in abortion than are other comparable low-income women. The analysis suggests that this relation weakens and reverses itself as the state's stance on abortion grows more pro-life. If TANF works at all as an alternative to abortion, it works that way only for the very most economically marginal women. This analysis addresses speculation that welfare is pro-life, reducing abortion by improving poor women's economic capacity to choose childbirth. The results provide evidence for this hypothesis, but that evidence is found only in states where public opinion, policy choices, and a scarcity of abortion providers signal a preference for birth over abortion. In other words, the state abortion rights climate moderates the relation between welfare and pregnancy decision-making. The study argues that this finding may be due to interstate differences in the types of economic resources that welfare provides to disadvantaged women and to the types of messages (about the acceptability and desirability of abortion) that women may receive. It also argues that those messages are magnified through participation in the TANF program. In theory, public assistance in states with pro-life stances on abortion reduces the material cost of childbearing by offering a set of basic resources that other disadvantaged women may struggle to secure. The state does not limit welfare recipients' abortion access any more than its policies constrain access for other disadvantaged women, but neither does it offer resources like Medicaid that may help disadvantaged women obtain abortions. This study's results imply that expanding eligibility for TANF may reduce

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				abortions, at least in states where a pro-life stance prevails. But these results should be read very cautiously since data limitations prevent this study from testing some very plausible alternative explanations. One question that these results invite concerns the consistency of low-income women's pregnancy decisions with their true reproductive preferences.
(Izugbara and Ukwayi 2003) [Nigeria]	To profile the characteristics and health conditions of the clientele of traditional birth homes (TBHs) in four rural communities in southeastern Nigeria	Users of TBHs and traditional birth attendants (TBAs) in rural southeastern Nigeria	Qualitative interviews	Local girls and women are attracted to the TBHs largely because of the sociocultural and economic responsiveness of TBH services. Women are attracted to TBHs because the services are low cost, the women require privacy about their conditions, the TBHs are close by, and the women are confident in the abilities of TBHs. Rural women are bound by poverty, culture, and local values in their choices of services.
(Jejeebhoy, Kalyanwala et al. 2010) [India]	To shed light on the experiences of unmarried young abortion-seekers aged 15–24, compare their experiences with those of their married counterparts, and explore the proximate factors leading to delays in them obtaining abortions into the second trimester	Survey of abortion seekers aged 15-24 years at facilities in two poorly developed neighbouring states in north India with weak health systems, Bihar and Jharkhand (n=795) In-depth interviews with selected unmarried survey respondents (n=26)	Survey and in-depth interviews	Thirty-seven percent of married (n=246) respondents reported economic reasons for abortion.
(Jerman, Frohwirth et al. 2017) [United States]	To examine the breadth of barriers, beyond those related to individual state-level abortion restrictions, that such women encounter and any associated consequences	Patients seeking abortion services (n=29)	In-depth interviews	"Concerned about how a pregnancy and giving birth would impact her role as caregiver for a sick family member, her own health and her job, Julia had decided to terminate the pregnancy." Because women often cite reasons for abortion such as an inability to afford a child, the desire to better care for existing children, and the wish to maintain their job or finish school, it stands to reason that being prevented from having a wanted abortion could adversely affect mental health and wellbeing. The authors' findings support this idea.
(Johansson, Le Thi Nham et al. 1996) [Vietnam]	To explore the circumstances of abortions from women's perspectives	All women in the two villages who had had an abortion during 1991	Analyses of public health data and interviews	The most common reasons given for having an abortion were financial, such as wishing to save money to build a house or wanting to avoid being fined for having too many children. One woman recalled: 'My husband was even more concerned than me. He was afraid of having to pay the

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				fine if we had a fifth child. He complained that the family was not rich enough to feed so many mouths.... He wanted me to have an abortion, and finally I complied with his request.'
(Johnson, Horga et al. 1996) [Romania]	To combine quantitative data from a previous report of the research with women's own words about the following issues: their decisions to have an abortion, the impact of abortion restrictions under the Ceausescu government, and their needs and desires for improved reproductive health services. To present gynaecologists' views of abortion restrictions and needs for improved family-planning services to make a compelling case for the need for safe, legal, comprehensive abortion care in Romania and elsewhere	Women who were seeking or obtained an abortion	Qualitative interviews and focus groups	Interestingly, most women's decisions to terminate their pregnancies were based not on their fear of immediate or delayed physical complications, but rather on their immediate economic difficulties or simply their (and/or their spouse's) unpreparedness for another child. Respondents' expressions of economic difficulties ranged, including a woman who said, 'We have a new apartment and we have to work.'
(Jones, Upadhyay et al. 2013) [United States]	To fill in the gaps about how women pay for abortion services. To provide insights into why women with private health insurance do not use it to pay for abortion services and the role of financial assistance in subsidizing these costs. To examine the ancillary expenses	Clinic patients seeking an abortion or having an abortion follow-up appointment at purposively sampled facilities, aged 15 or older, and able to speak English or Spanish	Survey	Substantial minorities of women who obtained money from abortion funds and family members also characterized the experience as "lifesaving," although few women who obtained money from men indicated this response.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	that many abortion patients incur and how women feel about requesting financial support			
(Kalyanwala, Zavier et al. 2010) [India]	To seek information from a survey about the experiences of unmarried young women in India who seek to terminate an unintended pregnancy	Unmarried women seeking abortion	Survey of women seeking abortion	One factor that is clearly associated with prompt abortion-seeking is the support of the partner. Our findings showed that partners were the leading source of support for young women. Indeed, women whose partner did not fully support them were more likely than those whose partner gave both emotional and financial support to have had a second-trimester abortion rather than one in the first trimester. We also found that young women who confided in and were accompanied to the facility by their mother were more likely to obtain a second-trimester abortion than a first-trimester procedure, and this may be explained by how women seek assistance. For example, we hypothesize that young women are most likely to confide in their partner, and if he does not provide emotional or financial support, or if the respondent is not in a position to involve her partner, she would then turn to her mother, other family members or friends. Hence, women who had a supportive partner were more likely than others to have obtained first-trimester abortion, whereas lack of partner support—and consequent reliance on the mother and others—delayed the abortion-seeking process into the second trimester. It is notable that young women were reluctant to confide in their father or other male relatives, and that overall these family members were less likely to offer support than were partners, mothers, other female relatives ends.
(Kinoti, Gaffikin et al. 2004) [sub-Saharan Africa]	To provide a basis for continued policy dialogue and reform to address the problem of death due to abortion complications among the East, Central and Southern Africa Health Community countries	Abortion complication patients and health providers at selected districts and tertiary care hospitals in three countries (Uganda, Malawi, Zambia)	Literature review Reviews of logbook data and interviews	In Uganda, 76% of the providers (80% of the doctors) indicated economics as a reason for women seeking abortion. Overall, there was a significant difference (p=0.001) between the proportion of doctors (60%) versus nurses (25%) who felt that economics was a reason why women in their hospital seek an abortion.
(Loeber and Wijsen 2008) [Netherlands]	What are the most important motivations and reasons for delay of women who have had a	Consecutive files of women at three different clinics in 2007: at clinic A, 100	Review of clinical records and registry data	Reasons for having an abortion that were much less frequent include spacing of children, study/work, no wish for children, older age, health or financial problems. Often several reasons were mentioned, for example, too early, no finances, still a student and no stable relationship were often

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	second trimester abortion? Are there specific sub-groups of women who are more likely to have later abortions? Are there aspects of abortion service delivery that cause delays in obtaining an abortion until the second trimester?	women with a pregnancy of 18+ weeks, of whom 70 came from abroad; at clinic B, 94 mostly Dutch women with an abortion between 12–22 weeks of pregnancy, of whom 15 came from abroad; and at clinic C, 60 women up to 14 weeks of pregnancy, of whom 8 came from abroad		combined.
(Margo, McCloskey et al. 2016) [United States]	To examine the impact of state policies along with other barriers when women seek abortion care	Women in South Carolina who obtained an abortion	Interviews	Many women spontaneously described multifaceted reasons for their decision. Most described being unprepared to care for a new child in the manner they would like. Often their unreadiness was related to unstable finances, employment or housing, or to their relationship with the man involved in the pregnancy. A 28-year-old white woman who lived in a rural area noted that her boyfriend had three roommates and that she didn't "make enough to pay all of my bills [while living] at my grandmother's house, so there's no way that we would have been able to afford a little one at the moment." A 20-year-old multiracial woman who lived in an urban area shared similar concerns: "[I'm] already struggling with my first child. In all reality, I got to look at the what-ifs and how things are going to be along down the line. Working a minimum-wage job and trying to take care of me and my child and [not having] my own place is already really hard. I know how it would be with two [children], so that's really it." A few women focused on a desire to preserve the capacity to continue their education or career. Some women said that they either felt unready for or were finished with childbearing.
(Medoff 1999) [United States]	To estimate the demand for abortion by teenagers (ages 15–19) for the year 1992	Teenagers and their abortion demand	Pooled time-series estimates	Teenage women have 46 more abortions per 1,000 pregnancies in Medicaid states. Labor force participation is significantly positive while Christian Fundamentalism is significantly negative. Consistent with the cross-section results, marital status is not a significant determinant in a teenager's abortion decision. Teenage abortion decreases during recessions and increases during expansions. Education is not a significant determinant of teenage abortion demand. The AFDC benefits variable is positive and statistically significantly different from zero. In the long run,

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				decreases in AFDC benefits decrease teenage abortion demand. This result is consistent with the work of Akerloff, Yellen, and Katz (1996) who argue that decreases in the financial incentives for having a child may result in a long-run modification in teenage sexual behavior.
(Medoff 2000) [United States]	To analyse abortion demand by black women	Black women in cross-sectional state data from 1992	Econometric analysis of time series data	Abortion is a normal good with respect to income for black women. The income elasticity of demand, evaluated at the sample mean, is 1.25. The estimated black income elasticity of demand figure is more than 50% higher than the figure reported for all childbearing women. This suggests that black abortion demand is considerably more responsive to income changes than it is for white women. This finding bears out Kenneth Clark's argument that increases in income cause changes in black personal and family aspirations making abortion increasingly a more acceptable and desirable option.
(Mitchell, Kwizera et al. 2010) [Mozambique]	How do women in Maputo evaluate method choices and experiences? How do individual women choose whether or not to pursue a home-based abortion method and how might their perspectives vary based on their personal circumstances, prior experiences, the quality of care rendered, and the clinical outcome? What do women and nurses think about participating in clinical abortion research?	Women seeking abortion in Maputo	Interviews with women and nursing professionals	Nurses identified demanding work or travel as perceived barriers to misoprostol use and study participation. Pregnant women who entered the misoprostol study were more likely to be studying and living in rented housing raising the possibility that the monetary reimbursement (US$14) could have played a role in their method choice. Although infrequently mentioned by women, nurses noted that some women voiced concerns regarding potential study involvement. Nurses noted that some women were anxious about possible hidden motives behind the reimbursement.
(Molland 2016) [Norway]	To estimate the benefits of increasing abortion access to teenagers in Oslo	Teenage women in Oslo	Analysis of national data using a difference in difference approach and others	Starting in 1969, teenagers in Oslo had access to abortion services that were generally denied to teenagers in other parts of Norway. Mapping into birth cohorts, this implies that cohorts born between 1951 and 1954 had much better access as teenagers in Oslo than in the rest of the country. This abortion access translated into lower rates of teen fertility, higher age at first birth and a small increase in completed family size. Evidence also shows that greater abortion access led to higher educational

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				attainment, and teen abortion access led to higher labor market attachment at younger ages but lower attachment after about age 35. These findings are consistent with abortion leading to a delay in fertility that increases labor market attachment at younger ages but decreased it later. Finally, early abortion access led to lower teen pregnancy rates and welfare use in the next generation. It is also associated with a more academic high school track and increased college going. Therefore, there appear to be positive spillover effects to the next generation.
(Penfold, Wendot et al. 2018) [Kenya]	To inform improvements in safe abortion and post-abortion family planning (PAFP) services, this study aimed to explore the pathways, decision-making, experiences and preferences of women receiving safe abortion and post-abortion family planning (PAFP) at private clinics in western Kenya	Women who had received an abortion or post-abortion care service at one of nine clinics (n=22)	Semi-structured interviews	Some respondents also struggled to obtain money and had to delay obtaining the service while they gathered funds. However, most respondents viewed the services as good value. The reasons for terminating the pregnancy were most commonly that respondents were still in education or were caring for another young child.
(Roberts, Gould et al. 2014) [United States]	To describe payment for abortion care before new restrictions among a sample of women receiving first and second trimester abortions	English- and Spanish-speaking women aged 15 and older, with no known fetal anomalies or demise, presenting for abortion care at one of 30 facilities throughout the United States between January 2008 and December 2010 and meeting specific gestational age criteria	Interviews and regression analysis	In a multivariate analysis, living in a state where Medicaid for abortion was available, having Medicaid or private insurance, being at a lower gestational age, and higher income were associated with lower odds of reporting cost as a reason for delay. Out-of-pocket costs for abortion care are substantial for many women, especially at later gestations. There are significant gaps in public and private insurance coverage for abortion. Other organizations, such as abortion funds, were more commonly reported as sources of payment among women with pregnancies beyond the first trimester and that women receiving abortions after 20 weeks were likelier to have had financial assistance from insurance and other organizations than women receiving first trimester abortions. In addition, the findings echo existing research documenting increased travel costs associated with obtaining abortion at later gestational ages.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Suffla 1997) [South Africa]	To explore participants decision-making in abortions, including circumstances of procedure and perceptions of coping.	Black women who had undergone an induced abortion within a period of three months of the study (n=5)	Qualitative interviews	The economic context of four of the five women was significant in the abortion trajectories, including their reasons for obtaining abortions (e.g. not being able to afford to have a child; expense of raising children). Women also cited a desire to finish their studies or the impact on their employment as reasons for their abortions.
(Wainer 2008) [Australia]	To illuminate an important clinical question that had been inaccessible to researchers until the 1970s: What effect did an abortion have on normally rule abiding women?	Women seeking abortion services	Interviews	The most important change reported by the women was an increased capacity to run their own lives. The women discovered that they could make and carry out difficult decisions, that they could alter the course of events and exert their wishes over their destiny. Single, nulliparous women took mothering seriously and had an abortion to avoid becoming inadequate mothers. Abortion was a challenge to the married womens' sense of themselves as good mothers, and their motives related to good mothering. The working class women had histories of managing tough and challenging life events, and they used the strengths, skills and networks they had established and applied those to the abortion decision.
(Weitz and Cockrill 2010)[United States]	To understand abortion care in relation to providers of women's health care	Pregnant people seeking abortions across three clinics in two states in the U.S. Heartland	Qualitative interviews	Case study of Joy [pseudonym] who chose her general provider in anticipation of the costs being cheaper. It was more important, if the costs were the same, for Joy to use her regular clinic as it was "comfortable".
(Zamberlin, Romero et al. 2012) [Latin America]	To summarize the findings of a literature review on women's experiences with medical abortion in Latin American countries where voluntary abortion is illegal	Studies on women's experiences with medical abortion in Latin American countries where voluntary abortion is illegal	Literature review	Women perceived medical abortion as safer, more practical and less expensive than other methods.

Appendix J. Summary of studies reporting abortion-related stigma and micro-economic costs

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Acosta de Hart, Umaña et al. 2002) [Colombia]	To descriptively review Orientame's service over 25 years	People living in Bogota that are seeking care	Narrative description (historical)	The study found that women with low incomes have nearly no access to qualified service providers in general. This access is further limited for stigmatized conditions like unwanted pregnancy or incomplete abortions.
(Ahmed, Islam et al. 1999) [Bangladesh]	To find out where women go for induced abortion in rural Bangladesh today, their contraceptive practice prior to and after getting pregnant, their reasons for choosing abortion, who makes the decision for abortion, what complications they develop, and where they go for treatment for these complications	All women seeking abortion-related care at six health facilities (two rural hospitals and four static clinics) in two rural sub-districts of Bangladesh in 1996-1997 (n=143)	Semi-structured questionnaire with interviews	One study participant claimed that the doctors and staff at the facility did not give her adequate care because she was poor.
(Aiken, Gomperts et al. 2017)[Ireland]	To examine the characteristics and experiences of women in Ireland and Northern Ireland seeking at-home medical termination of pregnancy (TOP) using online telemedicine	Women who requested at-home medical TOP through online telemedicine initiative Women on Web from 2010-2015 (n=5,650) Women who completed TOP in 2010-2012 (n=1,023)	Logistic regression and content analysis of women's evaluations	The association the authors observed between having few financial resources and reporting a lack of support could be explained by a higher likelihood of experiencing stigma in communities with lower socio-economic status or by a reverse association, where lack of ability to confide in family and friends is associated with having fewer financial resources due to the inability to borrow money for the donation.
(Aiken, Guthrie et al. 2018) [United Kingdom]	To examine reasons for seeking abortion services outside the formal healthcare system in Great Britain, where abortion is legally available	Women resident in England, Scotland, and Wales who requested at-home medication abortion through online telemedicine initiative Women on Web in 2016-2017 (n=519)	Mixed methods	Key categories of circumstances and reasons for accessing abortion services outside the formal healthcare setting in Great Britain (n=209): perceived or experienced stigma (12.9%). Study participants expressed feelings of shame and embarrassment to return to clinics where they have received an abortion in the past, and/or they do not want to go to a facility in a small area as there is a lack of confidentiality.
(Baum, White et al. 2016) [United States]	To explore qualitatively the experiences of women who were most affected by restrict abortion	Women recruited from ten abortion clinics across Texas. The	Qualitative, in-depth interviews	Beyond financial costs, having to travel longer distances for care imposes social costs for women. Women's social networks were essential for helping them minimize the out-

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	laws in Texas: those who had to travel farther to reach a facility and those desiring medication abortion	purposive sample included women who obtained or strongly preferred medication abortion or traveled ≥50 miles one way to the clinic. (n=20)		of-pocket expenses associated with their clinic visits, including borrowing a car or getting a ride and assistance with childcare. However, women who expressed fear of stigma by friends and family or ways that drawing on these networks might compromise their desire for confidentiality.
(Baxerres, Boko et al. 2018) [Benin, Burkina Faso]	To document the means women use to obtain abortions in the capital cities of Benin and Burkina Faso, and to learn whether or not use of misoprostol has become an alternative to other methods of abortion, and the implications for future practice.	21 women in Cotonou and 13 women in Ouagadougou, including 5 secondary school students.	Qualitative in-depth interviews	Decision-making was often influenced by the need for secrecy, which meant that pregnancy people would travel further away from their homes to seek clinics or providers that they could consult.
(Bennett 2001) [Indonesia]	To examine the experience of premarital pregnancy and induced abortion among young, single women in Lombok, Eastern Indonesia	Single women and their families, and health care providers in Mataram, the capital city of Lombok, between August 1996 and February 1998	Ethnography	This study reports that abortion-based stigma often results in poor quality of care and increased risk of morbidity for unmarried women who have unequal access to abortion services, relative to married women. The decision of a single woman to continue a premarital pregnancy is also constrained by lack of social autonomy and the absence of acceptable alternatives.
(Bessett, Gorski et al. 2011) [United States]	To learn about women's experiences applying for subsidized insurance and to identify barriers to obtaining insurance or its use for abortion services	English-speaking women who met the eligibility requirements for subsidized insurance programs in Massachusetts: Women whose household income is less than 300% FPL, who are uninsured, who are U.S. citizens or have been permanent residents for more than 5 years, and who are Massachusetts residents (n=39)	Systematic, qualitative interviews with women	A few study participants reported that concerns about abortion stigma caused them to avoid mentioning their pregnancy or their intention to obtain an abortion to state employees and insurance advocates, compounding their difficulties in navigating the application process. Study participants also reported difficulties in obtaining accurate information regarding insurance coverage of abortion services.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Doran and Hornibrook 2014) [Australia]	Identify factors that New South Wales (NSW) rural women experience in relation to their ability to access an abortion service and follow-up care.	Rural clinics in NSW (n=7) and women who sought abortion services at those clinics (n=13).	Qualitative: Surveys and interviews	Reducing stigma and negative attitudes was mentioned by all study participants to improve access to appropriate care, service delivery and community understanding. One participant needed to visit five rural GPs before she received a referral and described the process as 'demoralising' and significantly delayed the procedure. Another participant found it challenging as she needed overnight childcare. One participant commented on 'moralistic ideology and judgement' around abortion and the propaganda about RU486, which she thought limited availability. Others had to travel 4 hours for this procedure when a curette could be offered in the local hospital.
(Ganatra and Hirve 2002) [India]	To explore adolescent women's access to abortion services, decision-making on abortion, determinants of provider choice and extent of morbidity experienced.	Women (primarily those currently married) who had undergone an induced abortion in the study area in an 18-month reference period during 1996–1998	Questionnaires and a qualitative in-depth time-line of sequence of events	Private practitioners provided young women the confidentiality they needed and were a reasonable distance away, but the cost of their services was high and so they were accessed only by those girls with financial support from their parents or brothers. One young girl, who was asked to pay Rs. 1200 (US$25) for a first trimester abortion, was told: ''Yes, I can do it. You can go home in two hours. No one will come to know. But for illegal cases like yours, I am taking a big risk. I have to charge accordingly.'' (private provider, male)"
(Hung 2010) [Hong Kong]	To describe the experience of teenage women in Hong Kong from deprived backgrounds who seek an abortion and the extent to which their access to legal services is constrained by age, income and class.	Young women [n=29] from deprived backgrounds in Hong Kong who had had an abortion, and key informants [n=4]	Qualitative cross-sectional descriptive	Five of the respondents, either out of their own savings or with the financial support of family members, were able to afford the costs of private medical services, including visiting private doctors and having the abortion in a private hospital which is of better quality, less stigmatized and can better ensure privacy than using public services.
(Potdar, Fetters et al. 2008) [Cambodia]	To describe the loss of productive time and income related to abortion care and care-seeking.	160 women seeking elective abortions or care for complications of abortion from a purposefully selected group of public and private clinics and hospitals.	Cross-sectional survey	The stigma that surrounds abortion prevents many women from making informed and educated choices about an unwanted pregnancy. The results of this study indicate that the amount of time and money spent accessing information and appropriate abortion care is highly variable, even in Cambodia, where abortion is technically legal and theoretically safe. Women's inability to make informed decisions because of a lack of reliable information affects not only her health but also the direct and indirect costs of her care.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Raifman, Anderson et al. 2018)	To explore capacity of University of California (UC) and California State University (CSU) student health centers (SHCs) to provide medication abortion (MA) and SHC staff perspectives on providing MA.	Providers and staff at student health center	Mixed methods	Survey responses indicated that cost, fear of protesters, lack of providers, lack of family support are all barriers to students seeking abortion services.
(Singh 2010) [Global]	This article will review the scientific evidence on the consequences of unsafe abortion, highlight gaps in the evidence base, suggest areas where future research efforts are needed, and speculate on the future situation regarding consequences and evidence over the next 5–10 years.	Women who obtained unsafe abortions globally.	Literature review	Studies in Uganda and Zimbabwe show similar findings regarding the attitudes of men towards women who have abortions: most men perceive that women who have had or are having abortions are doing so because they are pregnant by a man other than their husband, and state that they would not provide support (financial or otherwise) to a woman in such a situation to help her obtain the abortion or postabortion care.
(Wu, Maru et al. 2017) [Nepal]	To review abortion care in Nepal 15 years after it was legalized.	n/a	Review	Fear of stigma also prevents some women from seeking abortion services. According to one study focused on young women, many such women do not seek abortion for an unintended pregnancy due to several factors, including partner and family influences as well as limited socioeconomic resources.

Appendix K. Summary of studies reporting abortion-related stigma and micro-economic impact

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Aiken, Johnson et al. 2018) [Ireland]	(1) to examine the factors affecting whether women in Ireland choose to access abortion by travelling or by using online telemedicine; and (2) to explore their experiences in accessing care through each pathway	Women (n=38) identified through three organisations: Women on Web, Abortion Support Network, For Reproductive Rights Against Oppression, Sexism and Austerity. Criteria: aged over 18, had an abortion within 8 years of study, lived in Ireland at time of abortion, had travelled or used telemedicine to access abortion care.	Qualitative in-depth interviews	Fears and judgement led pregnant people in Ireland to travel for their abortions: Study participants reported that their fears in confiding with their local doctor would negatively impact their relationship, and were therefore motivated to travel to receive an abortion.
(Bennett 2001) [Indonesia]	To examine the experience of premarital pregnancy and induced abortion among young, single women in Lombok, Eastern Indonesia	Single women and their families, and health care providers in Mataram, the capital city of Lombok, between August 1996 and February 1998	Ethnography	Participants in this study felt that while abortion was a sin, it was also acceptable in certain circumstances. In the focus group discussions, they tended to focus on whether marriage was possible and the wishes of the man involved. Many felt that abortion was preferable to continuing a pregnancy if he refused to take responsibility or rejected marriage as a solution. Study participants often argued that causing personal and family shame, having a child out of wedlock and raising a fatherless child were greater sins than abortion.
(Brack, Rochat et al. 2017) [Colombia]	To identify the key barriers to legal abortion, and to explore the ways they may work separately and together to delay the receipt of high quality, legal abortion care	Women who had obtained a legal abortion in Bogotá, Colombia (n=17). Women were eligible for inclusion if they were aged 18 or older, had obtained an abortion in the past 12 months and exhibited	Qualitative: In-depth interviews with women	Three study participants described the stigma attached to having a child, in contrast to the stigma of having an abortion, given their current educational endeavors, and romantic and financial situations. They noted that in Colombian society, people pass judgment on single mothers and think poorly of them for having to drop out of school, for having a child out of wedlock and for being unable to afford the child. These participants stated that their families would also judge them for these reasons.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
		verbal proficiency in Spanish		
(Moore, Dennis et al. 2018) [Zambia]	To compare the financial costs for women when they have an induced abortion at a facility, with costs for an induced abortion outside a facility, followed by care for abortion-related complications	Women seeking care at two public hospitals and two private clinics, one each in Lusaka and in Kafue districts in Zambia. The data were collected from women (n = 38) obtaining a legal termination of pregnancy (TOP), or care for unsafe abortions (CUA).	Mixed methods: household wealth data at one point in time (T1) and longitudinal qualitative data at two points in time (T1 and T2, three-four months later), in Lusaka and Kafue districts, between 2014 and 2015.	In some cases, other costs were opportunity costs which were incurred as the news of the abortion spread and stigma was enacted on the woman in her social or professional life. One woman described being “chased” from her job because of her abortion, and had to find a new job elsewhere.

Appendix L. Summary of study reporting abortion-related stigma and micro-economic benefits

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Svanemyr and Sundby 2007) [Cote d'Ivoire]	To analyse how illegally induced abortion is understood in terms of social processes.	Women seeking care for abortion complications and key informants	Qualitative cross-sectional	Muslim women are seeking to give priority to education and financial independence so they prefer abortion even though this is strongly in opposition to their values and norms.

Appendix M. Summary of studies reporting meso-economic costs

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Aantjes, Gilmoor et al. 2018) [eastern and southern Africa]	To identify and synthesize the literature on postabortion care (PAC) in eastern and southern Africa with the aim of reporting on the reach, quality, and costs of these services	Varied by studies on PAC, health workers, and abortion-related service reviews	Systematic review	Medical abortion (MA) is the cheapest method followed by manual vacuum aspiration (MVA) and then dilatation and curettage (D&C). In Malawi in the absence of complications, researchers estimated MA to cost U$ 12, MVA to cost U$ 19, and D&C to cost U$ 19. In the presence of complications, PAC costs increased to U$ 63 for severe non-surgical complications and U$ 128 for severe surgical complications. In South Africa, researchers estimated MA to cost U$ 61 and MVA to cost U$ 69. In Swaziland, MA cost U$ 75 and D&C cost U$ 115. In Rwanda, PAC costs were higher if treated in regional health facilities (U$ 239) than in district hospitals (U$ 93) or health centres (U$ 72). Treatment costs for one instance of post-abortion morbidity represented more than three times the annual per capita health expenditure in Uganda and more than five times that in Ethiopia. Law reform and provision of safe abortion could cut this expenditure by 2-2.5 times.
(Acosta de Hart, Umaña et al. 2002) [Colombia]	To descriptively review Orientame's service over 25 years	People living in Bogota that are seeking care	Narrative description (historical)	Clinics offer a sliding scale of fees for services, so that the 40% of patients with higher incomes subsidize the 60% with lower incomes. This practice allows the clinics to be self-supporting. When there has been more income than costs, the money has been invested in community-based programs in the slum areas of Bogota.
(Afable-Munsuz, Gould et al. 2007) [United States]	To: 1) describe the range of practice models, in terms of staff mix and number of visits, used to provide medication abortion in 11 abortion care settings across the United States; 2) document financial	Abortion-seeking patients, facility staff and managers, administrative facility documents, and medical chart at 11 sites across the United States	Mixed methods	Total cost per episode includes direct staff costs (clinical and nonclinical costs), space costs, and indirect costs. The mean total episode cost across sites was $346 (range $252-460). Costs for medication ranged from $80 to $102. Clinical staff costs were highest for medical doctors (mean of $38). The mean cost for nurse practitioners/physician's assistants/sonographers

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	costs, including staff salary costs, to providers of medication abortion in the 11 abortion care settings; and 3) examine whether variation in practice models is associated with variation in cost and/or patient satisfaction			ranged from $12-52. The lowest mean cost ($19) was for medical assistants/social workers/registered nurses. Total staff time with each patient ranged from 37-103 min. Total staff costs ranged from $27-122. Sites with a mix of nurse practitioners and medical assistants were able to provide more staff time with the patient while maintaining moderately low clinical staff costs.
(Anjum 2000) [United Kingdom]	An audit to assess the efficacy, practicality and cost-effectiveness in clinical practice	All women presenting for medical termination of pregnancy before 63 days of gestation at the Northern General Hospital in Sheffield (n=369 terminations)	Clinical audit	Reducing the dose of mifepristone from 600mg (costing £41.83) to 200mg could save £28.60. Using misoprostol as part of the treatment regimen cost £48 and was significantly cheaper than gemeprost.
(Ayanore, Pavlova et al. 2017) [Ghana]	To explore what direction women perceive gender roles to influence their reproductive choice and care	Data from women with records of recent birth (max 2 years prior to study) (n=90), health staff (n=16), policymakers (n=6)	Qualitative ethnographic study using focus groups and in-depth interviews	At the community, facility, and district facility levels, PAC services are neither provided nor covered under the antenatal/postnatal fee exemption policy under the health insurance scheme. To account for these charges, staff members asked women to pay (US$ 25) for care.
(Babigumira, Stergachis et al. 2011) [Uganda]	To perform a comprehensive assessment of the economic burden of induced abortion in Uganda in terms of its costs	Databases on abortion incidence and cost throughout Uganda	Cost analysis	The national annual expenditure on induced abortion is projected to be $23.6 million in direct medical costs and $7.0 million in direct non-medical costs. Most healthcare costs can be attributed to the treatment of the complications of unsafe abortions. Per case, the average direct medical cost was $65 (range $49–$86), and the average direct non-medical cost was $19 (range $16–$23).
(Baird 2015) [Australia]	To consider the context through which medical abortion (MA) has become available in Australia since 2013	Narrative review of the introductive of MA in Australia	Mixed methods: Historical analysis complemented by expert interviews	In addition to the cost of the MA drugs, there are medical practitioner consultation fees, ultrasound costs, and blood tests or other tests. Insurance companies that provide medical indemnity initially considered the risks of providing MA to be the same as providing surgical abortions. Doctors who may have considered incorporating MA into their practice were thus faced with a prohibitive annual increase in their medical indemnity insurance. After this disparity was remedied at the end of 2014, one doctor hope that the extensions of the authorised use of mifepristone would ease the

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				time pressure and enable more general practitioners to incorporate MA into their practice. In Victoria, the uptake of MA in rural settings was supported by offering information and training sessions; as a result, two additional general practices provide MA and only charge the patient the cost of the medication. An Australia-wide telephone consultation home medical termination of pregnancy service has been developed to reach women in rural areas with limited access to abortion services.
(Baird 2017) [Australia]	To argue that while decriminalization is consistent with feminist goals and human rights principles, unless there have been specific legal restrictions on abortion provision beyond defining the legality of doctors' authority to decide, it will make little or no challenge to the sources of inadequate access to abortion in Australia	Documentary evidence in four Australian jurisdictions and interviews with experts	Literature review and expert interviews	In the early 2000s, the clinic had about ten lawsuits against it. Plaintiffs alleged various forms of poor practice, most in relation to abortion. Most women were supported by Catholic anti-choice agencies. Then the HIH Insurance company went into provisional liquidation. The abortion clinic and its doctors were forced into more expensive insurance arrangements. Whilst the clinic was committed to means-tested fees and "payment plans," the opportunity for women to pay for their abortion over time became financially unviable.
(Battistelli, Magnusson et al. 2018) [United States]	To improve understanding of the organizational facilitators of and barriers to the provision of abortion care by nurse practitioners, certified nurse midwives and physicians' assistants. Specifically, our qualitative analyses examined how organizations participating in Health Workforce Pilot Projects implemented changes to their provision of abortion care following the law's implementation in California	20 administrators from five organizations based in metropolitan areas that operate abortion clinics	Qualitative: interviews	Shifting services among provider groups had logistical and financial costs. Participating organizations were tasked with moving nurse practitioner, certified nurse midwife and physicians' assistant abortion provision from the research environment to every-day clinical practice. Interviewees described interrelated disincentives to instituting these changes that could be broadly categorized as organizational reliance on physicians, reduced demand for abortion services and state Medicaid reimbursement rates. The shifting of clinician roles can require changes in clinical operations and staffing that sometimes cost an organization more, at least in the short term. Several respondents cited the state's low Medicaid reimbursement rate for abortion services as a key driver of the maldistribution of care. Some organizations consolidated abortion services into

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				a few high-volume clinics to be economically sustainable.
(Baxerres, Boko et al. 2018) [Benin and Burkina Faso]	To document the means women use to obtain abortions in the capital cities of Benin and Burkina Faso To learn whether or not use of misoprostol has become an alternative to other methods of abortion and the implications for future practice	Women in Cotonou (n=21) and in Ouagadougou (n=13), including 5 secondary school students	Qualitative in-depth interviews	In Burkina Faso, health centres used curettage, MVA, and injections to induce abortions. Fees were recorded as 30,000 CFA (US$ 48.50) in public health centres and 60,000 CFA (US$ 97) in private clinics. In Benin, the general consultation fee at of the few private clinics in Cotonou was expensive (upwards of 10,000 CFA or US$ 16.18). Small private health centres, found in the southern part of the country, charge comparable prices (between 15,000-55,000 CFA or US$ 24.50-89) to public health clinics.
(Belton and Whittaker 2007) [Thailand]	To examine the need for provision of reproductive services to displaced populations, specifically Burmese migrant workers along the border with Thailand	Burmese women with postabortion complications (n=43), lay midwives (n=15), health workers (n=20), male partners of women with postabortion complications (n=10), and community members	Mixed-methods ethnographic study involving a retrospective review of medical records, directed group discussions, semi-structured interviews, and informal conversations	The cost of 116 days of PAC in the hospital for 31 women was 71,432 Baht (US$ 1,748). Mae Tao clinic paid the costs of cases they referred to the Thai hospital; self-referred undocumented migrant workers paid for their own care. Misoprostol, reportedly used in the past, no longer appeared to be available in Mae Sot. Induced abortions conducted by trained medical staff can be obtained at private clinics in regional towns. Fees ranged between 3,000 and 7,500 Baht (US$ 70-174) depending on the service and gestation of the pregnancy. Their illegality forces the prices up, and little follow-up care exists.
(Benson, Nicholson et al. 1996) [Sub-Saharan Africa]	To document the magnitude of abortion complications in Commonwealth member countries and document the research gaps	Literature on women seeking unsafe abortion services in sub-Saharan Africa	Literature review	The study in Kenya found that the average length of stay was shorter for patients treated with manual vacuum aspiration (MVA) versus sharp curettage (SC); the reduced patient stay resulted in lower hospital costs. The cost of treating incomplete abortion patients with MVA was much less than that associated with SC. The average cost per SC patient in one district hospital was US$ 15.25; MVA decreased the cost by 66%. These reductions reflected decreases in the amount of resources used (e.g. staff time, bed space, pain medication). A study in Nigeria found that average treatment costs for a septic abortion patient were US$ 223.11. It cost the hospital an average of US$ 7.50 per

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				patient to treat abortion complications compared to an annual Ministry of Health per capita budget of US$ 1.00.
(Benson, Okoh et al. 2012) [Nigeria]	To: (1) describe current postabortion care (PAC) caseloads and treatment regimens in selected study public hospitals; (2) calculate estimates of the per-case costs of treatment of abortion complications; and (3) calculate estimates of annual costs of treatment of abortion complications in all public hospitals in the three study states	PAC-providing public hospitals in Ogun, Lagos, and Abuja (n=17)	Survey/data collection tool	PAC treatment with moderate complications cost an average of US$ 112 per case, 60% more than a simple PAC case (US$ 70). Treating a PAC case with severe complications (US$ 258) was >3.5 times the cost of treating a simple PAC case. Estimated per-case costs of each procedure varied widely across facilities: MVA/electric vacuum aspiration (EVA) (US$ 43 to US$ 141); dilatation and curettage (D&C)/dilation and evacuation (D&E) (US$ 44 to US$ 114); misoprostol alone (US$ 48 to US$ 129); and expectant management (US$ 32 to US$ 104). Overall average per-case cost of inpatient PAC treatment (US$ 95) was 38% more expensive than outpatient treatment (US$ 69). Reliance on physician providers contributed to overall higher costs. For the 17 study facilities, the total annual cost under current treatment conditions is US$ 274,015. All 79 PAC-providing public hospitals in the 3 included Nigeria states are estimated to spend US$ 807,442 on PAC provision annually.
(Benson, Gebreselassie et al. 2015) [Malawi]	To estimate current health system costs of treating unsafe abortion complications and compare these findings with newly-projected costs for providing safe abortion in Malawi	Malawi's health system	Estimation study based on survey and costing data	The median per-case costs for labour and supply inputs for simple uterine evacuation (UE) were approximately $7 each. Within the study facilities, the estimated median per-case cost of treatment for all PAC cases was $40. The median cost per D&C case ($63) was 29% higher than an MVA case ($49). The median cost of care for a simple PAC case with D&C ($19) was 46% higher than with MVA ($13) and 58% higher than misoprostol ($12). The estimated median per-case cost also varied by treatment category. Treatment of a case with severe non-surgical complications ($63) was almost five times higher than that of a simple PAC case ($13). Although few in number, cases with severe surgical complications were especially costly to treat ($128), almost 10 times higher than a simple case. Even within the same UE procedure type, the more severe the complications, the

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				higher the estimated per-case cost. For women treated with MVA, the cost of a severe non-surgical case was almost five times higher than that of a simple case.
(Berer 2000) [global]	To examine the changes in policy and health service provision required to make abortions safe	Wide-ranging review of published and unpublished sources	Literature review	Where abortion is clandestine and unsafe, public health services often pay for the treatment of complications in tertiary level hospitals, where costs are highest. Covering the cost of safe abortions in public health services shifts expenditure away from complicated cases in tertiary level hospitals to safe, simple procedures that can be provided in primary clinics. A Tanzanian study estimated that the cost per day of treating abortion complications, including the costs of drugs, meals, staying costs, and surgical procedures, was more than seven times the Ministry of Health's annual per capita budget.
(Berer 2005) [global]	To discuss choice and acceptability of MA from the perspective of both women and abortion providers and argues that choice of method is important for both	Review of recent papers and information presented at a conference on MA	Review	A study on the cost of MA in the public health system in South Africa found that one of the main cost drivers is the dosage of mifepristone (200 vs. 600mg). While 200mg is just as effective, many countries approved mifepristone with a regimen of 600mg before this information was available. The change to 200mg has been slow due to the high price of mifepristone, type of provider involved, whether the clinic was in a primary or secondary level facility, and the currency exchange rate affecting imported drugs. Identifying the main cost drivers shows how costs might be reduced without reducing quality of care (e.g. locally produced, generic mifepristone and misoprostol, use of a 200mg dose of mifepristone, provision in primary care clinics with mid-level providers up to nine weeks and mid-level providers in secondary level facilities after nine weeks, with back-up from obstetrician-gynaecologists). A study in India showed that neither hospital beds, operating theatre or ultrasound were required for MA, which is important for cost reduction. Unless the costs of surgical and MA are broadly similar, many women, health providers, and health insurance companies will feel they need to choose the cheaper option that limits choice.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Betala Belinga, Valence et al. 2010) [France]	To measure the actual cost of abortion within a public health facility by comparing it to the cost of similar care: an ended pregnancy (spontaneous miscarriage) requiring ambulatory care	Abortion procedures that were valued/costed and invoiced by the regional maternity unit in the regional maternity hospital in Nancy during 2008 (n=528)	Evaluation of revenue/cost data	Based on the cost evaluation of 528 surgical abortions with anaesthesia, the cost per abortion is € 562. This cost includes the direct cost of service (€ 212), the indirect block charge (€ 110), the indirect block anaesthesia load (€ 80), and the cost of hotel and logistics (€ 160). After applying the tariffs, the cost to the facility is reduced to € 180. This results in a loss varying between € 66,660 and € 87,497 for the management of surgical abortions.
(Billings and Benson 2005) [Latin America and Caribbean]	To review results from 10 major PAC operations research projects conducted in public sector hospitals in seven Latin American countries, completed and published between 1991 and 2002	Review of results of 10 PAC operation research projects in seven countries	Review	Significant improvements in PAC services can be made in public sector hospitals while simultaneously reducing the cost of service delivery. In two study sites, the UE procedure was moved from the operating theatre to an obstetrics-gynaecology ambulatory care area, resulting in reduced costs and average length of patient stay (ALOS). Treating women with incomplete abortion can absorb more than 50% of facilities' obstetric and gynaecologic budgets. The high cost of services may be a barrier to obtaining clinical services. Switching to MVA while reorganizing services to an outpatient basis tends to substantially reduce ALOS and treatment costs to the facility. In some cases, administrators passed these savings on to the patients by reducing fees. As a result of these changes, one hospital was recovering almost 98% of the full cost of providing PAC services at the 2000 follow-up compared with 45% of the cost prior to the intervention.
(Brown and Jewell 1996)[United States]	To estimate directly the responsiveness of abortion demand to county-level variations in travel-cost component of the full cost of abortion services	Abortion providers in Texas	Log-linear regressions using data that were obtained from health facilities on each abortion performed and data on the localities of these facilities	Counties with providers have higher time costs, resulting from higher median household incomes.
(Cano and Foster 2016) [Canada]	To document women's experiences seeking and obtaining abortion services	Women who accessed abortion services on/after January 1, 2005, while	Qualitative study involving semi-	All of the procedures through Whitehorse General Hospital were covered by Yukon's territorial health insurance.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	while residing in Yukon Territory, identify financial and personal costs, and explore avenues through which services could be improved	residing in the Yukon (n=16)	structured in-depth interviews	
(Chełstowska 2011) [Poland]	To examine the economic consequences of the stigmatisation and illegality of abortion and its almost complete removal from public health services in Poland since the late 1980s	Polish women	Mixed methods review of data from government documents, reports of non-governmental and international organisations, and published articles	In the private sector, a vast new, profitable market in health care emerged without any government control on price, quality of care, or accountability. If the cost of a surgical abortion is on average 2,000 PLN, and an estimated 150,000 procedures are carried out annually, that would make about 300 million PLN of annual income (approximately US$ 95 million or € 75 million) unregistered and tax-free. Neither the real number of procedures, nor the exact cost is known since the private sector is outside government control.
(Choobun, Khanuengkitkong et al. 2012) [Thailand]	To compare the hospital charges, duration of in-hospital procedures, clinical course and complications between MVA and SC	Women undergoing first-trimester abortions at the Songklanagarind Hospital (n=80)	Prospective observational study	The total hospital cost for MVA was significantly lower than that for SC, roughly a 64 % reduction in the total expenditure (US$ 54.67 vs. US$ 153.97). The most substantial costs were related to equipment and laboratory investigations, medication, and service costs; all were significantly less in proportion among MVA patients than the SC ones.
(Coast and Murray 2016) [Zambia]	To analyse the details of pathways to care, barriers and delays, and the role of others in influencing these pathways in order to develop knowledge and theorisation on abortion care-seeking behaviour and its influences	Adolescents and women aged 15-43 years (n=112) presenting for surgical abortion or PAC at an emergency ward in the Maternity Department at University Teaching Hospital in Lusaka	In-depth qualitative interviews	One participant said the 'doctor' (who may have been a doctor or a clinical officer) had asked her for K200 (£ 24.00) to go through with her treatment. This was a demand for an under-the-counter payment, not a hospital registration fee. Illegal, unofficial provider payments are quite frequently expected and paid in the formal health sector, and are an open secret. Abortion stigma gives providers leverage to extort such fees, knowing that women are desperate and unlikely to expose these financial demands for fear of revealing an abortion. When unofficial payments are paid, secrecy means that there can be substantial gaps between expected and actual costs. Some medical personnel in the public sector's gynaecology services also provided abortion-related care services at those facilities under private arrangements. The hospital had a private ward

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				and differential fee scales; there was also a difficult-to-quantify undercurrent of unofficial private practice that exploited the stigma surrounding abortion. Some providers charged high fees to women (up to 400 Kwacha or £ 48), far beyond the amounts set by the hospital (around 10—100 kwacha or £ 1.20—12 for standard procedures). Herbalists will extend a line of credit for clients, often with deferred payment until treatment has been successful.
(Cockrill and Weitz 2010) [United States]	To explore abortion patients' perspectives on abortion regulations	Abortion patients (n=20) at the only three high-volume abortion facilities in two states in the South and Midwest	Qualitative study using semi-structured interviews	Of the ten women who were insured, only two women attempted to get coverage for their abortion. The remaining women did not attempt to get coverage because they already suspected their insurance would deny them coverage or because they did not want their insurance provider, employer, or parents to know about their abortion.
(Colman and Joyce 2011) [United States]	To examine the impact of the Women's Right to Know Act in Texas (disclosure, waiting period, and surgical centre regulations) on number, timing, and cost of abortions and distance travelled	Reported data for abortions performed in Texas	Regression analysis	The charges for an abortion at 20 weeks' gestation increased about 37 % (or about $454) more in Texas between 2001 and 2006 relative to the other states. There was no relative increase in charges at 10 weeks' gestation. Recent state policies toward abortion have been targeted at the provision of abortion services. According to the major federation of abortion providers, these so-called targeted regulation of abortion provider laws can greatly increase the costs of providing abortion services. Arguably the most costly of these provisions is that abortions of a specified gestation be performed in an ambulatory surgical centre.
(Contreras, van Dijk et al. 2011) [Mexico]	To examine the experiences and opinions of health-care professionals after the legalization of abortion in Mexico City in 2007	64 semi-structured interviews with obstetricians/gynecologists, nurses, social workers, key decisionmakers at the Ministry of Health, and others	Qualitative study using semi-structured interviews	38% of health-care professionals were opposed to abortion services being provided free of charge, feeling that fees should be in place to recover procedure costs and to act as a deterrent of 'irresponsible' behaviour and repeat abortions.
(Costa 1998) [Brazil]	To examine women's experience with misoprostol and its impact on women's health	Women admitted to hospitals for abortions / PAC in Rio de Janeiro	Review: The study uses multiple data sources and reviews studies on abortions	The mean cost of misoprostol was US$ 6. In "clandestine clinics," the average abortion cost US$ 144 USD and catheter insertion cost US$ 42. Access to misoprostol was easier in smaller facilities than in larger ones.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				Inflated commercial value of misoprostol has led to reports that it is now being sold by unlicensed providers in the favelas of Rio de Janeiro and Sao Paulo.
(Couteau, D'Ercole et al. 2016) [France]	To propose a protocol for induction of labour to terminate pregnancy after 22 weeks of amenorrhea allowing to decrease the duration of labour and of hospitalization but also, allowing to reduce the number of emergency pretreatment-induced fetal death, to improve the experience of the patients and to limit the cost	Patients receiving medical termination of pregnancy (TOP) at 22 gestational weeks and beyond, in a maternity hospital, the North Hospital of Marseille (n=269)	Retrospective single-centre study	For TOP over 22 gestational weeks, the hospital receives € 1,996. The tariff remains the same for a period of hospitalization of 1 to 8 days. A day of hospitalization in the service of high-risk pregnancies and laminaria procedure cost maternity € 348 euros. The protocol put in place thus allows a saving of € 348 by termination of pregnancy.
(Creinin, Shore et al. 2005) [United States and India]	To evaluate relative differences in direct and total (direct and indirect) costs for MA regimens mifepristone and misoprostol or misoprostol alone	Modelled cost data	Modelled cost data	Although mifepristone costs US$ 83.33 for every 200-mg tablet in the United States, the actual excess cost of using a mifepristone regimen, as compared with a misoprostol-alone regimen, is only US$ 22 to US$ 32. The actual cost of a mifepristone regimen is lower than that of a misoprostol-alone regimen in India. In a hypothetical developing country, a mifepristone regimen is likely to be less expensive than regimens using misoprostol alone. Because of the higher efficacy of MA regimens using mifepristone and misoprostol and the need for fewer follow-up evaluations, such regimens are less expensive or only minimally more expensive than those using misoprostol alone.
(Creinin 2000) [United States]	To examine in a randomized trial the clinical efficacy and patient acceptance of medical abortion using oral methotrexate and vaginal misoprostol compared to surgical manual vacuum aspiration in women with pregnancies up to 49 days' gestation	Women (n=50) who were 18 years of age or older, requested an elective abortion, had a singleton intrauterine pregnancy not exceeding 49 days' gestation documented by vaginal ultrasound, were willing to be randomized to either medical or surgical abortion, were willing to	Randomized trial [with no control]	Based on a physician's hourly wage being three times that of a physician assistant and eight times that of a research assistant/counsellor, the study estimated that surgical abortion would be 10% more expensive than medical abortion. However, where the physician's hourly wage is two times that of a physician assistant, then surgical and medical abortion costs would be identical.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
		avoid intercourse for the first two weeks of study participation, had adequate venous access for multiple phlebotomies, had access to a telephone, and were willing to have a suction aspiration if randomized to medical abortion and surgical intervention was indicated		
(Crighton and Ebert 2002) [Europe; France; Germany]	To explore the impact of this controversial technology on abortion rates and practices in Europe, looking first at the EU region as a whole, then examining more closely the politics of RU 486 in France and Germany	Abortion rates, policies, and practices for each nation state	Policy analysis from published literature	Availability of services varies from clinic to clinic in many countries because physicians may choose for personal or economic reasons not to offer MA. For example, Germany and Great Britain limit access to Mifegyne indirectly because their public health systems do not cover physicians' treatment or facilities costs. Women who have just been given a prostaglandin are required to stay in the clinic for half a day or more as they wait to miscarry, so psychological support and a reasonably comfortable waiting room are minimum requirements. Since these services do not earn "performance points" under National Health Service (NHS) guidelines, clinics have little reason to introduce them. Another study listed two more disincentives for potential MA providers: the special licenses required for clinics offering these services and the high purchasing price of Mifegyne and associated prostaglandins. For medical providers, the cost of drugs and services associated with the Mifegyne+PG procedure renders surgical abortions more economic. The high cost to clinics of MA drugs and the low payment rates set by health ministries for MA providers are part of the explanation for access problems in both Germany and Great Britain.
(Dawson, Bateson et al. 2016) [United Kingdom; United States; Russia; Australia; New Zealand; Canada]	To identify quality studies of abortion services to provide insight into how access to services can be improved in Australia	United Kingdom (n=14), United States (n=7), Russia (n=2), Australia (n=2), New Zealand (n=3), Canada (n=1)	Systematic review	A study in an English primary health care trust noted that the cost of a medical TOP or a surgical TOP (day case) ranged from £462 to £578 per patient. Sharma et al.'s study of a pilot local anaesthetic outpatient surgical TOP service found that the cost could be reduced to

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				£366 per patient. However, if this involved outpatient consultation, the cost was £217 per patient; this cost could be further reduced to £177 if the nurse telephone clinic was used. The nurse telephone clinic reduced the time needed by the doctor to assess each patient, increasing the number of patients that could be seen per clinic. Research in the United Kingdom also examining a local anaesthetic outpatient surgical TOP service found that a cost savings was made of approximately £60,000 per year and that the operating theatre use was reduced by one termination list per week.
(Dennis, Manski et al. 2014) [United States]	To answer the following questions: (1) What do women know about the cost of abortion and the availability of Medicaid coverage for abortion? (2) Where do women obtain this information? (3) What are women's experiences paying for care?	Low-income women over the age of 18 who had an abortion within the past two years within one of the four study states (n=98)	Qualitative study: semi-structured interview	State-level differences existed in the information given to women by staff at abortion facilities. Women in Arizona and Florida said they were informed that the state Medicaid program does not cover abortion or that it would be extraordinarily difficult to obtain coverage. Women in New York, Oregon, and Massachusetts were almost universally informed that coverage was available. Women reported that staff at abortion facilities directed them to enrol in Medicaid, suggesting that these staff and facilities are an underutilized resource for helping pregnant women enrol in public or subsidized insurance.
(Díaz-Olavarrieta, Cravioto et al. 2012) [Mexico]	To identify the perceptions and opinions of people who provide abortion services in Mexico City, three years after implementation of elective abortion legal reforms	Health workers assigned to the legal abortion programs at a clinic (n=10) and a hospital (n=9) in Mexico's Federal District	Qualitative: interviews	Participants associated the exclusivity of the law in the Federal District with super-saturation of services, due to the great demand of attention and insufficient material and human resources to satisfy the demand. Participants were in favour of the rest of Mexico replicating the legal reforms, as it would prevent mobilization of women from other states that is expensive and increases the workload.
(Dobie, Gober et al. 1998) [United States]	To survey 31 family planning clinic sites in rural Washington State about their sponsorship, staffing, service provision and population coverage	Family planning clinics in rural Washington (n=31)	Cross-sectional survey	The most commonly mentioned barrier to providing additional services for patients was cost. Of the clinics surveyed, only one provided abortions on-site. Federal funding of most of these sites prohibits on-site pregnancy terminations.
(Doran and Hornibrook 2014) [Australia]	To identify factors that New South Wales (NSW) rural	Rural clinics in NSW (n=7) and women who sought	Qualitative: Surveys and interviews	Affordability and availability of services, correct referral process, continuity of pre- and PAC, and integration of

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	women experience in relation to their ability to access an abortion service and follow-up care	abortion services at those clinics (n=13)		services were seen as gaps in service provision. A shortage of doctors, especially women doctors, long waiting times, lengthy travel, and cost impacted on timely access to abortion and follow-up care.
(Duggal 2004) [India]	To examine the political economy of abortion care in India by reviewing cost and expenditure patterns for abortion care in India	Literature/database review	Literature/database review	A study of abortion providers in Delhi in 2002 found that the cost of abortions varied considerably, depending on the number of weeks of pregnancy, the abortion method used, the woman's marital status, type of anaesthesia, whether acceptance of contraception was involved, whether it was a sex-selective abortion, whether any diagnostic tests (e.g. pregnancy test, sonography, laboratory tests) were carried out, medications given, location of the clinic, whether the provider was certified and the clinic registered, whether hospitalisation was required, and the nature of the competition. In the public sector, abortion services are usually free, but in recent years some states have introduced user fees or have allowed private practice by public providers. The clinic charges for an abortion ranged from Rs. 135–534 (average Rs. 370) for public providers and Rs. 394–649 (average Rs. 497) for private providers. Of these, the doctors got an average of 42%, 21% was spent on medicines, and the rest was used for hospital charges like operating theatre and bed charges.
(Dzuba, Winikoff et al. 2013) [Latin America and Caribbean)	To present evidence of MA's contributions to reduced complications, describe strategies to enhance safe MA, and highlight existing barriers to access in Latin America and Caribbean (LAC), while examining MA's role in newly legal abortion services	Literature on women seeking abortion services in LAC	Literature review	The estimated per-patient cost to treat postabortion complications in LAC is US$ 94.00. In 2009, most abortion services were shifted from hospitals to primary care clinics to facilitate access and improve quality of care. Due to primary use of medical methods, the Secretariat of Health of Mexico City (SSDF) has the capacity to attend to more than 40 women seeking abortions each day. Since mifepristone was registered in Mexico in 2012, management with MA was extended to ten-week gestations and the SSDF has further enhanced efficiency; improved outcomes and fewer follow-up visits has lowered costs. However, numerous barriers still impede access to safe abortion. In Costa Rica, misoprostol is restricted to treatment of gastric ulcers, the labelled indication, and quarterly reporting is

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				required of pharmacists who dispense it to prevent its use for abortion.
(Ely, Hales et al. 2018) [United States, Republic of Ireland, United Kingdom]	To examine the experiences of abortion fund patients in the United States (USA) and Republic of Ireland (RI), Northern Ireland (NI) and Isle of Man (IM) to compare abortion fund patient experiences across these developed nations for the first time	Select abortion fund patients within each country (n=6,340 cases; 3,995 from the USA and 2,345 from the RI, NI and IM)	Cross-sectional descriptive analysis	In a linear regression model where procedural costs were regressed on a binary variable representing the respective datasets and the number of weeks pregnant, weeks pregnant explained 44% of the variation in procedural costs, while the datasets (representing organisation or country) explained 5% of the variation, both of which were significant.
(Esia-Donkon, Darteh et al. 2015) [Ghana]	To explore the pre- and post-experiences of young people (aged 12 to 24) who had their abortion three months prior to the study	Young people (aged 12 to 24) who had their abortion three months prior to the study at the Planned Parenthood Association of Ghana Cape Coast clinic	Qualitative: in-depth interviews	Comparing the cost at the clinic to facilities elsewhere, the former was economical. The facility coordinator indicated that the facility usually provides free services to young people who genuinely did not have money to pay for the services received.
(Font-Ribera, Perez et al. 2009) [Spain]	To describe the determinants of the voluntary pregnancy interruption (IVE) delay until the second trimester of pregnancy in the city of Barcelona, between 2004 and 2005	Women who reside in the city of Barcelona who obtained abortions for physical or mental health issues between 2004 and 2005 (n=9,175)	Cross-sectional study	The time of gestation and the moment in which the IVE occurs is important because it determines the abortion method that can be used, the risk of complications and mortality, and economic cost of the intervention. As gestational age increases, the abortive technique is more invasive and expensive, and poses a greater risk to the health of women; it is also more difficult to find a provider willing to perform it. Public centres have higher proportions of second trimester IVEs than private centres.
(Foy, Penney et al. 2004) [United Kingdom]	To evaluate the effectiveness and efficiency of a tailored multifaceted strategy, delivered by a national clinical effectiveness programme, to implement a guideline on induced abortion	All 26 hospital gynaecology units in Scotland providing induced abortion care	Randomized controlled trial	The mean cost of the intervention per gynaecology unit was £ 2067, with the audit and feedback component accounting for half of this cost. Intervention costs also included staff time, travel, consumables, and administration for the unit educational meetings.
(Foster and Kimport 2013) [United States]	To analyze data on women who sought and received an abortion at or after 20 weeks' gestation for reasons other	People who were seeking abortions after 20 weeks gestation across 16 sites (n=272) and people who	Mixed methods – qualitative data from interviews and	Insurance coverage complexities were a significant barrier for some abortion seekers. The increased cost of abortions at later gestational is likely to cause significant funding and insurance issues. Delays securing public or

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	than fetal anomaly or life endangerment	presented for first trimester abortions (n=169)	quantitative data for logistic regression	private insurance were greater among people seeking second trimester abortions (41%) than people seeking first trimester abortions (20%).
(Gallo and Nghia 2007) [Vietnam]	To understand the determinants of delaying obtaining abortion until the second trimester	Clients presenting for an abortion at 13–24 weeks of gestation in 5 health facilities in 3 provinces in Vietnam (n=60); abortion service providers (n=6)	Qualitative: semi-structured interviews	The high fees charged at the facilities for second-trimester abortion could further delay late-term abortions as a result of women needing additional time to accumulate funds. Providers differed in their views of how much should be charged for abortion. One provider suggested that fees should be reduced for women who cannot afford them. Yet, providers in this study and past studies have argued that abortion fees should be set high enough to discourage reliance on abortion.
(Gan, Zhang et al. 2011) [China]	To evaluate Chinese healthcare providers' knowledge of MA, to understand their perspectives regarding the main challenges to increasing its uptake, to understand their preferences for specific abortion methods, and to investigate the role of remuneration on the decision-making process	Abortion service providers from Shenzhen and Henan (n=658)	Cross-sectional study	In the rural area, there was not much difference in cost between MA and surgical abortion, and both methods were very cheap. In the urban area, even if there was a difference in cost between the two methods, the income associated with abortion was low compared with that for other services (e.g. obstetric and gynaecologic surgeries); therefore it was unnecessary for the providers to consider remuneration when recommending an abortion method. In 5.6% of cases, the abortion clinic charged for abortion counselling, and in 10.9% of cases it charged for abortion follow-up.
(Gibb, Donaldson et al. 1998) [United Kingdom]	To measure women's preferences and strength of preferences (expressed in terms of willingness-to-pay) for MA versus surgical vacuum aspiration	Women receiving abortion services at Aberdeen Royal Hospitals NHS Trust (n=50)	"Willingness to pay' (WTP) technique	When the costs to the NHS of providing the medical and surgical methods were compared, MA was found to use 8% less NHS resources than surgical. If a choice had to be made about which service to provide, WTP and cost data indicate that MA should be chosen. As use of MA increases, the costs of maintaining the surgical facility may rise.
(Glenton, Sorhaindo et al. 2017) [Bangladesh, Ethiopia, Nepal, South Africa and Uruguay]	To explore factors influencing the implementation of role expansion strategies for non-physician providers to include the delivery of abortion care	Non-physician providers of abortion services within multiple health facilities in each country non-physician providers	Qualitative: Case study, literature review, and key informants	While managers' and co-workers' attitudes towards the use of non-physician providers varied, female clients focused less on the type of health worker and more on factors such as trust, privacy, cost, and closeness to home. Health systems factors also played a role, including workloads and incentives, training, supervision and support, supplies, referral systems, and monitoring and evaluation.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Graff and Amoyaw 2009) [Ghana]	To identify barriers to sustainable MVA supply	Literature review; stakeholders involved with MVA policy, manufacturing, procurement, training, and provision (n=70)	Situational assessment	MVA services are reportedly free when it is an emergency and the woman cannot afford the cost; otherwise prices ranged from US$ 11—33 in public regional/district-level facilities, US$ 54—163 USD in private hospitals and clinics, and US$ 3—27 in private maternity homes. In addition to charging less than physicians for MVA, nurse midwives reported lower profit margins and less sustainable access to MVA supply. Low-volume, low-income nurse midwives were most likely to report that the cost of MVA equipment is too expensive, especially in rural areas. Some nurse midwives reported that even when funds are available at health facilities, there is often no source for supply in rural areas.
(Gresh and Maharaj 2011) [South Africa]	To examine the acceptability of medical abortion among young people in Durban, South Africa. To investigate the potential demand for and applicability of the method among women in South Africa	Sexually active women at the University of Durban and under 30 years of age (n=20)	Qualitative in-depth interviews	Abortion services are free in public hospitals under the current government legislation. Abortion services at private facilities cost approximately ZAR 900.
(Grossman, Ellertson et al. 2004) [global]	To review protocols and existing evidence on follow-up care for abortion	Global literature on follow-up visits for abortion care	Literature review	The costs to the abortion clinic of the routine follow-up visit are likely multiple. The high proportion of "no-shows" complicates scheduling, burdens administrative systems, and likely has the net effect of wasting clinician staff time and increasing waiting times for patients. If a clinic counts on 50% of patients skipping the follow-up visit but more attend on a given day, the clinic may become overwhelmed and patients will have long waits. If fewer patients attend follow-up visits than anticipated, the clinic may find itself over-staffed. Inefficiencies related to missed follow-up appointments may reduce providers' availability to perform abortions or other services and drive up the costs of care.
(Grossman, Baum et al. 2014) [United States]	To rapidly assess the change in abortion services after the first three provisions [of a	All licensed abortion facilities in the state of Texas	Observational study	After the law changed, the cost of MA increased. Under HB2, providers could either use the regimen included in the Mifeprex® labelling with 600 mg of mifepristone,

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	restrictive law] went into effect			which is considerably more expensive than the evidence-based regimen, or they could use the drug dosages in the 2005 ACOG Practice Bulletin on MA. This regimen was interpreted as allowing the use of mifepristone 200 mg followed two days later by misoprostol 800 mcg orally, a regimen supported by limited evidence. The cost of the procedure increased at most facilities offering the regimen with 600 mg of mifepristone.
(Guttmacher, Kapadia et al. 1998) [South Africa]	To examine the policies that have regulated accessibility of abortion and assesses their impact on reproductive health	South African policies	Review of policies and related evidence	Data from the Medical Research Council indicate that procedures for managing incomplete induced abortions are not cost-effective, and they are not safe or widely accessible outside the major hospital centres.
(Harries, Lince et al. 2012) [South Africa]	To better understand what doctors, nurses and hospital managers involved in second trimester abortion care thought about these services and how they could be improved	Abortion-related service providers and managers in the Western Cape Province, South Africa (n=19)	Qualitative: In-depth interviews	At medical induction sites, most participants thought the combined mifepristone–misoprostol regimen would improve service capacity, though they were concerned about cost. In the medical induction service, doctors were generally aware of the superior efficacy of the combined mifepristone–misoprostol regimen compared with misoprostol used alone, but they were concerned about the cost of mifepristone. Several pointed out that using mifepristone might be cost-effective, if it reduced the duration of hospitalization. Introducing the mifepristone regimen at public sector facilities that lack trained and willing D&E providers might improve the capacity of these services to meet the needs of women seeking second trimester abortion, especially if a low-cost mifepristone product becomes available.
(Harvey and Gaudoin 2005) [United Kingdom]	To compare nurse-led service for termination of pregnancy with previous service on waiting times and cost	Data on nurse-led clinics at Southern General Hospital (n=48)	Review/analysis of descriptive statistics	The calculated annual cost of the medically led clinic was £ 37,495 - 0.40 whole-time equivalents (WTE) for a staff grade doctor (£ 22,598) and 0.43 WTE for an F-grade staff nurse (£ 14,897). The clinic could be run in its present form by a G-grade nurse at an annual cost of £ 25,943 (0.80 WTE) - a financial savings of almost 40%.
(Henshaw, Naji et al. 1994) [United Kingdom]	To estimate and compare the relative costs to the NHS of providing legal termination of pregnancy using MA or vacuum aspiration; also to	Women receiving legal abortion services at a Scottish teaching hospital (n=363)	Cost analysis	MA used 8% less of NHS resources (£ 343 vs. £ 374) when compared to vacuum aspiration. The conclusions are likely to be valid for most NHS units. Substantial NHS resource savings are unlikely to follow the widespread introduction of MA services in their current form.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	estimate and compare the relative financial costs incurred by women undergoing these procedures			
(Henshaw 1995) [United States]	To provide information on the percentage of women who travel long distances to obtain abortion services, the availability of abortion providers for second trimester services, the need to make more than one trip to the abortion facility and the amount abortion providers charge for services. In addition, it presents a measure of antiabortion harassment	Abortion providers in the United States (n= 1,525)	Cohort	In 1993, on average, nonhospital providers charged $604 for an abortion at 16 weeks and $1,067 at 20 weeks; the median charges were slightly lower. Fees ranged as high as $2,500 at 16 weeks and $3,015 at 20 weeks. In the period between the two previous surveys, 1986 to 1989, abortion charges rose more than the cost of living. For women who seek abortions with general anaesthesia, costs may be significantly higher. Relatively few nonhospital providers—33% of abortion clinics, 17% of nonspecialized clinics and 17% of physicians' offices—reported offering general anaesthesia. Sixty-three per cent of facilities that offered general anaesthesia charged extra for it, which varied according to provider type, averaging $114 at abortion clinics, $136 at non-specialized clinics and $306 in physicians' offices.
(Henshaw and Finer 2003) [United States]	To document the current status of abortion service accessibility in the United States, on the basis of data collected in a survey of all known U.S. abortion providers conducted in 2001–2002 by the Alan Guttmacher Institute (AGI)	Facilities documented in the AGI Abortion Provider Survey (n=1,819)	Quantitative; survey	Providers reported that about 13% of abortions are reimbursed by Medicaid. An estimated 13% of abortions are covered by private insurance billed directly by the facility. The proportion of providers that bill private insurance for their clients' abortions is higher than average for nonhospital providers performing fewer than 30 abortions per year and for physicians' offices (45% vs. 27%). The mean charges for a mifepristone abortion and for a methotrexate abortion were $490 and $438, respectively. Providers who used 600 mg of mifepristone charged $74 more, on average, than providers who used 200 mg. More than two in five providers (43%) charged between $400 and $499 for mifepristone, and 38% charged $500 or more. For 80% of MA providers, the basic charge for a MA included the cost of a subsequent vacuum aspiration, should an incomplete abortion or continuing pregnancy occur.
(Henshaw, Adewole et al. 2008) [Nigeria]	To examine and document the characteristics of women who are admitted to hospitals for	All women who were admitted for treatment of pregnancy loss during the	Survey using structured questionnaires	The cost of using MVA to perform an abortion was slightly higher than the cost of using D&C (3,446 vs. 3,090 naira). Because MVA is a relatively new

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	complications from unsafe abortion (or to obtain an induced abortion), the conditions under which women obtain abortions, the nature and severity of complications resulting from unsafe abortions, the type of treatment used for abortion complications, and the cost of treatment	study period as well as those who came to request an abortion (n=2,093) in 33 hospitals in eight states across Nigeria. Women reporting spontaneous abortions were included because it is not always easy to distinguish such events from induced abortions. The health care provider (e.g. attending physician or nurse) for each surveyed woman was interviewed to provide matched physician data for each respondent	in face-to-face interviews	technology, Nigerian providers may not yet have factored this lower cost into the amount they charge clients or they may be charging for single-use MVA kits. The instruments used for D&C procedures, on the other hand, last for a long time, resulting in lower costs for individual women. Unsafe abortion absorbs health care resources and creates a major problem in both the more developed and more traditional areas of Nigeria.
(Hollander 1995) [United Kingdom]	To describe evidence on the effectiveness of MA regimens	Data from two previous studies on women receiving MA care	Synthesis of two other studies	The combination of mifepristone followed by vaginal misoprostol is considerably less costly than the standard MA regimen of mifepristone and gemeprost. Nurses can manage most of this procedure that costs one-fourth of the standard regimen of mifepristone and gemeprost.
(Htay, Sauvarin et al. 2003) [Myanmar]	To describe the process undertaken by the Department of Health to address the issue of abortion complications, by integrating PAC and contraceptive service delivery into existing health care services	Women treated for postabortion complications in the hospitals (one station and four township hospitals) (n=170)	Mixed methods: structured interviews, focus group discussions, inventory of equipment and supplies within health facilities, observation checklist to assess clinical care, an informal ward round, surveys	Hospital staff members keep a fund with donations for treatment of poor patients. The community supports transportation and food. The midwife accompanies the patient to hospital to get treatment free of charge if she is poor. The midwife makes this decision, as she knows who in the village is rich or poor.
(Hu, Grossman et al. 2009) [Mexico]	To assess the comparative health and economic outcomes associated with three alternative first-	Computer-based model simulation looking at three alternative first-trimester abortion techniques	Cost analysis and projections	Given the baseline assumptions, clinic-based MVA was least costly and most effective. Hospital-based MVA was as effective as clinic-based MVA but more costly. D&C and MA using vaginal misoprostol provided comparable

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	trimester abortion techniques in Mexico City and to examine the policy implications of increasing access to safe abortion modalities within a restrictive setting			benefits, but costs associated with the latter were substantially lower. General results were the same when time and personal costs were included, though average per-woman costs increased by 6 to 34%. In comparison to the magnitude of health gains associated with all modalities for safe abortion, the relative differences between strategies were more pronounced in terms of their comparative economic costs. Even assuming 100% access to D&C, shifting to clinic-based MVA would save nearly $100,000 per 1,000 women. Relative to unsafe abortion, these savings double in magnitude.
(Hu, Grossman et al. 2010) [Nigeria and Ghana]	To explore the policy implications of increasing access to safe abortion in Nigeria and Ghana, the authors developed a computer-based decision analytic model that simulates induced abortion and its potential complications in a cohort of women, and comparatively assessed the cost-effectiveness of unsafe abortion and three first-trimester abortion modalities: hospital-based D&C, hospital- and clinic-based MVA, and MA using misoprostol	Available clinical and cost related data for abortion care services in Nigeria and Ghana	Decision analytic model	Costs related to complications ranged from 9—26% of total costs for surgical strategies and were substantially higher for MA with misoprostol (31—57% of total costs), largely due to method failure without complications. In Nigeria, clinic-based MVA was the least costly and most effective option; therefore, it dominated the competing strategies. While equally as effective as clinic-based MVA, hospital-based MVA was the most expensive strategy. D&C and MA using vaginal misoprostol provided comparable benefits although the latter was less costly. In Ghana, MA was the most cost-effective option owing to its low procedural cost (approximate one-third the cost of clinic-based MVA). Clinic-based MVA was more effective than MA but was associated with a cost of $16,855 per life-year gained. Hospital-based MVA and D&C were more expensive and no more effective than clinic-based MVA; therefore, they strongly dominated. When the analysis was conducted from a limited health payer perspective that considers the direct medical costs of only abortion-related complications (not the original procedure), MVA (either clinic- or hospital-based) was the least costly and most effective strategy in both countries.
(Ilboudo, Greco et al. 2016) [Burkina Faso]	To estimate the costs of six abortion complications treated in two public referral hospital facilities in	PAC-registers	Retrospective review	Across six types of abortion complications, the mean cost per patient was US$ 45.86. Treatment costs of abortion complications in both hospitals ranged from US$ 23.71 for an incomplete abortion to US$ 85.08 for a

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	Ouagadougou and the cost saving of providing safe abortion care services	Key-informant interviews in maternity wards and in hospital facilities		case of infection/sepsis. Incomplete abortion and haemorrhage were the least expensive services, at US$ 23.71 and US$ 26.30 per case, respectively. Uterus perforation and infection/sepsis were the most expensive services at the tertiary level teaching hospital at a cost of US$ 73.76 and US$ 94.39, respectively. The average per-patient cost of treating any complication of abortion was US$ 45.86. This cost was higher in the tertiary teaching hospital compared to the secondary-level hospital: US$ 51.09 versus US$ 36.50, respectively. The total cost to these two facilities for treating the complications of abortion was US$ 22,472.53 in 2010, equivalent to US$ 24,466.21 in 2015. Provision of safe abortion care services to women who suffered from complications of unsafe abortion and who received care in these public hospitals would only have cost US$ 2,694, resulting in potential savings of more than US$ 19,778.53 in that year.
(Jerman and Jones 2014) [United States]	To document several measures of access to abortion services in the United States--cost, gestational age limits, and harassment--using data from the Guttmacher Institute's most recent Abortion Provider Census To assess regional differences in abortion access	All known abortion-providing facilities in the United States were asked to respond to the survey (n=1,720)	Survey	In 2011 and 2012, the median charge for a surgical abortion at ten weeks gestation was $495. By comparison, the inflation-adjusted charge for the same procedure in 2009 was $503, suggesting little to no change. The cost of abortion varied by facility type and gestational age. Abortion clinics charged the least for a surgical abortion at ten weeks' gestation ($450); abortions were most expensive at physicians' offices ($550). Facilities with the largest caseloads charged the least ($450), and those that performed fewer than 30 procedures per year charged the most ($650). In 2011, the median charge for early medication abortion was similar to surgical abortions at ten weeks' gestation at $500, although the average amount women paid was slightly higher than that for a surgical abortion at ten weeks ($504). Adjusting for inflation, the median charge for early medication abortion in 2009 was $524.Abortions at 20 weeks' gestation typically take two or more days to complete and involve greater skill and resources. The median charge for an abortion at 20 weeks' gestation in 2011 and 2012 was $1,350. That the

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				number of early medication abortions increased during this period and could be a both a cause and a consequence of the small drop in the cost of this procedure; greater demand may have resulted in a lower cost, or lowering the cost could have made it more affordable for more women. Median charges for abortion showed little to no change over time and may represent an effort on the part of providers to keep services affordable, in spite of increases in both restrictions and related costs of health care provision.
(Johnston, Gallo et al. 2007) [Uganda]	To establish the utility of the model and assess the order of magnitude of the difference in costs of care when different service delivery approaches are used	Data from the Ugandan Safe Motherhood Programme Costing Study	Cost estimation and analysis	The 'savings' model suggests that regardless of whether abortion law is restrictive or liberal, a recommended approach based on recommended technical interventions for abortion-related care delivered at a decentralised level could substantially reduce costs compared to a conventional approach. For example, changing from the restricted conventional setting to the restricted-recommended setting decreases the mean cost per unsafe abortion complication case by 43% (i.e. from $45 to $25). Similarly, the use of the liberal-recommended scenario instead of the liberal conventional scenario reduces costs by 81% (i.e. from $34 to $6). The greatest reduction in costs is associated with changing from the conventional system within a restrictive law setting (restrictive-conventional) to a planned, decentralised system within a setting that allows legal, elective abortion (liberal-recommended). This change decreases the mean case cost from $45 to $6, representing a savings of 86%. Although the model calculates the estimated savings as dollars, the saved resources (e.g. staff time, equipment, and supplies) are unlikely to be realised as a reduction in health care costs. Instead, these savings likely would be shifted to other patient services.
(Johnston, Oliveras et al. 2010) [Bangladesh]	To present collected health system expenditure data and then used the Savings model to estimate comparative costs to the health system of	Data on menstrual regulation and abortion complication care from select facilities in Dhaka, Barisal, and Sylhet divisions	Cost comparison and analysis	This study analysis confirmed that on a per-case basis, the incremental costs of providing menstrual regulation and related care following recommended practices (including use of MVA for UE, providing services in outpatient facilities, having mid-level providers offer UE

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	providing menstrual regulation and care for abortion complications			and other care, and providing contraceptive counselling and services) are much lower than those associated with providing care for abortion complications. The application of Bangladesh data to the Savings model demonstrates that on a per-case basis, provision of menstrual regulation care cost 8-13% of the cost of treatment for severe abortion complications, depending on the level of care at which menstrual regulation and PAC were offered.
(Johnston, Akhter et al. 2012) [Bangladesh]	To assess incremental health system costs of service delivery for abortion-related complications in the Bangladesh public health system and confirmed that providing PAC with vacuum aspiration is less expensive than using D&C	Public-sector health facilities in Bangladesh (n=17)	Qualitative: purposive sampling and informational interviews	Providing PAC with vacuum aspiration is less expensive than using D&C. Treatment for severe complications, including surgical care for vaginal, cervical, and uterine lacerations, was three times as expensive as treatment for moderate complications. Care for moderate complications was less expensive to the health system when provided at the primary as opposed to the tertiary level. Implementing several evidence-based best practices, such as replacing D&C with vacuum aspiration, reducing use of high-level sedation, authorizing mid-level providers to offer PAC, and providing postabortion contraceptive counselling and services to women while still at the health facility, could increase the quality and cost efficiency of PAC.
(Jones and Weitz 2009) [United States]	To provide a legal review of a set of laws that directly target abortion providers, which ultimately has a significant capacity to reduce access to and quality of abortion care in the United States by making the provision of abortion more difficult and costly and providing strong incentives for physicians not to offer abortion services	Review of laws in the United States	Review	Twelve states restrict abortion coverage in insurance plans for public employees, and five states restrict insurance coverage of abortion in private insurance plans. Combined with the public controversy over abortion, confusion over insurance coverage prompts many women to pay out of pocket rather than seek coverage clarification. Some abortion clinics do not accept third-party payers.
(Jones, Ingerick et al. 2018) [United States]	To examine differences in abortion service delivery according to the policy climate in which clinics must operate	All known abortion-providing facilities in the United States (n=1,662)	Cross-sectional study	Abortions at later gestational lengths require greater technical skills and resources; in turn, it costs more. In 2014, the median charge for an abortion at 20 weeks gestation was $1,195. Meeting state abortion

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				requirements, such as providing in-person counselling and converting to Ambulatory Surgical Centres, can be expensive. Presumably some of these costs are passed on to patients in hostile states. A greater reliance on advanced practice clinicians in supportive states may reduce the cost of care compared with facilities that relied almost exclusively on physicians.
(Kacanek, Dennis et al. 2010) [United States]	To investigate the following questions: What are providers' experiences with Medicaid reimbursement for abortion in cases of rape, incest and life endangerment? What is the process for applying Medicaid reimbursement? What factors facilitate or hinder reimbursement?	Abortion providers in Florida, Idaho, Kansas, Kentucky, Mississippi, Pennsylvania, South Dakota, and Wyoming, where Medicaid funding is limited (n=25)	Qualitative: purposive interviews	The median costs were $450 for a medication abortion, $425 for a first trimester surgical abortion, and $900 for a second-trimester abortion. Of the 245 reported abortions that should have qualified for Medicaid reimbursement, 143 were not reimbursed. Of the 102 that were reimbursed, 99 were in one state; within that state, 27 qualifying abortions were not reimbursed. Eighteen respondents reported that no qualifying abortions were reimbursed.
(Kamali, Hohmann et al. 1998) [Germany]	To determine the best approach to inducing abortion in order to minimize the psychological and physical stress to the patient	Abortion patients between the 15th and 24th week of gestation (n=79) between 1992-1994	A randomized, prospective study	For the cost analysis per patient, the costs incurred were at about the same level for Group 1 [Dinoproston (Prepidi I)] (190, - DM), Group 2 [Sulproston Gel (Nalador)] (183, - DM) and Group 4 [Gemeprost-Yaginalsuppositorien (Cergem, I mg, max. 4 rng/24h)] (181, - DM). Group 3 incurred significantly higher costs per patient (317 DM). These cost analyses do not include personnel costs. The cost of gemeprost treatment was lower in comparison to repeated use of dinoprostone. Applying cervical gels had a higher expenditure of time and personnel than the application of Cergem suppositories. The Sulprostone infusion times in Group 4 continued at shorter supervision times in the Kreil3saal. This too led to a reduction in costs.
(Koontz, Molina de Perez et al. 2003) [El Salvador]	To examine the introduction of MVA services in a regional training hospital in El Salvador and report on its implications	Women who present with incomplete abortion at a training hospital in El Salvador (n=154)	Controlled clinical trial	Overall time in hospital was significantly reduced for MVA patients (19.7 hours) as compared to the SC patients (27.2 hours). The total cost of an MVA procedure and hospital stay was significantly lower than

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				the SC procedure, roughly a 13% reduction in total cost ($54 vs. $62). The most substantial costs were related to the overhead costs of hospital stay, followed by personnel costs and costs of services such as lab tests and meals, of which the costs were significantly less for MVA patients than SC patients. Though a small proportion of total costs, the cost of supplies and equipment for MVA was significantly higher than for SC.
(Lalley, Jelsema et al. 2001) [United States]	To complete a cost effectiveness evaluation for women who received either prostaglandin E2 (PGE2) or misoprostol for a second trimester termination of pregnancy with either a living or dead fetus	Medical records of women seeking abortion care services at Butterworth Hospital in Grand Rapids, Michigan (n=78)	Cost comparison and analysis	Average treatment cost per patient for misoprostol was $298.86 and for PGE2 was $548.21, a savings of $249.35 for misoprostol (P<0.01). The mean cost of treatment when initial medication was successful was $2.40 for misoprostol and $483.90 for PGE2 (P<0.01). Although misoprostol was associated with a higher failure rate, it was more cost-effective than PGE2 for second trimester termination, even when misoprostol alone was unsuccessful in terminating pregnancy.
(Levin, Grossman et al. 2009) [Mexico]	To assesses abortion outcomes and costs to the health care system in Mexico City in 2005 at a mix of public and private facilities prior to the legalization of abortion	Three public hospitals and one private clinic in Mexico City	Cost estimates and projections	The average cost per abortion with D&C was US$ 143. MVA was US$ 111 in three public hospitals and US$ 53 at a private clinic. The average cost of MA with misoprostol alone was US$ 79. The average cost of treating severe abortion complications at the public hospitals ranged from US$ 601 to over US$ 2,100. These estimates represent the opportunity cost of all resources used in the treatment of incomplete abortion and other complications from the health system perspective, including personnel, drugs, disposable supplies, and medical equipment for inducing abortion or treating incomplete abortions and other complications.
(Li, Song et al. 2017) [China]	To investigate the efficacy, safety, and acceptability of low-dose mifepristone combined with self-administered misoprostol for ultra-early MA	Women with ultra-early pregnancy and regular menstrual cycles who sought MA from an institute of obstetrics and gynaecology at four hospitals (n=744)	Randomized control trial	The mean time and cost expenditures per participant were greater in the hospital administration group (557 minutes, US$ 40.12) than in the self-administration group (18 minutes, US$ 1.96). Generally, one hospital visit involving serum b-hCG detection (US$ 7.67/test) and vaginal ultrasound examination (US$ 11.49/scan) costs at least US$ 19.15, and at least 3 hours were required to get the results.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Limacher, Daniel et al. 2006) [Canada]	To compare the costs (considered from the perspectives of society, the health care system, and the patient) of four options for early medical and surgical abortion in Ontario	Available data on abortion procedures in Ontario	Cost analysis	In the model, medical options for early abortion compare favourably with surgical options in terms of total cost to society, the health care system, and the patient. For society and the health care system, the direct costs of MA are less than those of surgical abortion, but for patients the direct costs of MA are higher. Although the procedures and outcomes for early surgical abortion are essentially identical in the hospital and clinic settings, the clinic has a cost advantage from the perspectives of both society and the health care system because of its lower overhead and its greater efficiency that is due to specialization in a single procedure.
(Lince-Deroche, Constant et al. 2015) [South Africa]	To assess women's costs of accessing second-trimester labour induction and D&E services at four public hospitals in Western Cape Province, South Africa	Cost data for women accessing second-trimester labour induction and D&E services at four public hospitals in Western Cape Province	Study 1: Randomized controlled trial Study 2: Repeated, cross-sectional observations over time	Some women reported visiting private doctors before accessing care in the public sector. More women reported paying a private doctor's fee than visiting a private doctor's office. This discrepancy may have been the result of visiting "backstreet providers" who charged a fee but did not work in a formal office.
(Lince-Deroche, Fetters et al. 2017b) [South Africa]	To estimate the costs and cost effectiveness of providing first-trimester medication abortion and MVA services to inform planning for first-trimester service provision in South Africa and similar settings	Data from three facilities on cost of medication abortion and MVA services	Cost analysis using secondary data	Considering the base case cost estimates, medication abortion was less costly than MVA. However, considering the uncertainty analysis ranges, the plausible ranges for the costs of the two procedures overlap, suggesting that the costs of the two procedures could be the same in some circumstances. Personnel costs were the largest contributor to total costs for both procedures. Given the extremely low rate of hospitalization among women who had a MA and a study follow-up visit (0.4%, 3/714) in the operations research study, the contribution of hospitalization costs to the total average cost of medication abortion is minimal. Because no women who had an MVA were hospitalized, there are no hospitalization costs for MVA. Laboratory costs are zero for both procedures because no site conducted investigations requiring outsourced testing.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Lince-Deroche, Constant et al. 2018) [South Africa]	To estimate the costs and cost effectiveness of providing three safe second-trimester abortion services (D&E), medical induction with mifepristone and misoprostol (MI-combined), or medical induction with misoprostol alone (MI-misoprostol) in Western Cape Province, South Africa	Cases presenting for second trimester care at public hospitals in Western Cape Province	Repeated cross-sectional observations	D&E was least costly at $88.89 per woman seen. Medical induction with a combined regimen was less costly than induction with misoprostol alone at $298.03 and $364.08, respectively. However, overlap in plausible ranges in costs for the two medical procedures suggests that the two procedures may cost the same in some circumstances.
(Magotti, Munjinja et al. 1995) [Tanzania]	To compare the cost effectiveness of managing abortions by newly introduced MVA technique with contemporary evacuation by curettage	Patients with incomplete abortions admitted to Muhimbili Medical Center (n=199)	Questionnaire and cost analysis	The direct costs revealed a cost differential of electric vacuum aspiration over evacuation by curettage of Tshs 776.9 (US$ 2.6). MVA is more cost-effective than contemporary evacuation by curettage.
(Manouana, Kadhel et al. 2013) [Guadeloupe]	To describe the typical profile and to assess the motivations of women who underwent illegal abortion with misoprostol in Guadeloupe (French West Indies)	Women who consulted the obstetric-gynaecological department at CHU de Pointe-à-Pitre/Abymes (Guadeloupe) after failure or complication of an illegal abortion with misoprostol	Descriptive, prospective	At Pointe-à-Pitre University Hospital, part of the payment (€ 50-60) remains the responsibility of the patient and can be supported by a health insurance supplement or exempted. In comparison, illegal abortion with misoprostol can cost less than € 1. The misoprostol box costs around € 19 for 60 pieces, a little less than 32 cents per pill. The purchase price misoprostol could reportedly reach € 10 in illegal circuits. These abortions give rise to a lucrative and fraudulent parallel economy that can motivate some to promote and disseminate this demedicalized method.
(Medoff 2008b) [United States]	To examine whether state restrictive abortion laws have a significant impact on the price abortion providers charge for providing abortion services	National data set of state-level data for the years 1982, 1992, and 2000	Econometric analysis of price data and price elasticity	The enforcement of a parental involvement law has a statistically and numerically positive impact on a provider's price of an abortion. The enforcement of a parental involvement law increases the price of an abortion by 9.7—13%. The enforcement of a mandatory counselling law has a statistically and numerically significant cost impact on a provider's price for an abortion. The enforcement of a mandatory counselling law causes abortion providers to raise their prices by 9.3% (or US$ 35).

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Messinger, Mahmud et al. 2017) [Bangladesh]	To investigate the knowledge, attitudes and practices regarding mHealth of both menstrual regulation (MR) clients and formal and informal sexual and reproductive healthcare providers in urban and rural low-income settlements in Bangladesh	MR clients (n=24) purposively selected based on the number of children they had and educational status Formal (n=10) and informal (n=16) close-to-community health providers Doctors, paramedics, and programme staff of the non-governmental organisation clinics (n=8)	Qualitative approach using in-depth interviews	Both formal and informal providers have to bear the cost of their mobile phone credits in order to communicate with their clients. All expressed that providing a mobile phone service makes their clients feel content and enables both current and new clients to contact them regarding community health services. However, all formal providers, including governmental providers, mentioned that mobile phone costs are not usually included in their salary. All providers said that they do not mind paying the phone bills as long as it is for a good cause that is serving the community.
(Murthy and Creinin 2003) [global]	To conduct a complete review that includes background information on the history and incidence of abortion, who chooses to get an abortion, who provides that service and at what cost	Women who chose to have a MA	Literature review	When patients are covered by private insurance, the physician is reimbursed by the insurers at an agreed rate. Unlike other service provided in the United States, a single combination fee is not charged or paid with MA. Because of the method of Food and Drug Administration (FDA) approval, the mifepristone company can only sell directly to the physician who can then dispense that medication directly to the patient. Each tablet costs US$ 90; at the FDA recommended dose, each abortion would cost US$ 270. To provide this service, the physician is obligated to accept this initial capital outlay. In contrast, misoprostol costs about US$ 1.03 for a 200-µg tablet. A full dose of misoprostol for one MA would be an additional US$ 4 per patient (using 800 µg as per the alternative regimen).
(Ordinioha and Brisibe 2008) [Nigeria]	To find out the motivations and experiences of medical practitioners in private clinics who still provide abortion services despite abortion being illegal in Nigeria	34 doctors at 15 clinics	Small-scale survey	Respondents charge an average of 5,000 naira for an eight-week pregnancy. All clinics considered patients seeking abortion to be the private patients of the doctor that provided the service, so the service charge was shared to reflect the fact that the provider had to bear the consequences for any complication that arose. Most clinics (75%) collected money just for the consumables and the use of the clinic's theatre, while 25% had a fixed amount paid to clinic that varied with the gestational age of the pregnancy terminated.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Parmar, Leone et al. 2017) [Zambia]	To provide estimated costs of abortion care and PAC services in Zambia	Provision of safe abortion and PAC services at the University Teaching Hospital (UTH) in Lusaka	Mixed methods	The costs for MA and for treating incomplete abortion are similar (US$ 33); MVA is slightly more expensive (US$ 39). For UTH, the cost of PAC for unsafe abortion is estimated at US$ 109,811 per year, 13 times greater than the cost of safe abortion. Providing MA and MVA cost significantly less than treating sepsis and shock. PAC for unsafe abortion was provided nine times more than safe abortion. Although MA costs less than MVA, when estimated over a year, MA at UTH costs more (US$ 5,898 vs. US$ 1,772) simply because more MA services are provided than MVA. Safe abortion on average costs US$ 14 per case less than PAC following unsafe abortion.
(Payne, Debbink et al. 2013) [Ghana]	To describe major barriers to widespread safe abortion in Ghana through interviews with Ghanaian physicians on the front lines of abortion provision	Ghanaian physicians known for their commitment to safe reproductive health services (n=4)	Qualitative: Open-ended interviews with key informants	Though services are more affordable at earlier stages of pregnancy, the costs often exceed what most women are able to pay. For women seeking second trimester abortion, physicians asserted that most safe second trimester surgical abortion is available only through a small handful of private providers in two urban centres, and the cost for this procedure is prohibitive for many women.
(Penney, McKessock et al. 1995) [United Kingdom]	To estimate the cost and effectiveness of a low-dose regimen of mifepristone and misoprostol	Women with pregnancies of up to 63 days requesting MA at one NHS hospital in Scotland (n=360)	Controlled clinical trial	The NHS drug costs of the reduced regimen are less than one quarter that of the standard regimen (and also costs less than a suction termination). Patients are managed almost entirely by pregnancy counselling nurses.
(Pheterson and Azize 2005) [Anguilla, Antigua, St Kitts, Sint Maarten]	To contribute to an improvement in abortion care in the region, we sought to identify practitioners who were qualified, informed and potentially influential	Interviews with physicians (n=26), of whom 16 provided abortion care	Qualitative in-depth interviews	Pharmacies sell Cytotec by the pill at an extreme mark up, and incomplete abortions are reported as common. When patients could not afford the estimated US$ 560 for an abortion, physicians referred them to buy medical abortions at pharmacies and return to the physician in case of complications.
(Pillai, Welsh et al. 2015) [United Kingdom]	To assess the applicability, acceptability and cost implications of introducing the MVA technique with local anaesthesia for fully conscious first-trimester termination of pregnancy within the [NHS] service and for the population	Women seeking abortion services within an outpatient setting at a Pregnancy Advisory Service within a NHS facility	Review of routinely collected facility data on uptake, demographic details, timing, pain score, complications, contraceptive uptake, and	Within four months of introducing MVA, it was possible to replace one of three weekly theatre lists with MVA. The saving on the theatre recharge was £ 92,000 per annum. The costs for setting up and running the MVA sessions amounted to £ 28,000 per annum. However, the procedure room containing the scanner, the electric gynaecology couch and a mobile light were already in use by the service and were more fully utilized once the

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
			economic implications for the service	MVA sessions commenced. There were additional setup costs for purchase of dilator sets and theatre clothing. Overall, the difference in cost of the weekly theatre list against running two MVA sessions per week resulted in an annual saving of around £6 0,000.
(Prada, Maddow-Zimet et al. 2013) [Colombia]	(1) To estimate the costs incurred by health care facilities in treating complications of unsafe abortion (2) To estimate the total annual cost to the health system of providing PAC (3) To compare the cost of treating complications of unsafe abortion with the cost of providing legal abortion services, and explore some of the factors driving these differences	Estimates based on a sample of facilities	Estimation	The median direct cost of treating a woman with abortion complications ranged from US$ 44—141. A legal abortion at a secondary or tertiary facility was costly (medians, $213 and $189, respectively), in part because of the use of D&C as well as because of administrative barriers. At specialized facilities, where MVA and medication abortion are used, the median cost of provision was much lower ($45). Provision of PAC and legal abortion services at higher-level facilities results in unnecessarily high health care costs. These costs can be reduced significantly by providing services in a timely fashion at primary-level facilities and by using safe, non-invasive, and less costly abortion methods.
(Ramos and Rios 2015) [Peru]	To explore debates of whether a woman with an incomplete abortion should be treated with surgical procedures or medical procedures	Debates on the topic of MVA versus MA in Peru	Non-systematic literature review	MVA is cheaper than EVA.
(Robson, Kelly et al. 2009) [United Kingdom]	To determine the acceptability, efficacy and costs of medical TOP compared with surgical TOP at less than 14 weeks' gestation, and to understand women's decision-making processes and experiences when accessing the termination service	Women accepted for TOP with pregnancies <14 weeks' gestation on the day of abortion	A partially randomised preference trial and economic evaluation with follow-up at two weeks and three months	Surgical TOP cost more than medical TOP due to higher inpatient standard costs. Although complication rates were higher with medical TOP, it was still more cost effective. Mean cost by procedure type (excluding out-of-pocket costs) are as follows: legal, MA in clinic was $165 with complications and $132 without complications; legal MVA in clinic was $223 with complications and $197 without complications; legal MVA in hospitals was $467 with complications and $374 without complications; MVA PAC in hospitals was $563 with complications and $231 without complications; D&C in hospitals was $821 with complications and $657

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				without complications; D&C PAC in hospitals was $2,301 with complications and $458 without complications.
(Rodriguez, Mendoza et al. 2015) [Colombia]	To compare the costs to the health system of three approaches to the provision of abortion care in Colombia: PAC for complications of unsafe abortions, and for legal abortions in a health facility, misoprostol-only MA and vacuum aspiration abortion	Women seeking abortion care at three high-volume facilities in Columbia (n=1,411)	Cost analysis	For every 1,000 women receiving PAC instead of legal abortion, 16 women had unnecessary complications at a cost of US$ 48,000. For legal abortion, both misoprostol and MVA were less costly than D&C for both complicated and uncomplicated cases. For uncomplicated PAC, the average cost for an MVA was nearly half the cost of a D&C at the same type of facility ($ 231 versus $ 458). Assuming a 9% spontaneous abortion rate, and if the remainder of PAC cases currently observed were replaced with legal abortion (medical or MVA), the health system would save an additional $ 163,000 and prevent 16 complications per 1,000 abortions. Additionally, the health system could save $177,000 (per 1,000 women) from baseline by replacing D&C with MVA.
(Sethe and Murdoch 2013) [United Kingdom]	To determine whether abortion or in-vitro fertilization (IVF) treatment has the greater 'regulatory burden' the authors consider the impact of the law, licensing, inspection, amount of paperwork and reporting requirements, the reception by practitioners and costs on these two clinical procedures	Anyone considering abortion or IVF in the United Kingdom	Literature review	Independent IVF and abortion clinics pay a fee to the Care Quality Commission of £ 2,505—5,705. NHS hospital fees are based on bed number, ranging from £ 15,000—75,000. This fee applies to all activities within a Trust, within which both IVF and abortion services will only be a small factor.
(Sharma and Guthrie 2006) [United Kingdom]	To find ways of improving access to earlier and safer abortion, and to offer women more choice of method, by assessing the feasibility of (1) a telephone booking clinic and (2) a local anaesthetic outpatient surgical termination of pregnancy service	Females seeking an abortion at the Women and Children's Hospital, Hull Royal Infirmary	Descriptive study of two pilot projects Cross-sectional survey	Cost of a medical TOP or a surgical TOP (day case) ranges from £ 462—578 per patient. The trial outpatient local anaesthetic outpatient surgical termination of pregnancy clinic cost £ 366 per patient. The present cost per outpatient consultation of £ 217 per patient could be reduced to £ 177 if the nurse telephone clinic was used.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	To assess whether mainstream implementation of these changes could be achieved at no extra cost			
(Shearer, Walker et al. 2010) [global]	To evaluate the quality of costing studies of PAC from low- and middle-income countries and to describe costs in various settings	Facilities in different countries that provide PAC	Regression analysis and systematic review	Data indicate that the cost (in 2007 international dollars) of PAC in Africa and Latin America is $ 392 and $ 430, respectively, per case. Differences in PAC costs were associated with region, procedure, facility level, and case severity.
(Sheldon and Fletcher 2017) [United Kingdom]	To provide a detailed reassessment of the relevant law (on doctors performing MVA procedures) and the clinical evidence that supports this assumption	Medically-trained abortion providers (doctors, nurses, midwives)	Reassessment of relevant law and clinical evidence that supports the law's assumption	Allowing nurses to provide vacuum aspiration for induced abortion potentially offers a more sustainable and economically efficient basis for the long-term development of excellent care. It would free up doctors to focus on those aspects of service provision where their specific expertise is needed.
(Singh 2010) [global]	To review the scientific evidence on the consequences of unsafe abortion, highlight gaps in the evidence base, suggest areas where future research efforts are needed, and speculate on the future situation regarding consequences and evidence over the next 5–10 years	Women who obtained unsafe abortions globally	Literature review	Prior to 2005, studies examining cost of providing PAC included supplies, drugs, labour, and overhead or health systems costs. As a group, these studies demonstrate that providing PAC is a costly undertaking for the patient, for the hospital, and for the health system as a whole. When comparing the cost of MVA to the cost of D&C, MVA is a more cost effective and safer treatment than D&C.
(Sjostrom, Kopp Kallner et al. 2016) [Sweden]	To calculate the cost-effectiveness of early MA performed by nurse-midwifes in comparison to physicians in a high resource setting where ultrasound dating is part of the protocol	Healthy women seeking abortion services at an outpatient clinic of a university hospital in Sweden (n=85)	Cost effectiveness analysis	The direct costs of the woman’s first visit to the clinic of the standard treatment was € 58.3 per procedure, and the cost of the intervention treatment was € 45. The physician providers’ consultations lasted 14 minutes on average. Less experienced physicians consulted more often than more senior physicians. Nurse-midwife consultations lasted six minutes on average.
(Sundari Ravindran and Fonn 2011) [global]	To review studies relating to social franchising initiatives and the impact these have had on reproductive health services	45 clinical social franchises across 27 countries	Review	Franchises that reported out-of-pocket payment as the sole source of payment included 19 that specifically targeted low-income groups. The Ghana Blue Star franchise recommends charging US$ 25-40 for abortion services, in the context of women earning on average US$ 33 a month.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Tewari, Pirwany et al. 1995) [United Kingdom]	To compare the costs of two regimes of mid-trimester medical termination of pregnancy	Women seeking abortion care at a district general maternity hospital	A prospective observational study and cost comparison	Median cost of TOP was £ 420 in the mifepristone group vs. £ 885 in the PGE2 group (p<0.0001). Pre-treatment with mifepristone in second trimester termination of pregnancy results in substantial savings in the cost of treatment.
(Thapa, Neupana et al. 2012) [Nepal]	To compare abortion service users between 2005 and 2010 in Nepal	People seeking surgical abortions from the Maternity Hospital abortion clinic, Nepal, in 2005 (n=672) and 2010 (n=392)	Comparison of two rounds of cross-sectional surveys	The cost incurred by the clinic providing abortion services decreased from Rs 971 (US$ 13.20) in 2005 to Rs 796 (US$ 10.96), reflecting an increase in clients. The revenues from user fees offset the clinics expenditures on abortion services.
(Thomas…2003)(Thomas, Paranjothy et al. 2003) [United Kingdom]	To describe the outcome of a National Audit of Clinical Practices in Induced Abortion	Abortion care providers in England and Wales (n=240)	Review of an audit conducted via a postal survey	While manufacturers recommend a dose of 600 mg for medical abortions up to 9 weeks, randomized controlled trials indicated that a 200mg dose is as effective. Each 200mg dose costs £ 14. The conventionally used prostaglandin E1 analog is gemeprost, which costs £ 20 per 1mg pessary. The alternative, misoprostol, costs £ 1 per dose.
(Tunc 2008) [United States]	To review the vacuum aspirator's history and answer why, in less than a decade, electric vacuum suction became American physicians' abortion technology of choice	Review of vacuum aspirator’s history in the United States	Historical review	When New York State's abortion laws were liberalized in 1970, Dr. Nathanson, who had vowed to make abortion safe and legal, bought a Berkeley apparatus for his clinic that was the largest legal abortion clinic in the western world. Nathanson maintained that the Berkeley suction unit was inexpensive, much cleaner, more reliable, and more suitable for the new outpatient setting than D&C. As the success spread, other aspirator manufacturers began to appear, and the technology entered mainstream medicine. Because it could be used with any aspiration apparatus and then simply discarded, the Karman cannula also reduced sterilization costs and the risk of infection and cross-contamination between patient.
(Tupper, Speed Andrews et al. 2007) [United Kingdom]	To report on setting up and running a new outpatient service for early medical termination under seven weeks gestation	Women seeking abortion care at an outpatient service for early medical termination	Cost analysis	Estimated cost per case in the first year was £ 156, representing a considerable cost saving compared to £ 498 for surgical termination and £423 for inpatient medical termination.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Upadhyay, Cartwright et al. 2018) [United States]	To assess medication abortion access among California's public university students. Specifically, this study estimated current medication abortion use and travel time, costs, and appointment availability at the abortion facilities closest to each of the 34 campuses	California's 34 public university students and the 152 abortion-providing facilities in California	Projections and "mystery shopper" calls	Almost all facilities closest to campus accepted state Medicaid; one did not, but the next closest facility was only .05 miles further away.
(Upadhyay, Johns et al. 2018) [United States]	To assess the incidence of abortion-related emergency department visits in the United States by estimating the proportion of visits that were abortion-related and described the characteristics of patients making these visits, the diagnoses and subsequent treatments received by these patients, the sociodemographic and hospital characteristics associated with the incidents and observation care only, and the rate of major incidents for all abortion patients	Data from the Nationwide Emergency Department Sample on women seeking emergency care for abortion-related issues (n=27,941)	Retrospective observational study	Average emergency department costs were $ 4,719, with 8.6% of emergency department visits costing $ 10,000 or more.
(Visaria, Barua et al. 2008) [India]	To understand gynaecologists' perspectives on MA and chemists' understanding of marketing strategies and drug distribution	Gynaecologists and chemists in 2004 in the Ahmedabad urban area	Exploratory qualitative study using interviews	The cost of mifepristone tablets ranged from rp 325—930. Misoprostol costs ranged from rp 31—60. The total cost of MA was estimated to be rp 1,200 including cost of three ultrasounds. Service providers believed that cost of surgical abortion at a government facility would be substantially less than this amount.
(Vlassoff, Walker et al. 2009) [global]	To estimate the health system costs of PAC in Africa and Latin America	Women seeking PAC services and women hospitalized for serious medical complications of	Cost estimations	Cost-per-case averages, including overhead and capital costs, yielded averages of $ 114 for Africa and $ 130 for Latin America. The overall costs of PAC per patient using the WHO Mother-Baby Package model showed considerable variability across the five countries, from $

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
		induced abortion in Africa and Latin America		10—112 (in 2006 US$) for actual practice, and from $31—212 for care based on WHO standards. Costs in Latin America were substantially higher than those in Sub- Saharan Africa—$ 109 vs. $ 57 for actual practice, and $ 172 vs. $ 65 for WHO-recommended care—primarily reflecting higher Latin American salaries.
(Vlassoff, Musange et al. 2015) [Rwanda]	To estimate the cost of PAC to the national health-care system disaggregated by health-care level, region, severity of complication, and cost component	Randomly selected public and private health facilities (n=39) representing three levels of health care across all five regions	Cost estimation	The average annual PAC cost per client, across five types of abortion complications, was $ 93 and was directly related to the level of care: treatment of postabortion cases at referral hospitals was the most costly ($ 239 on average); per-case PAC treatment at district hospitals cost $ 93, while $ 72 was spent per case at health centres. The total cost of PAC nationally was estimated to be $ 1.7 million per year, 49% of which was expended on direct non-medical costs. Satisfying all demands for PAC would raise the national cost to $ 2.5 million per year. Expenditure at district hospitals was only a little over half that at referral hospitals; health centres spent about one-quarter as much. Shock was the most costly complication ($ 53 per treatment), whereas cervical and vaginal lacerations were the least expensive ($12).
(Vlassoff, Singh et al. 2016) [Ethiopia, Uganda, Rwanda and Colombia]	To expand the research findings of these four comprehensive national surveys of the cost of PAC to national health systems in Ethiopia, Uganda, Rwanda, and Colombia and to make use of their extensive datasets	Costing studies from Ethiopia, Uganda, Rwanda, and Colombia	4-country comparative costing study	Labour cost varies widely: in Ethiopia and Colombia doctors spend about 30–60% more time with PAC patients than do nurses; in Uganda and Rwanda an opposite pattern is found. Labour costs range from I$ 42.80 in Uganda to I$ 301.30 in Colombia. The cost of drugs and supplies does not vary greatly, ranging from I$ 79 in Colombia to I$ 115 in Rwanda. Capital and overhead costs are substantial, amounting to 52–68% of total PAC costs. Total costs per PAC case vary from I$ 334 in Rwanda to I$ 972 in Colombia. The financial burden of PAC is considerable: the expense of treating each PAC case is equivalent to around 35% of annual per capita income in Uganda, 29% in Rwanda, and 11% in Colombia.
(White, Adams et al. 2019) [United States]	To compare pregnancy options counselling and referral practices at state- and Title X-funded family planning organizations in Texas after	Publicly funded family planning organizations in Texas	Qualitative: semi-structured interviews	Some respondents advised women that not all facilities offered medication and surgical abortion; others suggested that women call to inquire about the cost of the procedure and funding available to help them cover their expenses. Respondents noted that the limited

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	enforcement of a policy restricting abortion referrals for providers participating in state-funded programs, which differed from Title X guidelines to provide referrals for services upon request			number of local facilities made it challenging to provide information. While respondents rarely mentioned informing women about how they might cover the cost of abortion care or locations where different abortions methods were offered, respondents were willing to facilitate women's access to prenatal care. This difference may reflect that providers know less about abortion than prenatal services or do not feel comfortable discussing abortion.
(Winikoff, Hassoun et al. 2011) [United States and France]	To examine the commercial, political, regulatory, and legislative history of the introduction of mifepristone misoprostol in France and the United States	Different subgroups across the United States and France, such as researchers, non-profits, government, and women seeking services	Historical narrative	The insurance situation in the United States has important implications for the use and accessibility of mifepristone. On the one hand, because few women use insurance to cover the procedure, insurance companies exert little influence over practice patterns or standards of care compared to other surgical or reproductive health procedures. As a result, clinics and providers have been free to develop innovative service models for provision of the service that ultimately may have reduced the overall cost of the procedure. On the other hand, the price of the procedure has a wide range. Studies have found that the adjusted cost of providing MA care varies significantly depending upon the practice model used (from $252—460 per abortion, median $351). Consequently, the method may be more or less accessible or a more or less attractive alternative to surgical abortion depending upon the practice and pricing model in place.
(Wu, Maru et al. 2017) [Nepal]	To review abortion care in Nepal 15 years after it was legalized	This paper reviews abortion care in relation to practitioners, women seeking abortion services, national policies, etc., from the national to the individual level	Review of current status of abortion in Nepal	While the 2009 Supreme Court decision established the legal framework for the government to mandate free and accessible abortion services in the public sector, there was no policy to implement safe abortion services until the passage of the Safe Abortion Service Guidelines of 2016. Under these guidelines, all government facilities should provide free abortion services. However, the provider reimbursement scheme outlined in the guidelines is less profitable for providers than it was when women paid out of pocket. It remains to be seen whether these new guidelines thus create monetary incentives that encourage providers to shift

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				abortion provision from the public to the private sector, thereby adversely affecting access at public facilities.
(Xia, She et al. 2011) [China]	To compare the clinical efficacy, complications, side effects and direct costs of the two abortion methods for gestation up to 49 days in Guangzhou	Women seeking abortion up to 49 days gestation at the out-patient department of the Department of Obstetrics and Gynecology, First Municipal Hospital of Guangzhou (n=213 women receiving MA; n=21 women receiving surgical abortion)	Economic evaluation (cost-minimization) from a third-party payer's perspective	Accounting only for initial costs, surgical abortion appeared to be 32% more expensive than MA (CNY 367.56 ± 21.31 vs. CNY 279.25 ± 9.48). However, when the subsequent costs of examination and treatment due to incomplete abortion and bleeding within the period of 2-week follow-up were added, on average the medical group incurred almost equivalent costs as the surgical group (CNY 379.03 ± 27.75 vs. CNY 375.16 ± 12.81).

Appendix N. Health facility and health system costs

World region	Country	Abortion services	Health facility costs	Health system costs
Africa		Post-abortion care	The cost (in 2007 international dollars) of post-abortion care in Africa is $392 per case (Shearer, Walker et al. 2010). The average cost of post-abortion care per patient (in 2006 international dollars), including overhead and capital costs, was $294.35 in Africa and $315.16 in sub-Saharan Africa (Vlassoff, Walker et al. 2009).	
	Benin	Induced abortion	Consultation fees are estimated at 10,000 CFA (16.18 USD). Small private centers estimated fees averaging 15,000 and 55,000 CFA (24.50 – 89 USD). (Baxerres, Boko et al. 2018)	
	Burkina Faso	Treatment of abortion complications	Across six types of abortion complications, the mean cost per patient was USD45.86. This cost was higher in the tertiary teaching hospital compared to the secondary level hospital: USD51.09 versus USD36.50, respectively. Treatment costs of abortion complications in both referral hospital ranged from USD23.71 for an incomplete abortion to USD85.08 for a case of infection/sepsis. Incomplete abortion and hemorrhage were the least expensive services, at USD23.71 and USD26.30 per case, respectively. Uterus perforation and infection/sepsis were the most expensive services at the tertiary level teaching hospital, at a cost of USD73.76 and USD94.39, respectively. The average per-patient cost of treating any complication of abortion was USUSD45.86. This cost was higher in the tertiary teaching hospital compared to the secondary level hospital: USD51.09 versus USD36.50, respectively (Ilboudo, Greco et al. 2016).	
		Induced abortions using curettage, MVA, and injections	Fees were estimated as 30,000 CFA (48.50 USD) in public health centers and as high as 60,000 CFA (97 USD) in private clinics. (Baxerres, Boko et al. 2018)	
	Ethiopia	Cost impact of PAC		Post-abortion morbidity represented five times the annual per capita expenditure on health in Ethiopia (Aantjes, Gilmoor et al. 2018)
	Ghana	Manual vacuum aspiration	MVA prices ranged between $11-33 USD in public regional/district level facilities, between $54-163 USD in	

World region	Country	Abortion services	Health facility costs	Health system costs
			private hospitals and clinics, and between $3 to $27 USD in the private maternity homes (Graff and Amoyaw 2009).	
		Cost of post abortion care services	A woman recounted paying 25.00 USD for post-abortion care (Ayanore, Pavlova et al. 2017)	
		Social franchise costs for abortion services		The Ghana Blue Star Franchise recommends charging 25-40 USD for abortion services (Sundari Ravindran and Fonn 2011)
	Kenya	Sharp curettage for treating incomplete abortion patients	The average cost per sharp curettage patient in one district hospital was US $15.25 (Benson, Nicholson et al. 1996).	
		Manual vacuum aspiration for treating incomplete abortion patients	Using MVA rather than sharp curettage decreased costs by 66%. Thus, the average cost per MVA patient in one district hospital was US $5.19 (Benson, Nicholson et al. 1996).	
	Malawi	Estimated costs of abortions by method and PAC by complication	MA without complications: 12 USD MVA without complications: 13 USD D&C without complications: 19 USD PAC costs with non-surgical complications: 63 USD PAC costs with surgical complications: 128 USD (Aantjes, Gilmoor et al. 2018)	
	Nigeria	Treatment for septic abortion	Average treatment costs for a septic abortion patient were US $223.11 (Benson, Nicholson et al. 1996).	
		Post-abortion care	PAC treatment with moderate complications cost an average of US $112 per case, 60% more than a simple PAC case (US $70). Treating a PAC case with severe complications was more than 3.5 times the cost of treating a simple PAC case (US $258). The estimated per-case costs of each procedure type varied widely across facilities: MVA/EVA (US $43 to US $141); D&C/D&E (US $44 to US $114); MPAC (US $48 to US $129); and expectant management (US $32 to US $104). Although the 5 severe cases were not included in the overall calculations, the per-case cost (US $258, more than 3.5 times higher than that for a simple case) is illustrative of the negative impact such cases have on resource-poor health facilities (Benson, Okoh et al. 2012).	The total annual cost for the 17 facilities included in the study under current treatment conditions is US $274,015. It is estimated that together, all 79 PAC-providing public hospitals in the 3 included Nigeria states currently spend US $807,442 on PAC provision annually. Thirty-one percent of that cost (US $249 960) is spent on the treatment of women with moderate complications (Benson, Okoh et al. 2012).

World region	Country	Abortion services	Health facility costs	Health system costs
		Treatment of abortion complications	It cost the hospital an average of US $7.50 per patient to treat abortion complications compared to an annual MOH per capita budget of US $1.00 (Benson, Nicholson et al. 1996).	
		MVA vs D&C	The cost of using MVA to perform an abortion was slightly higher than the cost of using D&C (3,446 vs. 3,090 naira) (Henshaw, Adewole et al. 2008).	
	Rwanda	Post-abortion care	The average annual PAC cost per client, across five types of abortion complications, was $93 and was directly related to the level of care: treatment of post-abortion cases at referral hospitals was the most costly ($239 on average); per-case PAC treatment at district hospitals cost $93, while $72 was spent per case at health centers. Shock, estimated at $53 per treatment, was the most costly complication, whereas cervical and vaginal lacerations were the least expensive ($12) (Vlassoff, Musange et al. 2015).	The total cost of PAC nationally was estimated to be $1.7 million per year, 49% of which was expended on direct non-medical costs. Satisfying all demands for PAC would raise the national cost to $2.5 million per year (Vlassoff, Musange et al. 2015).
	South Africa	Dilation and evacuation	D&E was least costly (US$ 88.89 per woman seen) and most cost-effective at US$ 91.17 per complete abortion (Lince-Deroche, Constant et al. 2018).	
		Second-trimester induction with misoprostol	Medical induction with a combined regimen was less costly than induction with misoprostol alone at $298.03 and $364.08 respectively (Lince-Deroche, Constant et al. 2018).	
		Medication abortion	The total average cost per medication abortion was $63.91 (52.32–75.51) (Lince-Deroche, Fetters et al. 2017b).	
		Cost of medication abortion and MVA	Cost of MV and MVA estimated to be 61 USD and 69 USD respectively (Aantjes, Gilmoor et al. 2018)	
		Induced abortions (consultation and medical abortion fees)	Unofficial consultations were reported to cost 300 ZAR. Medical abortions in private clinics are estimated to cost 900 ZAR (Gresh and Maharaj 2011)	
	Swaziland	Cost of induced abortions	Induced abortions using MA: 75 USD Induced abortions using D&C: 115 USD (Aantjes, Gilmoor et al. 2018)	
	Rwanda	PAC costs		Differences across facility types: 239 USD for regional health facilities, 93 USD for district hospitals, 72 USD for health centers. (Aantjes, Gilmoor et al. 2018)

World region	Country	Abortion services	Health facility costs	Health system costs
	Uganda	Induced abortion		Induced abortion costs $23.6 million in direct medical costs annually (Babigumira, Stergachis et al. 2011).
		Complications of unsafe abortion		The largest part of the healthcare costs can be attributed to the treatment of the complications of unsafe abortions (Babigumira, Stergachis et al. 2011).
		Treatment of abortion complications	It cost the hospital an average of US $7.50 per patient to treat abortion complications compared to an annual MOH per capita budget of US $1.00 (Benson, Nicholson et al. 1996).	
		Cost impact of PAC		Post-abortion morbidity represented three times the annual per capita expenditure on health in Uganda (Aantjes, Gilmoor et al. 2018)
	Zambia	Medical abortion	The cost for a medical abortion is US$ 33 (Parmar, Leone et al. 2017).	
		Treating incomplete abortion	The costs for treating incomplete abortion are US$ 33 (Parmar, Leone et al. 2017).	
		Manual vacuum aspiration	The cost for an abortion using MVA is US$ 39 (Parmar, Leone et al. 2017).	
		PAC for unsafe abortion	For a university teaching hospital, the cost of PAC for unsafe abortion is estimated at US$ 109,811 per year, 13 times greater than the cost of safe abortion (Parmar, Leone et al. 2017).	
Asia	China	Ultra-early medical abortion (hospital-administration group)	In the hospital administration group, the mean time and cost expenditures per participant were 557 minutes and US$ 40.12 (Li, Song et al. 2017).	
		Ultra-early medical abortion (self-administration group)	In the self-administration group, the mean time and cost expenditures per participant were 18 minutes and US$ 1.96 (Li, Song et al. 2017).	
		Surgical abortion	Accounting only for initial costs, surgical abortion cost CNY 367.56 $\pm$ 21.31. However, when the subsequent costs of examination and treatment due to incomplete abortion and bleeding within the period of 2-week follow-up were added, the surgical group cost 375.16 $\pm$ 12.81 (Xia, She et al. 2011).	
		Medical abortion	Accounting only for initial costs, medical abortion cost 279.25 $\pm$ 9.48. However, when the subsequent costs of examination	

World region	Country	Abortion services	Health facility costs	Health system costs
			and treatment due to incomplete abortion and bleeding within the period of 2-week follow-up were added, on average the medical group incurred almost equivalent costs as the surgical group (CNY 379.03 ± 27.75 vs. 375.16 ± 12.81) (Xia, She et al. 2011).	
	India	Abortion	The clinic charges for an abortion ranged from Rs.135–534 (average Rs.370) for public providers and Rs.394–649 (average Rs.497) for private providers. Of these, the doctors got an average of 42%, 21% was spent on medicines, and the rest was used for hospital charges like operating theatre and bed charges (Duggal 2004).	
		Out-of-pocket costs for abortions	Households studies record out-of-pocket costs as Rs. 1220 in Maharashtra and Rs. 950 in Tamil Nadu (Duggal and Ramachandran 2004)	
		Costs of abortions within the health system		Based on 6.4 million abortions, the abortion economy was estimated as worth Rs. 6,950 million (154 million USD), representing 0.58 of the total out-of-pocket expenditure for healthcare (Duggal and Ramachandran 2004)
	Nepal	Clinical costs incurred for surgical abortions		The total costs incurred by clinics was Rs. 971 (13.2 USD) in 2004, which declined to R. 796 (10.26 USD) by 2009 (Thapa, Neupana et al. 2012)
	Thailand	Manual vacuum aspiration and sharp curettage	The total hospital cost for the MVA procedure (US$ 54.67) was 64% lower than that for the sharp curettage procedure (US$ 153.97) (Choobun, Khanuengkitkong et al. 2012).	
		Average cost of medical abortion	From 88 persons, the average cost of misoprostol was 663.16 ± 7II.32 Baht. (Pongsatha, Morakot et al. 2002)	
Europe	France	Surgical abortion with anesthesia	The cost per abortion at a regional maternity hospital is 562 €. This cost includes the direct cost of service (212 €), the indirect block charge (110 €), the indirect block anesthesia load (80 €), and the cost of hotel and logistics (160 €). After applying the tariffs, the cost to the facility is reduced to 180 €. This results in a loss of 66,660 € to 87,497 € for the management of surgical abortions (Betala Belinga, Valence et al. 2010).	
	Sweden	First visit to clinic for of early medical abortion	The direct costs of the woman's first visit to the clinic of the standard treatment (by physicians) was EUR 58.3 per procedure and the cost of the intervention treatment (by nurse-midwives) was EUR 45 (Sjostrom, Kopp Kallner et al. 2016).	

World region	Country	Abortion services	Health facility costs	Health system costs
	United Kingdom	Medical abortion	Medical abortion used 8% less of National Health System resources (£343 vs £374) when compared to vacuum aspiration (Henshaw, Naji et al. 1994). The full cost of an outpatient medical termination of pregnancy procedure (including all Trust overheads and laboratory tests/scans) was £462 per patient (Sharma and Guthrie 2006).	
		Nurse-led clinic	The calculated annual cost of the medically led clinic was £37,495 - 0.40 whole-time equivalents (WTE) for a staff grade doctor (£22,598) and 0.43 WTE for an F-grade staff nurse (£14,897). The clinic could be run in its present form by a G-grade nurse at an annual cost of £25,943 (0.80 WTE), resulting in an annual financial saving of almost 40% (Harvey and Gaudoin 2005).	
		Surgical abortion	In an English primary health care trust, the cost of a STOP (day case) ranged from £462 to £578 per patient. The cost of a local anaesthetic outpatient surgical abortion service could be reduced to £366 per patient. However, if this involved outpatient consultation the cost was £217 per patient that could be further reduced to £177 if the nurse telephone clinic was used (Dawson, Bateson et al. 2016). The full cost of a surgical termination of pregnancy (day case) (including all Trust overheads and laboratory tests/scans) was £482 or £578 per patient (Sharma and Guthrie 2006).	
		Local anaesthetic outpatient surgical termination of pregnancy clinic	The full cost of a pilot program in which patients obtained local anaesthetic outpatient surgical termination of pregnancy procedure at a clinic (including all Trust overheads and laboratory tests/scans) cost £366 per patient (Sharma and Guthrie 2006).	
		Outpatient consultation on termination of pregnancy	The cost per outpatient consultation (including all Trust overheads and laboratory tests/scans) was £217 per patient (Sharma and Guthrie 2006).	
		Legal, medical abortion in clinic with complications	The mean cost for a legal, medical abortion in a clinic was $165 with complications (Robson, Kelly et al. 2009).	

World region	Country	Abortion services	Health facility costs	Health system costs
		Legal, medical abortion in clinic without complications	The mean cost for a legal, medical abortion in clinic was $132 without complications (Robson, Kelly et al. 2009).	
		Legal MVA in a clinic with complications	The mean cost for legal MVA in a clinic was $223 with complications (Robson, Kelly et al. 2009).	
		Legal MVA in a clinic without complications	The mean cost for legal MVA in a clinic was $197 without complications (Robson, Kelly et al. 2009).	
		Legal MVA in hospitals with complications	The mean cost for legal MVA in hospitals was $467 with complications (Robson, Kelly et al. 2009).	
		Legal MVA in hospitals without complications	The mean cost for legal MVA in hospitals was $374 without complications (Robson, Kelly et al. 2009).	
		MVA post-abortion care in hospitals with complications	The mean cost for MVA post-abortion care in hospitals was $563 with complications (Robson, Kelly et al. 2009).	
		MVA post-abortion care in hospitals without complications	The mean cost for MVA post-abortion care in hospitals was $231 without complications (Robson, Kelly et al. 2009).	
		D&C in hospitals with complications	The mean cost for D&C in hospitals was $821 with complications (Robson, Kelly et al. 2009).	
		D&C in hospitals without complications	The mean cost for D&C in hospitals was $657 without complications (Robson, Kelly et al. 2009).	
		D&C post-abortion care in hospitals with complications	The mean cost for D&C post-abortion care in hospitals was $2,301 with complications (Robson, Kelly et al. 2009).	
		D&C post-abortion care in hospitals without complications	The mean cost for D&C post-abortion care in hospitals was $458 without complications (Robson, Kelly et al. 2009).	

World region	Country	Abortion services	Health facility costs	Health system costs
		Two regimes of mid-trimester medical termination of pregnancy	Median cost of TOP was £420 in mifepristone group vs. £885 in PGE2 group (Tewari, Pirwany et al. 1995).	
		New outpatient service for early medical termination under 7 weeks' gestation	Estimated cost per case in the first year was £156 (which represented a considerable cost saving compared to £498 for surgical termination, £423 for inpatient medical termination) (Tupper, Speed Andrews et al. 2007).	
Latin America and the Caribbean		Treatment of incomplete abortion	Treating women with incomplete abortion can absorb more than 50% of facilities' obstetric and gynaecologic budgets (Billings and Benson 2005).	
		Post-abortion care	The cost (in 2007 international dollars) of post-abortion care in Latin America is $430 per case (Shearer, Walker et al. 2010). The average cost of post-abortion care per patient (in 2006 international dollars), including overhead and capital costs, was $223.25 in Latin America (Vlassoff, Walker et al. 2009).	
		Treatment of post-abortion complications	The estimated per-patient cost to treat post-abortion complications is US$94.00 (Dzuba, Winikoff et al. 2013).	
	Anguilla, Antigua, St Kitts, Sint Maarten	Induced abortions	Doctors reported that abortions in clinics cost $1400 Eastern Carribbean (560 USD) (Pheterson and Azize 2005)	
	Colombia	Post-abortion care (complicated)		For every 1,000 women receiving PAC instead of legal abortion, 16 women had unnecessary complications, at a cost of US$ 48,000. Assuming a 9% spontaneous abortion rate, and if the remainder of PAC cases currently observed were replaced with legal abortion (medical or MVA), the health system would save an additional $163,000 dollars and prevent 16 complications per 1,000 abortions (Rodriguez, Mendoza et al. 2015).
		Post-abortion care	For uncomplicated PAC, the average cost for an MVA $231 (Rodriguez, Mendoza et al. 2015).	

World region	Country	Abortion services	Health facility costs	Health system costs
		(uncomplicated) with MVA		
		Post-abortion care (uncomplicated) with D&C	For uncomplicated PAC, the average cost for a D&C was $458 (Rodriguez, Mendoza et al. 2015).	The health system could save $177,000 (per 1,000 women) from baseline, by replacing D&C with MVA (Rodriguez, Mendoza et al. 2015).
		Legal, medical abortion in clinic with complications	A legal, medical abortion in the clinic cost $165 with complications (Rodriguez, Mendoza et al. 2015).	
		Legal, medical abortion in clinic without complications	A legal, medical abortion in the clinic cost $132 without complications (Rodriguez, Mendoza et al. 2015).	
		Legal, MVA in clinic with complications	A legal MVA in the clinic cost $223 with complications (Rodriguez, Mendoza et al. 2015).	
		Legal, MVA in clinic without complications	A legal MVA in the clinic cost $197 without complications (Rodriguez, Mendoza et al. 2015).	
		Legal MVA in hospitals with complications	A legal MVA in the hospital cost $467 with complications (Rodriguez, Mendoza et al. 2015).	
		Legal MVA in hospitals without complications	A legal MVA in the hospital cost $374 without complications (Rodriguez, Mendoza et al. 2015).	
		MVA post-abortion care in hospitals with complications	MVA post-abortion care in hospitals cost $563 with complications (Rodriguez, Mendoza et al. 2015).	
		MVA post-abortion care in hospitals without complications	MVA post-abortion care in hospitals cost $231 without complications (Rodriguez, Mendoza et al. 2015).	
		D&C in hospitals with complications	D&C in hospitals cost $821 with complications (Rodriguez, Mendoza et al. 2015).	

World region	Country	Abortion services	Health facility costs	Health system costs
		D&C in hospitals without complications	D&C in hospitals cost $657 without complications (Rodriguez, Mendoza et al. 2015).	
		D&C post-abortion care in hospitals with complications	D&C post-abortion care in hospitals cost $2,301 with complications (Rodriguez, Mendoza et al. 2015).	
		D&C post-abortion care in hospitals without complications	D&C post-abortion care in hospitals cost $458 without complications (Rodriguez, Mendoza et al. 2015).	
	El Salvador	MVA procedure and hospital stay	The total cost of an MVA procedure and hospital stay was US$ 54 (Koontz, Molina de Perez et al. 2003).	
		Sharp curettage procedure	The total cost of the sharp curettage procedure was US$ 62 (Koontz, Molina de Perez et al. 2003).	
North America	Canada	Abortion by vacuum aspiration (in hospital)	The average case cost for abortion by vacuum aspiration in the hospital was Can$ 419.00 (Limacher, Daniel et al. 2006).	From the health care system perspective, the direct cost of a vacuum aspiration procedure in a hospital was Can$ 842.63 (Limacher, Daniel et al. 2006).
		Abortion by vacuum aspiration (in clinic)	The average case cost for abortion by vacuum aspiration in the clinic was Can$ 233.83 (Limacher, Daniel et al. 2006).	From the health care system perspective, the direct cost of a vacuum aspiration procedure in a clinic was Can$ 518.77 (Limacher, Daniel et al. 2006).
		Treatment of bleeding after abortion	The average hospital case cost for bleeding after abortion was Can$ 646.68 (Limacher, Daniel et al. 2006).	
		Treatment of infection after abortion	The average hospital case cost for infection after abortion was $1,021.00 (Limacher, Daniel et al. 2006).	
		Procedure with mifepristone-misoprostol		From the health care system perspective, the direct cost of a procedure with mifepristone-misoprostol was Can$ 361.93 (Limacher, Daniel et al. 2006).
		Procedure with methotrexate-misoprostol		From the health care system perspective, the direct cost of a procedure with methotrexate-misoprostol was Can$ 385.77 (Limacher, Daniel et al. 2006).
	Mexico	Abortion with dilatation and curettage	The average cost per abortion with dilatation and curettage was US $143 (Levin, Grossman et al. 2009).	

World region	Country	Abortion services	Health facility costs	Health system costs
		Abortion with manual vacuum aspiration	The average cost per abortion with manual vacuum aspiration was US $111 in three public hospitals and US $53 at a private clinic (Levin, Grossman et al. 2009).	
		Medical abortion with misoprostol	The average cost of medical abortion with misoprostol alone was US $79 (Levin, Grossman et al. 2009).	
		Treatment of severe abortion complications	The average cost of treating severe abortion complications at the public hospitals ranged from US $601 to over US $2,100 (Levin, Grossman et al. 2009).	
	United States	Medical abortion	The mean total episode cost (including direct, indirect, and space costs) across 11 sites was $346 (range $252- $460) (Afable-Munsuz, Gould et al. 2007). In 2001-2002, charges for a mifepristone abortion and for a methotrexate abortion were $490 and $438, respectively. Providers who used 600 mg of mifepristone charged $74 more, on average, than providers who used 200 mg. More than two in five providers (43%) charged between $400 and $499 for mifepristone, and 38% charged $500 or more. For 80% of medical abortion providers, the basic charge for a medical abortion included the cost of a subsequent vacuum aspiration, should an incomplete abortion or continuing pregnancy occur (Henshaw and Finer 2003). In 2011, the median charge for early medication abortion was similar to surgical abortions at 10 weeks' gestation at $500, although the average amount women paid was slightly higher than that for a surgical abortion at 10 weeks ($504). The median charge for an abortion at 20 weeks' gestation in 2011 and 2012 was $1,350 (Jerman and Jones 2014). The median cost was $450 for a medication abortion (Kacanek, Dennis et al. 2010).	
		Abortion from non-hospital providers	In 1993, on average, non-hospital providers charged $604 for an abortion at 16 weeks and $1,067 at 20 weeks. Fees ranged as high as $2,500 at 16 weeks and $3,015 at 20 weeks (Henshaw 1995).	
		Surgical abortion	In 2011 and 2012, the median charge for a surgical abortion at 10 weeks gestation was $495. Abortion clinics charged the least for a surgical abortion at 10 weeks' gestation ($450); abortions were most expensive at physicians' offices ($550).	

World region	Country	Abortion services	Health facility costs	Health system costs
			Following this pattern, facilities with the largest caseloads charged the least ($450), and those that performed fewer than 30 procedures per year charged the most ($650) (Jerman and Jones 2014). The median costs were $425 for a first trimester surgical abortion and $900 for a second-trimester abortion (Kacanek, Dennis et al. 2010).	
		Abortion at 20-weeks gestation	In 2014, the median charge for an abortion at 20 weeks gestation was $1,195 (Jones, Ingerick et al. 2018).	
		Abortion-related emergency department visits	Average abortion-related emergency department costs were $4,719, with 8.6% of abortion-related emergency department visits costing $10,000 or more (Upadhyay, Johns et al. 2018).	
		Induced abortion drug costs	50mg of oral methotrexate costs 20 USD, whereas the appropriate dose of parenteral methotrexate cost 4 USD (Creinin 1997)	
		Induced abortions	The average cost of abortion was 519 USD for first-trimester abortions and 2,014 USD for later abortions. (Foster and Kimport 2013)	

Appendix O. Summary of studies reporting meso-economic impacts

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Alouini, Uzan et al. 2002) [France]	To determine whether women undergoing repeat abortions are exposed to risk factors that might be amenable to preventative measures and the methods employed by carers in these cases	30 women who had undergone two abortions prior to or in 1997 at the Family Planning Centre of Hospital Jean Verdier in Bondy The care team: two gynaecologists, two marital counsellors, two nurses and a senior nursing officer	Evaluation using a questionnaire for women and interviews with the care team	The medical manpower available to provide patients with psychological help is well below what is required to meet their needs.
(Baxerres, Boko et al. 2018) [Benin and Burkina Faso]	To document the means women use to obtain abortions in the capital cities of Benin and Burkina Faso To learn whether or not use of misoprostol has become an alternative to other methods of abortion and the implications for future practice	Women in Cotonou (n=21) and in Ouagadougou (n=13), including 5 secondary school students	Qualitative in-depth interviews	In Benin, misoprostol can be obtained without prescription but is also available at informal drug markets, increasing exposure and use. International networks and information sharing between healthcare professional bodies (e.g., gynaecologists) and non-governmental organizations (NGOs) has increased awareness of misoprostol. Misoprostol was included on the essential medicines list in both Benin in November 2013 and Burkina Faso in December 2014.
(Berer 2000) [global]	To examine the changes in policy and health service provision required to make abortions safe	Varied due to a wide-ranging review of published and unpublished sources used, but includes women obtaining treatment for abortion complications, abortion providers, and those impacted by national policies	Literature review	Most authors agree that treating abortion complications in sub-Saharan Africa consumes a disproportionate amount of hospital resources. In Bangladesh, up to 50% of hospital gynaecology beds are reportedly used for abortion complications. The cost and complexity of treatment is increased among women who wait to seek help until complications become severe. The use of untrained providers results in more visits by women and greater spending on care than the use of trained providers. In Guyana, about 25% of the blood available at the main public hospital was used to treat abortion complications before the abortion law was liberalized.
(Bessett, Gorski et al. 2011) [United States]	To learn about women's experiences applying for subsidized insurance and to identify barriers to obtaining	English-speaking clients older than 18 who met the eligibility requirements for subsidized insurance	Systematic, qualitative interviews	MassHealth, a subsidized state health insurance program, does not enrol patients right away or cover abortion care provided by out-of-state providers. Although at least one woman was able to obtain and use Commonwealth Care for a medication abortion in a timely way, the

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	insurance or its use for abortion services	programs in Massachusetts (n=39)		approaching deadline prompted abortion funds to provide grants to at least two desperate women who were eligible. Both women were later deemed eligible for MassHealth, suggesting that the costs for abortion should have been covered by insurance. The delays caused by attempts to enrol in subsidized insurance had a disproportionate impact on women who sought medication abortion, forcing them to pay out of pocket or placing their preferred method for termination out of reach.
(Billings and Benson 2005) [Latin America and the Caribbean]	To review results from 10 major postabortion care (PAC) operations research projects conducted in public sector hospitals in seven Latin American countries, completed and published between 1991 and 2002	Varied by study but included patients, policymakers, administrators, and health care providers	Literature review of operations research studies	<u>Cost and resource use (time-motion) studies</u> Moving the uterine evacuation procedure from the operating theatre to an obstetrics-gynaecology ambulatory care area resulted in reducing costs and average length of patient stay. <u>Cost studies, including opportunity costs</u> Treating women with incomplete abortion can absorb more than 50% of facilities' obstetric and gynaecologic budgets. Switching to manual vacuum aspiration (MVA) while concurrently reorganizing services to an outpatient basis tends to substantially reduce average length of stay and treatment costs to the facility. While most studies reported marked decreases in average length of stay and costs when MVA was used to treat incomplete abortion in ambulatory settings, some showed differing results. A 1993 study in Ecuador showed that facilities that switched to MVA while continuing to treat postabortion patients with general anaesthesia in an operating room actually had similar average length of stay and costs than facilities that continued using sharp curettage (SC) under the same conditions. These data reinforce the conclusion that reorganizing services is critical for efficient services. When SC was performed on an outpatient basis in Mexico, switching to outpatient MVA generated no additional savings over outpatient SC. Similarly in Peru, average length of stay between SC and MVA and cost per patient treated were comparable. Reorganizing services can substantially reduce opportunity costs to the facilities. In some cases, administrators passed these savings on to the patients. Based on data in Peru, the director of the hospital cut patient fees in half for ambulatory patients (from approximately US$32 to $16). The hospital was recovering almost 98% of the full cost of providing PAC services at the 2000 follow-up compared with less than half (45%) prior to the intervention.
(Brown and Jewell 1996) [United States]	To estimate directly the responsiveness of abortion	Abortion providers in Texas, health facility data	Log-linear regressions	The location of facilities significantly impacts the cost of the abortion.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	demand to county-level variations in travel-cost component of the full cost of abortion services			
(Coast, Norris et al. 2018) [global]	To present a new conceptual framework for studying trajectories to obtaining abortion-related care	Varied, as this is a global review paper, but includes health systems and those affected by national and international policies	Review paper	International institutions can shape the availability of abortion in other national and sub-national contexts, both ideologically and financially. Health system financing (e.g. free, subsidised, insurance, co-payments) affects how abortion-related care is sought and paid for. Legal settings increasingly recognize the scale and consequences of unsafe abortion, including the costs for health systems.
(Contreras, van Dijk et al. 2011) [Mexico]	To examine the experiences and opinions of health care professionals after the legalization of abortion in Mexico City in 2007	64 semi-structured interviews with obstetricians/gynaecologists, nurses, social workers, key decision makers at the Ministry of Health, and others	Qualitative study using semi-structured interviews	The number of conscientious objections was problematic for hospitals and health centres providing legal abortions; reports noted that these objections were not for moral or ethical reasons but rather to avoid extra workloads. Objectors also reported providing abortions in their private practices, suggesting financial incentives. Objecting professionals created hostile environments for care seekers, including making them wait longer for their services.
(Cook, de Kok et al. 2017) [Malawi]	To investigate factors contributing to the limited and declining use of MVA in Malawi	17 health workers of different cadres (doctors, nurses and clinical officers), genders and levels of experience and seniority who provided PAC in a central hospital and a district hospital	Small-scale qualitative study involving interviews supplemented by unstructured observations of care practices	<u>Shortage of physical resources</u> MVA instruments are an increasing problem; there has not been a reliable supply to replace old and broken donated equipment. Unreliable equipment supplies, make MVA a more difficult option than curettage. In the absence of MVA equipment, providers would perform D&C rather than delay the procedure. As a result, health workers sometimes automatically resorted to D&C since they became accustomed to no MVA equipment. <u>Staff shortages (especially amongst those trained in PAC) and roles</u> Staff shortages led to staff feeling overworked and demotivated, potentially affecting quality of care. One or two nurses covered up to 70 patients. Unsafe abortions, thought to be increasing, contribute to a large proportion of admissions and may be compounding feelings of being overworked. When motivation and prioritization are low, staff will likely opt for the easier option, which may not be what is best for the patient. Staff shortages may also affect MVA use, since nurse shortages required nurses trained in MVA to engage with other tasks and junior interns received little on-the-job training in MVA. Furthermore, senior interns usually trained juniors only in D&C, in which they tended to be more confident. Participants said this is leading to MVA becoming a 'forgotten skill.' Demarcations between nurses and doctors in terms of role and status

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				may have contributed to doctors discontinuing MVA, which became seen as a simple innovation of lower standing, designed for nurses.
(Crane and Dusenberry 2004) [global]	To examine the effect of the Global Gag Rule on family planning organizations in countries receiving American assistance	Family planning organizations within multiple countries	Literature review	Some organisations were forced to close clinics, terminate staff, and cut not only family planning programmes but also programmes for maternal health and well-baby care, sexual health education, youth outreach, and the prevention and treatment of sexually transmitted infections and HIV/AIDS. The Gag Rule also led to the termination of all American contraceptive supply shipments to leading family planning organisations in 29 countries.
(Cunningham, Lindo et al. 2017) [United States]	To document the effects of abortion-clinic closures on clinic access, abortions, and births using variation generated by a law that shuttered nearly half of Texas' clinics	Women of reproductive age and children	Regression analysis	In the immediate aftermath of House Bill 2 (HB2), the average clinic service population rose from 150,000 to 290,000 in Texas. This occurred for two reasons: (1) as clinics closed in small cities, women had to travel to clinics that remained in larger cities, shrinking the number and expanding the sizes of service regions; and (2) as clinics closed in large cities, there were fewer providers of abortion services. There is substantial variation in how access changed across Texas. The average service population did not change in eastern Texas, where only one clinic closed in the fourth quarter of 2013 (though several closed the following year). In the Dallas-Fort Worth region, where distances had not changed, the average service population increased by 250,000. Clinic closures continued through 2014, and the average service population continued to rise. In Dallas-Fort Worth, an additional clinic closure in June 2015 increased the average service population from 380,000 to 480,000.
(Díaz-Olavarrieta, Cravioto et al. 2012) [Mexico]	To identify the perceptions and opinions of people who provide abortion services in Mexico City, three years after implementation of elective abortion legal reforms	19 health workers assigned to the legal abortion programs at a clinic and a hospital in Mexico's Federal District	In-depth interviews	Payment exemptions for women that have any form social security plan or are vested in other institutions are considered by clinic personnel to negatively impact the quality of the services because these exemptions generate work overload and material and human resources shortages.
(Doran and Nancarrow 2015) [United States, Canada, Australia, New Zealand, France, Norway, Sweden, Norway, and the United Kingdom]	To identify the factors that facilitate and hinder access to abortion services for women in developed countries in relation to first-trimester abortions, from the perspective of both the woman and the service provider	As a systematic review, included studies looked at multiple populations including women seeking abortions and abortion providers	Systematic review	A Canadian study reported that waiting times for an abortion are significantly shorter in private clinics than for government-funded services.
(Duggal 2004) [India]	To examine the political economy of abortion care in India by reviewing cost and	This national-level analysis includes health providers	Descriptive analysis of the political economy	While there is no dearth of medical providers who can be certified to perform abortions, unregistered and illegal abortions continue to take place in overwhelmingly large numbers. Legalisation of abortion in 1971 potentially provided the medical profession with a monopoly over

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	expenditure patterns for abortion care			abortion and a means to medicalise it. Legal abortion services began to expand but did not significantly threaten traditional abortion providers. On the contrary, abortion was seen as a growing business and many medical practitioners, unqualified and untrained in abortion, entered the fray. Since regulation of medical practice remained weak, this put a damper on the expansion of legal services. Abortion services have remained predominantly in the private sector. The state has played a subtler role by providing subsidies to select private abortion providers if they make abortion provision dependent on acceptance of sterilisation or an intrauterine device. An unmet demand for public abortion services and the lack of any effective regulatory mechanisms further opened the floodgates for all sorts of private providers, unqualified persons, non-allopathic doctors, and paramedics. Despite early legalisation of abortion, the problem of illegal providers and unsafe abortion looms large. This translates into a political economy of abortion which is controlled by providers, with those who are unqualified and unregistered exploiting the vulnerability of women seeking abortion and contributing to widespread post-abortion problems and mortality. Given that a large number of providers are unqualified to do abortions, the cost of unsafe abortions must also be factored in. Post-abortion costs due to botched abortions and complications could be high. The insistence on curettage even for very early abortion, and so- called check curettage after vacuum aspiration, is widespread amongst both certified and non-certified providers, adding to the cost as well the risk of post-abortion infections and other problems.
(Erim, Resch et al. 2012) [Nigeria]	To synthesize the best available data, adapt a model of pregnancy and pregnancy-related morbidity and mortality to the Nigerian context, and conduct national and regional analyses that quantify the payoffs from investing in safe pregnancy and childbirth to provide qualitative insight into the most efficient strategies to	National level estimates	Synthesize the best available data, adapt a model of pregnancy and pregnancy-related morbidity and mortality to the Nigerian context, and conduct national and regional analyses	Strategies that only improved family planning and safe abortion had very low cost-effectiveness ratios (i.e., very attractive), but reduced mortality by 20.5%. A strategic approach that involves simultaneous improvement in intrapartum care, family planning, and safe abortion was the most efficient and associated with incremental cost-effectiveness ratios between the two aforementioned strategies. Strategies that scale up maternal health services by systematically making stepwise improvements in family planning, safe abortion, and intrapartum care will be more effective and efficient in the long-run than solely focusing on any one of these alone. A strategy that involved phasic and concurrent improvements in the availability and standard of

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	meet Millennium Development Goal 5		that quantify the payoffs from investing in safe pregnancy and childbirth	emergency obstetric care facilities, referral systems, access to skilled birth attendants, facility deliveries, availability and use modern contraceptives and access to safe abortion services could prevent three to four out of five maternal deaths. This strategy had cost-effectiveness ratios that were a fraction of Nigeria's per capita gross domestic product.
(Foster, LaRoche et al. 2017) [Canada]	To document women's experiences obtaining abortion care in New Brunswick (NB) before and after the Regulation 84-20 amendment; identify the economic and personal costs associated with obtaining abortion care; and examine the ways in which geography, age and language-minority status condition access to care.	New Brunswick residents who received abortion services (n=36)	Qualitative: semi-structured interviews	Although the 2015 changes to Regulation 84-20 represent an important step in aligning New Brunswick with the rest of Canada, the amendment does little to mitigate the challenges imposed by the province's refusal to fund clinic-based abortion care within or outside of the province. Even if the elimination of the two-physician requirement were to be fully implemented, this would have only marginal impact on women's ability to access affordable and timely abortion care.
(Foster and Kimport 2013) [United States]	To analyze data on women who sought and received an abortion at or after 20 weeks' gestation for reasons other than fetal anomaly or life endangerment	People who were seeking abortions after 20 weeks gestation across 16 sites (n=272) and people who presented for first trimester abortions (n=169)	Mixed methods – qualitative data from interviews and quantitative data for logistic regression	Provides information from a case study where the time taken to find a clinic that would provide the necessary abortion meant that the person's gestational age had advanced to the point of needing more costly methods. To find the final clinic required calling two clinics and visiting a third prior to finding a clinic that would provide care.. 600 USD was provided from an abortion fund.
("Fourteenth Amendment" 2016) [United States]	1. To review the Whole Woman's Health v. Hellerstedt case, in which the Supreme Court held two health-related abortion restrictions unconstitutional under the undue burden standard 2. To discuss how the Court resolved much of the doctrinal uncertainty that plagued the undue burden standard, but it allowed for continued judicial discretion where abortion restrictions fit less comfortably into a cost-benefit framework	Those impacted by state-level and national policy/law, including abortion providers and women seeking abortions	Law review	<u>Inability to meet demand for abortion services</u> The court noted that few remaining clinics would be unable to meet demand for abortion services, due to the admitting-privileges requirement that closed almost half of the state's abortion facilities and the surgical-centre requirement that would lead to more closures. Over 75% of Texan clinics closed as a result of these two requirements. The Court concluded that the closures created a substantial obstacle by severely limiting abortion access, that the quality of care would likely decline due to fewer clinics managing the same demand, and that the state had the burden to prove that remaining clinics could meet this demand. <u>Clarity added to undue burden standard</u> The Court added clarity to the undue burden standard by translating the undue burden inquiry into a cost-benefit analysis framework that will likely be applied with greater consistency. However, the court's decision may provide less guidance where courts are asked to weigh burdens and benefits that fit less neatly into a cost-benefit framework. Since the

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				undue burden standard remains a standard, its application depends upon the personal beliefs of judges and Justices. Thus, it remains to be seen precisely how much order Whole Woman's Health will bring to the Court's abortion jurisprudence.
(Haddad, Yanow et al. 2009) [United States]	To explore provider responses to the Partial-Birth Abortion Ban Act of 2003 in one state in order to identify important indicators for a national study	Facilities that provided second-trimester abortions in Massachusetts	Key informant surveys	In reference to the 2007 Supreme Court decision to uphold the Partial-Birth Abortion Ban Act, three hospital facilities increased their charges from second-trimester abortion services, attributing these increases to the cost of providing care since the ban. State regulations specify that abortions beyond 18 weeks and 6 days will only be reimbursed if performed at a hospital; therefore, people seeking abortions at 19 weeks or later must rely on hospitals to secure Medicaid. Medicaid reimbursement rates did not increase with the increased procedure costs after the ban, thus making abortions more expensive to provide.
(Hendrickson, Fetters et al. 2016) [Zambia]	To examine sales practices, knowledge, and behaviour of pharmacy workers regarding medical abortion in 2009 and 2011 in Zambia, where hostile and stigmatizing attitudes still result in high rates of unsafe abortion	Pharmacy workers at government-certified pharmacies in the intervention areas (76 pharmacies in November 2009 and 80 in November 2011)	Descriptive cross-sectional design	Most pharmacy workers mentioned valid medical abortion products to the mystery clients; however, a far smaller number offered to sell mystery clients these medications. Among the pharmacy workers who offered to sell mystery clients a drug or offered information, 51% offered to sell the client a known and approved medical abortion drug in 2009, compared with 72% in 2011 (P = 0.0380). Pharmacy workers offered either Cytotec or an imported Chinese pill. None offered mifepristone although it was available in the study areas. Among those offering known medical abortion drugs, an increase was observed in 2011 in the number who provided important information on medical abortion; however, the provision of specific information was still low overall. None of the pharmacy workers who offered to sell misoprostol in 2009 mentioned the correct number of tablets for initial dosage the patient would need to induce a medical abortion; in 2011, 21% of the pharmacy workers included in the study did provide the correct dosage information (P = 0.0185). In 2011, all of the pharmacy workers who offered to sell medication to the mystery clients also provided one or more pieces of correct information about medical abortions; this is in comparison with only 78% providers in 2009 that provided similar information (P < 0.001).
(Hu and Schlosser 2010) [India]	To study the impact of prenatal sex selection on the wellbeing of girls by analysing changes in children's nutritional status and mortality during the years since the diffusion of sex-selective abortion in India	Households and children (the last two children born within 3 years prior to each survey round)	Econometric analysis of national survey data	Estimates of the main male-female ratio (MFR) effect suggest that regions with increasing MFR experienced improvement in some family characteristics, in particular, an increase in the level of parental education and mother's age at first birth and a decline in the likelihood of living in a rural area. On the other hand, there is no association between MFR and maternal age or the household wealth index.
(Johnston, Oliveras et al. 2010) [Bangladesh]	To estimate comparative costs to the Bangladesh health system	Government health facilities that provide menstrual	Cost estimates	On a per-case basis, the incremental costs of providing menstrual regulation and related care following recommended practices (i.e., use

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	of providing menstrual regulation and care for abortion complications	regulation or care for abortion complications Facilities were purposively and systematically selected by location (urban or rural), facility level (primary, secondary or tertiary) and division or district performance (high, median, or low rate of procedures performed)		of MVA for uterine evacuation, providing services in outpatient facilities, having midlevel providers offer uterine evacuation and other care, and providing contraceptive counselling and services) are much lower than those associated with providing care for abortion complications using conventional practices. On a per-case basis, provision of menstrual regulation care cost 8-13% of the cost of treatment for severe abortion complications, depending on the level of care at which menstrual regulation and PAC were offered. By providing menstrual regulation care as a basic service, the Bangladesh government is providing women with much-needed care and preventing unnecessary and expensive complications. The menstrual regulation program has played an important role in reducing abortion-related morbidity and mortality, and thereby has also played an important role in reducing health system costs associated with treating abortion-related complications. If all women experiencing abortion-related complications were able to access the care they needed, the total annual health system costs of providing care for abortion-related complications would be much higher. The Bangladesh health system could better meet the reproductive health needs of women by making menstrual regulation more accessible, further reducing recourse to unsafe abortion.
(Johnston, Akhter et al. 2012) [Bangladesh]	To assess incremental health system costs of service delivery for abortion-related complications in the Bangladesh public health system and confirmed that providing PAC with vacuum aspiration is less expensive than using dilation and curettage	Public-sector health facilities in Bangladesh (n=17)	Qualitative: purposive sampling and informational interviews	Despite the presence of a decentralized menstrual regulation program, designed in part to reduce complications of unsafe abortion, abortion complications remain a frequent event. On average, each tertiary facility received more than four patients with abortion-related complications every day; this is consistent with previously generated estimates that suggest the public health system treats roughly 70,000 such patients annually.
(Jones and Weitz 2009) [United States]	To addresses a set of laws—laws that directly target abortion providers, make the provision of abortion more difficult and costly, and provide strong incentives for physicians not to offer abortion services—which have a significant capacity to reduce access to and quality of	Those impacted by the policies, including health facilities providing abortions, facility staff, and women seeking abortions	Legal review	The type of regulation unnecessarily requires abortions to be performed in ambulatory surgery centers (ASC) set up for more sophisticated and intrusive surgical procedures. These costly requirements may force many providers to stop offering services or to raise their prices to levels prohibitive for some women seeking care. The regulations require the practice of abortion care to change without regard to evidence or clinical judgment and reduce access to quality second-trimester abortion care.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	abortion care in the United States			ASC regulations are generally quite extensive and are often extremely costly for abortion providers to comply with. These costs are particularly onerous in states that apply the physical plant requirements of their ASC regulations to existing abortion facilities, rather than grandfathering those facilities for purposes of construction standards until such time as the facilities move or undertake substantial renovations. For example, the physical renovations alone at one facility would cost $750,000, according to the administrator of a Texas abortion clinic. The costs and burdens stemming from the imposition of ASC requirements have hindered or prevented physicians in some states from providing abortions.
(Jones 2015) [Ghana]	To examine Ghanaian women's response to a reduction in the availability of modern contraceptives in terms of contraceptive access and use, resulting pregnancies, use of induced abortion, and resulting births. The exogenous change in availability results from a United States policy, driven entirely by domestic politics, that cut funding to non-governmental organizations (NGOs) providing reproductive health services in poor countries.	Individual women aged 17-25 years in a nationally representative, cross-sectional sample from the Ghana Demographic and Health Surveys (n=24,500)	Regression analysis	Though NGOs providing reproductive health services closed clinics in both rural and urban areas, they reported that the primary change in service provision resulting from the funding cuts was a reduction in contraceptive supplies and outreach in rural areas. On the basis of clinic availability data, stocks of modern birth control methods dropped by about 10% nationwide, driven by reductions in the private sector.
(Kacanek, Dennis et al. 2010) [United States]	To investigate three questions: 1) What are providers' experiences with Medicaid reimbursement for abortion in cases of rape, incest and life endangerment? 2) What is the process for applying Medicaid reimbursement? 3) What factors facilitate or hinder reimbursement?	25 abortion providers in six states with restrictive abortion laws	Qualitative interviews	<u>Financial issues</u> Respondents reported varying reimbursement rates. Some stated that rates were so low, they would not be able to stay in business if they continued to bill Medicaid. Some providers received a flat reimbursement regardless of the gestational age at abortion, even though the cost of abortion increases as the pregnancy progresses. One respondent reported that Medicaid reimbursed $212 for an abortion that cost $420. All but two respondents reported relying on abortion funds. If Medicaid reimbursed all qualifying cases, abortion funds would be able to cover more women who are ineligible for Medicaid. <u>Giving up on Medicaid</u> Some respondents no longer contracted with Medicaid, or worked with Medicaid as little as possible, because of the numerous administrative and systematic barriers they experienced. Because of low

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				reimbursement rates and the expense of staff time to pursue Medicaid dollars, many providers avoid working with the system by offering discounts, providing loans, or absorbing the costs of abortions themselves. Some respondents said that they absorb between $1,000 and $60,000 annually in free or reduced-cost services.
(Mercier, Buchbinder et al. 2016) [United States]	To describe recent research with abortion providers in North Carolina to illustrate how providers adapt to new regulations, and how compliance with regulation leads to increased workload and increased financial and emotional burdens on providers	31 healthcare professionals in North Carolina who were involved in multiple aspects of abortion provision at 11 distinct clinical practices	Interviews	Most providers made changes to meet the law's requirements and also to minimize the burden of the law on patients. For example, they chose to implement telephone counselling rather than require two in-person clinic visits. Implementation of telephone counselling, however, required significant adaptations. Several high-volume providers hired additional nurses and developed a call-centre infrastructure with dedicated staff for telephone counselling. Lower-volume providers responded to the new requirements by changes in scheduling and work tasks. Providers who worked in small or solo-practice clinics frequently extended the hours of existing staff to meet demands. In general, we observed a trade-off between cost and time burdens, depending on the practice type and structure. Costs were greatly increased by the requirement that a licensed medical professional perform the state-mandated counselling. The clinic administrator noted at one large abortion clinic in an urban setting described the law as having "a huge financial impact ...you know, nurses are expensive." In contrast, for lower-volume clinics, solo practitioners, and hospital-based clinics, costs did not increase, as no additional staff was hired. However, the providers, typically physicians, described how they and their colleagues worked more uncompensated hours to meet the law's requirements. In general, providers absorbed both the financial and time burden of these changes. No providers reported increasing their prices to compensate, and several specifically stated that they made an explicit decision not to pass the cost onto patients. Larger practices with greater resources performed dedicated fundraising activities to support the increased costs.
(Mutua, Manderson et al. 2018) [Kenya]	To illustrate how the quality of PAC in healthcare facilities is impacted by law and government policy	21 patients and 16 providers (eight were nurses and eight were clinical officers)	Cross-sectional design with in-depth interviews	<u>Increased access to abortifacients</u> In 2016, misoprostol and mifepristone were registered and included as essential drugs for the management of obstetric and gynaecological indications, resulting in increased access. As a result, the use of crude means of abortion termination decreased. However, some service providers found challenges with the unregulated access of these drugs, often without proper controls on drug prescription and usage. <u>Evidence of capacity gaps</u> Emergency care was significantly impeded by the unavailability of the

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				right providers for certain procedures, especially doctors, and during the night, weekends, or public holidays. These capacity gaps were also evident in the number of patients who required multiple evacuations, often leading to longer hospital stays and increased the cost of care to both the patients and the healthcare system.
(Osur, Baird et al. 2013) [Kenya, Uganda]	To evaluate implementation of misoprostol for PAC (MPAC) in two African countries	Public and private health facilities in Rift Valley Province, Kenya, and Kampala Province, Uganda (n=25) MPAC providers, health facility managers, Ministry of Health officials, and NGO staff involved in program implementation (n=45)	Pre/post intervention study using a comprehensive site assessment tool (pre-implementation) and an independent evaluation including in-depth qualitative interviews (post-implementation)	MPAC providers believed that use of misoprostol offered women greater privacy, reduced cost, and the option of a non-invasive treatment for their incomplete abortion.
(Ramos and Rios 2015) [Peru]	To explore debates of whether a woman with an incomplete abortion should be treated with surgical procedures or medical procedures	Debates on the topic of MVA versus MA in Peru	Literature review	Treating incomplete abortion has substantial costs for the health system.
(Roberts, Gould et al. 2014) [United States]	To describe payment for abortion care before new restrictions among a sample of women receiving first and second trimester abortions	English- and Spanish-speaking women aged 15 and older, with no known fetal anomalies or demise, presenting for abortion care at one of 30 facilities throughout the United States between January 2008 and December 2010 and meeting specific gestational age criteria	Interviews and regression analysis	There are significant gaps in public and private insurance coverage for abortion.
(Sagala 2005) [sub-Saharan Africa]	To examine the effect of the Global Gag Rule on family planning organizations in countries receiving American assistance	Family planning organizations within multiple countries	Literature review	In Zambia, the Planned Parenthood Association of Zambia (PPAZ) lost 24% of its core grant for refusing to sign a pledge to enforce the Global Gag Rule. PPAZ further lost $137,092 in contraceptive supplies. The loss of funds disrupted family planning services and hindered the design and production of training materials. In September 2003, the Planned Parenthood Association of Ghana (PPAG) refused to sign a pledge to

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				enforce the Global Gag Rule and lost more than $200,000. This led to cutbacks in PPAG's family planning programs. The loss of funding from USAID has shattered rural outreach programs by reducing nursing staff by more than 40%. In Ethiopia, the Global Gag Rule requirements forced the Family Guidance Association of Ethiopia (FGAE) to sever its ties with Pathfinder International, a sub-grantee of USAID. USAID responded by defunding FGAE. With the defunding, FGAE no longer services some 300,000 clients, who desperately need reproductive health care services that the Ethiopian government cannot provide. In addition, the Family Planning Association of Ethiopia lost $56,000; money that would have been used to procure and distribute much needed contraceptives. With the implementation of the Global Gag Rule directives, USAID/Kenya-NGO partnerships have broken down and several NGO run reproductive health clinics have been gutted. The Global Gag Rule curtailed family planning and maternal and child health care services and weakened the collective Kenyan NGO response to HIV/AIDS. The Global Gag Rule has also forced the Family Planning Association of Kenya (FPAK) and Marie Stopes Clinic to close down their major urban clinics and service centres. FPAK lost more than $580,000 and consequently closed three clinics that served over 56,000 poor and underserved clients. Similar results have been recorded in Senegal and Zimbabwe.
(Schaff and Schaff 2010) [United States]	To review evidence relating to mifepristone ten years after its legalization in the United States	Evidence on mifepristone across the United States	Review	Medical liability insurance for medical abortion has reportedly been denied or is cost-prohibitive for non-specialists; as a result, primary care physicians are unable to afford the costs of insurance to practice.
(Schiavon, Collado et al. 2010) [Mexico]	To know which factors (e.g., fear of staff attitudes, ignorance about the law, lack of information on where to access services, fear of breaches in confidentiality, burdensome requirements) were driving women in Mexico City to continue seeking private abortion services despite the availability of low-cost, safe, legal abortion services in the public sector	135 physicians in the private sector who confirmed they were direct abortion providers	Descriptive	Nearly half of surveyed abortion providers reported that the number of women seeking abortion services at their facilities had increased since legalization, while 10% reported that the demand had decreased. Nine in ten respondents said they had started offering abortion services only after the legalization of abortion, suggesting that legalization may have led to an increase in abortion providers. Alternatively, some of these providers may simply have been reluctant to admit they had been providing abortions before legalization.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Sheldon and Fletcher 2017) [United Kingdom]	To provide a detailed reassessment of the relevant law (on doctors performing MVA procedures) and the clinical evidence that supports this assumption	Medically-trained abortion providers (doctors, nurses, midwives)	Reassessment of relevant law and clinical evidence that supports the law's assumption	Allowing nurses to provide vacuum aspiration for induced abortion potentially offers a more sustainable and economically efficient basis for the long-term development of excellent care. It would free up doctors to focus on those aspects of service provision where their specific expertise is needed. It might also improve the job satisfaction of nursing and midwifery staff, potentially impacting positively on sickness absence and staff retention rates.
(Singh 2010) [global]	To review the scientific evidence on the consequences of unsafe abortion, highlight gaps in the evidence base, suggest areas where future research efforts are needed, and speculate on the future situation regarding consequences and evidence over the next 5–10 years	Women who obtained unsafe abortions	Literature review	A recent study in Nigeria (1) estimated the cost of providing the necessary contraceptive services and supplies to prevent the unintended pregnancies that resulted in unsafe abortions and (2) compared this cost with the cost of providing PAC. It found that the cost-to-benefit ratio is $4:$1. Other types of economic costs have not been studied because of the difficulty in collecting data to document these costs.
(Sjostrom, Kopp Kallner et al. 2016) [Sweden]	To calculate the cost-effectiveness of early medical abortion performed by nurse-midwifes in comparison to physicians in a high resource setting where ultrasound dating is part of the protocol	Healthy women seeking treatment for abortion at an outpatient clinic of a university hospital	Cost effectiveness analysis	In a high-resource setting where ultrasound dating is part of the protocol, the randomized-controlled equivalence trial showed that provision of medical abortion by nurse-midwifes was superior to provision by physicians, with a risk difference for effectiveness, complete abortion without surgical intervention, of 1.6% (95% CI; 0.2–3.6%, p = 0.027). This means that for every 100 patients (procedures), the intervention treatment resulted in 1.6 fewer follow-up surgical abortions than the standard treatment. The authors also examined the incremental cost effectiveness (ICER) of different measures of costs. For the direct cost per woman treated, the difference in costs per case ranged from € 45–58.3, and the difference in efficacy per case was 0.016. The ICER was -831.2. For the direct costs including waiting time for the consecutive patient, the difference in costs per case ranged from € 41–58.3, and the difference in efficacy per case was 0.016. The ICER was -1081.2. Lastly, for the total direct and indirect costs, the difference in costs per case ranged from € 78–106.3, and the difference in efficacy per case was 0.016. The ICER was -1768.8.
(Vlassoff, Walker et al. 2009) [global]	To estimate the health system costs of PAC in Africa and Latin America	Top-down approach: PAC patients Bottom-up approach: women hospitalized for serious medical complications of induced abortion	Cost estimations	The health care system cost of treating serious abortion complications is only one component of the total economic impact on society of unsafe abortion. The costs of treating long-term health consequences, such as chronic pelvic infections and infertility, have hardly been studied. The indirect economic costs of unsafe abortion are also essentially unmeasured. The health system costs of PAC in Africa and Latin America ranged from $159 million to $476 million per year, depending on the estimation method used. The average estimates from the two

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				approaches largely coincide: $280 million using the top-down approach, and $274 million using the bottom-up approach (averaging actual and standard practice estimates). These considerable sums impose an added burden on the already overstretched health resources of developing countries.
(Wu, Maru et al. 2017) [Nepal]	To review abortion care in Nepal 15 years after it was legalized	Abortion providers, women seeking abortions, those impacted by national policies	Review of current status	Implementing first-trimester medical abortion services has further expanded abortion access, since medical abortion can be more easily provided in rural areas. Medical abortions now constitute over 50% of all abortions in Nepal. Facilities providing first-trimester medical abortions do not need to have surgical abortion capacity. Preventing medication stock-outs at remote health care facilities is critical. In some areas, the supply chain for medical abortions has been poorly managed and there are reports of women being denied legal abortions due to a lack of abortion medications. This has been further complicated by the black market for medical abortion medications of questionable quality, especially along the Indian border. Private pharmacies have emerged as a prevalent dispenser of medical abortion medications, although most pharmacists are not government-approved to do so and have not had adequate training on medical abortion counselling. United States foreign policy continues to influence the implementation of safe abortion services in Nepal. As a consequence of the Helms Amendment, many government and non-profit clinics receiving USAID funding cannot provide abortions. USAID selectively supports post-abortion care and artificially separates it from comprehensive abortion care. While the same manual vacuum aspirator can be used to perform both abortions and post-abortion care, many USAID-supported clinics will perform only the latter while turning away women seeking services for the former. These funding restrictions marginalize abortion services from the existing health care system and create clinics that provide less efficient care. In the early 2000s, when the Global Gag Rule was active, several Nepali organizations rejected the terms of the rule and, in turn, suffered significant funding losses that resulted in program cutbacks and layoffs.
(Zamberlin, Romero et al. 2012) [Latin America]	To summarize the findings of a literature review on women's experiences with medical abortion in Latin American countries where voluntary abortion is illegal	Studies on women's experiences with medical abortion in Latin American countries where voluntary abortion is illegal	Literature review	Difficulty in obtaining misoprostol was related to different regulatory environments (e.g., local, governmental control of pharmacy sales). Stricter controls restrict access and push pregnant people to access misoprostol through unofficial markets at higher prices. Where misoprostol is sold under prescription, women used strategies to obtain a prescription or buy misoprostol without one, including paying for a prescription, claiming the drug is not for gynaecological purposes (e.g.,

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				obtaining it from a non-gynaecological specialist), or asking an older man or woman to buy the drug on their behalf.

Appendix P. Summary of studies reporting meso-economic value/benefit

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Aiken, Gomperts et al. 2017) [Ireland]	To examine the characteristics and experiences of women in Ireland and Northern Ireland seeking at-home medical termination of pregnancy (TOP) using online telemedicine	Women in Ireland and Northern Ireland who filled out an online consultation form requesting TOP between January 2010 and December 2015; follow up information for women to whom medications for TOP were shipped between 1 January 2010 and 31 December 2012	Analyses of online telemedicine for medical abortion (MA) services	The option of online telemedicine partly resolves the disparity in reproductive health and rights, addressing delays in accessing abortion care and situations where abortion care is rendered impossible.
(Benson, Gebreselassie et al. 2015) [Malawi]	To estimate current health system costs of treating unsafe abortion complications and compare these findings with newly-projected costs for providing safe abortion in Malawi	Malawi health system costs	Estimation study based on survey and costing data	In the 93 post-abortion care (PAC)-providing public facilities, two scenarios shifting treatment of abortion complications to legal, safe abortion both resulted in substantial annual cost savings: (1) If all women seeking first-trimester induced abortion choose manual vacuum aspiration (MVA), it results in an estimated cost reduction of 20%; (2) Making both MVA and misoprostol available results in an estimated 30% reduction. A liberalized abortion law and access to safe abortion in public health facilities yielded a 20-30 % decrease in current PAC costs.
(Billings and Benson 2005) [Latin America and the Caribbean]	To review results from 10 major postabortion care (PAC) operations research projects conducted in public sector hospitals in seven Latin American countries, completed and published between 1991 and 2002	Review of results of 10 PAC operation research projects in seven countries	Review	In studies from Mexico-Oaxaca and Peru-Callao, sharp curettage was used to treat all women with abortion complications prior to the PAC intervention. Following provider training, staff supervision, and technical assistance, use of MVA increased to 78% and almost 90% of patients, respectively. Approximately 3 years after the original intervention in Peru-Callao, 99% of all eligible women continued to be treated with MVA, demonstrating the sustainability of the service.
(Brack, Rochat et al. 2017) [Colombia]	To identify the key barriers to legal abortion, and to explore the ways they may work separately and together to delay the receipt of high quality, legal abortion care	Women aged 18 or older who had obtained a legal abortion in Bogotá, Colombia in the past 12 months and exhibited verbal proficiency in Spanish (n=17)	In-depth interviews	Insurance representatives hung up abruptly when participants mentioned abortion, did not return participants phone calls, or told participants that abortion was not covered. Inconsistent instructions regarding necessary authorizations further delayed women from getting approval and obtaining an abortion

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				in a timely manner. Insurance companies acted as a barrier to timely access to legal, safe abortion care, even though they are legally obligated to authorize the procedure. Religious sentiments appeared to underlie the behaviour of company representatives.
(Cheng, Zhou et al. 2012) [China]	To investigate providers' knowledge and attitudes about MA and their views regarding the main challenges to expanding the use of MA in urban and rural areas in China	Abortion service providers at the selected study sites, including ob-gyns, nurses, midwives, and family planning service providers who had been offering MA, surgical abortion, or both for more than 2 months	Multistage stratified cluster sampling design	Providers in the city of Shenzhen (38.2%) and rural Henan (33.1%) stated that a specific advantage of MA is that it is less expensive than surgical abortion. MA provides a low-cost, low-risk alternative to surgical abortion.
(Choobun, Khanuengkitkong et al. 2012) [Thailand]	To compare the hospital charges, duration of in-hospital procedures, clinical course and complications between MVA and sharp curettage	Women undergoing first-trimester abortions at the Songklanagarind Hospital (n=80)	Prospective observational study	This study confirms the benefit of MVA over sharp curettage in terms of less hospital visits, shorter duration of the procedure and hospitalization, less admissions, and less hospital-related expenditure.
(Cook, de Kok et al. 2017) [Malawi]	To investigate factors contributing to the limited and declining use of MVA in Malawi	17 health workers of different cadres (doctors, nurses and clinical officers), genders and levels of experience and seniority who provided PAC in a central hospital and a district hospital	Small-scale qualitative study involving interviews supplemented by unstructured observations of care practices	Compared to D&C, MVA is cheaper, simpler and quicker to perform, requires less staff and allows for rapid discharge of patients resulting in fewer in-patients.
(Comendant 2005) [Moldova]	To present information on the current abortion law, policy and services in Moldova and describe a project whose aim is to improve the quality of abortion services, including the introduction of MA through training of service providers and community education	Moldova	Mixed methods	Providers are pleased with the MVA services that are safe and effective, and save time and costs.
(Dennis, Manski et al. 2014) [United States]	To answer the following questions: 1) What do women know about the cost of abortion and the	Low-income women, defined as meeting the Medicaid income qualifications of the state where they had the abortion, aged 18 years or	Two similarly-focused studies using in-depth interviews	In states where Medicaid coverage of abortion is available, a range of health care providers provide pregnancy options counselling, offer information about costs and coverage, and direct women to abortion clinics. The referrals in this study in Medicaid coverage

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	availability of Medicaid coverage for abortion? 2) Where do women obtain this information? 3) What are women's experiences paying for care?	older who had an abortion within the past two years and who resided in one of the four study states at the time of the abortion		states—where staff at abortion facilities refer women to Medicaid and where primary care providers refer women to abortion providers—indicate a health system responding to women's comprehensive health needs.
(Díaz-Olavarrieta, Cravioto et al. 2012) [Mexico]	To identify the perceptions and opinions of people who provide abortion services in Mexico City, three years after implementation of elective abortion legal reforms	19 health workers assigned to the legal abortion programs at a clinic and a hospital in Mexico's Federal District	In-depth interviews	According to the ILE (legal pregnancy interruption) conscience objection is an exclusive right for medical doctors, but at times paramedic and administrative staff may assume themselves as objectors. Most participants mentioned that conscience objection is determined by cultural and religious views as well as by disinformation about reproductive health. A few medical doctors hold a double discourse because they refuse abortion practices in the public sphere but perform abortions in the private sphere, where it is more profitable.
(Gan, Zhang et al. 2011) [China]	To evaluate Chinese healthcare providers' knowledge of MA, to understand their perspectives regarding the main challenges to increasing its uptake, to understand their preferences for specific abortion methods, and to investigate the role of remuneration on the decision-making process	Profession/abortion providers (n=607)	Cross-sectional survey	Most providers said remuneration was not associated with recommending an abortion service. Only 17.8% of providers thought economic factors were important when recommending an abortion method. Overall, 10.5% considered provider income and 12.3% considered clinic income to be linked to the abortion method recommended. In 5.6% of cases, the clinic charged for abortion counselling, and in 10.9% of cases it charged for abortion follow-up. One hundred and fifteen healthcare providers (17.5%) stated that their income was related to the number of abortions they performed, and 72.2% reported that they did not receive any commission for providing abortion.
(Garcete and Winocur 2006) [Mexico]	To analyse different aspects that affect access to legal abortion in Mexico City and the characteristics that currently define such abortion services	Women who obtained or solicited legal abortion services between 2002-2006	Analysis of survey data	After the approval of the abortion law, the increase of induced abortion due to rape conducted by the Secretariat of Health of the Federal District during 2004 (n=13) was greater than the two previous years (n=5 in 2002, n=5 in 2003). Although the numbers are small, an increase of more than 100% is statistically significant.
(Ganatra, Manning et al. 2005) [India]	To report on a study examining how mifepristone and misoprostol are being	Chemists in the Indian states of Bihar and Jharkhand in 2004 (n=209)	Mixed methods: survey, in-depth interviews, observations	Some chemists thought that mifepristone and misoprostol were more effective than the other drugs; however, the belief that mifepristone was better was

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	used in the Indian context; who is using them; how women access them; or how providers, chemists, women and their partners perceive MA			often due to its higher price with cost being a proxy for quality.
(Gibb, Donaldson et al. 1998) [United Kingdom]	To measure women's preferences and strength of preferences (expressed in terms of willingness-to-pay) for MA versus surgical vacuum aspiration	Women prior to having, and following, termination of early pregnancy (n=50) at a gynaecology out-patient clinic in Aberdeen Royal Hospitals National Health Service Trust between August 1993 and February 1994	Willingness to pay technique	If a choice had to be made about which service to provide, the willingness-to-pay and cost data indicate that the medical method should be chosen over surgical vacuum aspiration. As use of the medical method increases, the costs of maintaining the surgical facility may rise. However, a decision maker may still consider retaining this option on the grounds of equity.
(Hu, Grossman et al. 2009) [Mexico]	To assess the comparative health and economic outcomes associated with three alternative first-trimester abortion techniques in Mexico City and to examine the policy implications of increasing access to safe abortion modalities within a restrictive setting	Three alternative first-trimester abortion techniques in Mexico City	Computer-based model simulation of induced abortion and its potential complications Assessment of cost-effectiveness of alternative safe modalities for first-trimester pregnancy termination	In Mexico City in 2005, MA using vaginal misoprostol required four clinic visits: an initial screening and counselling visit, a visit to provide the medications and two follow-up visits. This protocol can likely be streamlined to two or three clinic visits, reducing the personal and direct medical cost of MA without impacting patient safety.
(Hu, Grossman et al. 2010) [Nigeria and Ghana]	To explore the policy implications of increasing access to safe abortion in Nigeria and Ghana To comparatively assessed the cost-effectiveness of unsafe abortion and three first-trimester abortion modalities: hospital-based dilatation and curettage, hospital- and clinic-based MVA, and MA using misoprostol	A cohort of women in Ghana and Nigeria	Computer-based decision analytic model	Under a modified societal perspective, all safe abortion modalities were preferable to unsafe abortion and were associated with cost-savings relative to unsafe abortion. In Nigeria, clinic-based MVA was the least costly and most effective option. While equally as effective as clinic-based MVA, hospital-based MVA was the most expensive. Dilation and curettage (D&C) and MA using vaginal misoprostol provided comparable benefits although the latter was less costly. In contrast, in Ghana, MA was the most cost-effective option owing to its low procedural cost (approximately one-third the cost of clinic-based MVA). Clinic-based MVA was more effective than MA but was associated with a cost of $16,855 per life-year gained. Hospital-based MVA and D&C were more expensive and no more effective than

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				clinic-based MVA, and were therefore strongly dominated. Only 60% of all elective abortions in Nigeria are estimated to occur in public or private health facilities, mostly with D&C. A transition in practice pattern from one where 50% of women that would otherwise receive D&C to clinic-based MVA, without changing the percentage that pursue unsafe abortion, saves substantial costs. The provision of safe abortion in place of unsafe abortion is the single most important factor in improving health and economic outcomes associated with elective pregnancy termination. Clinic-based MVA is the most cost-effective surgical option for safe, first-trimester abortion. Wherever possible, transitioning from D&C to clinic-based MVA will result in lower costs, and reduce complications and deaths. MA will reduce health care costs and should be promoted as a nonsurgical option for elective abortion.
(Ilboudo, Greco et al. 2016) [Burkina Faso]	To estimate the costs of six abortion complications including incomplete abortion, haemorrhage, shock, infection/sepsis, cervix or vagina laceration, and uterus perforation treated in two public referral hospital facilities in Ouagadougou and the cost saving of providing safe abortion care services	Records of patients seeking PAC at two public referral hospitals in Ouagadougou (n=449) Key informants (e.g., gynaecologist, midwife, administrative personnel) in maternity wards and in hospital facilities	Review of PAC-registers using two structured questionnaires and key informant interviews	If safe abortion care services were available in 2010, the provision of these services would only have cost US$ 2,694 for both referral hospital facilities (representing only 12% of the facilities' total costs spent treating complications of unsafe abortions). An estimated US$ 19,778.53 would thus have been saved in 2010, if safe abortion care services were available.
(Johnston, Ved et al. 2003) [India]	To obtain information about where rural women seek care for abortion complications and about the quality of care they receive	Surveys of formal and informal organizations, institutions and key leaders in four selected villages in rural Uttar Pradesh Community mapping exercises in four selected villages in rural Uttar Pradesh	Descriptive surveys, community mapping exercises, focus group discussions, and in-depth interviews	Village-level providers have an opportunity to engage their patients in a formal network of care. The providers identified in the study, all of whom already provide PAC in some form, could contribute to decreasing maternal morbidity and mortality from unsafe abortion by appropriately referring women to higher-level care for abortion and PAC services; providing contraceptive counselling and methods, or referral; and linking PAC

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
		24 focus group discussions with informants from specific population subgroups, including married women and men, and single female and male young adults 88 in-depth interviews with 53 key informants who were married women that the interviewers identified as being particularly knowledgeable about abortion and PAC issues in their village In-depth interviews with 38 PAC providers		patients to reproductive health and other services as necessary.
(Jowett 2000) [low-income countries]	To review evidence on safe motherhood from low-income countries	Evidence from low-income countries	Review	In Kenya, switching from sharp curettage to MVA saved 38% in equipment costs and reduced hospital stays by 41-76%. In Brazil, incomplete abortion patients treated with MVA consumed 41% fewer resources than similar patients treated with sharp curettage.
(Levin, Grossman et al. 2009) [Mexico]	To assess abortion outcomes and costs to the health care system in Mexico City in 2005 at a mix of public and private facilities prior to the legalisation of abortion	Hospital staff, administrative records and patients at three public hospitals and one private clinic in Mexico City	Cost estimates and projections	Reducing complications by improving access to safe services in outpatient settings would reduce the costs of abortion care, with significant benefits to Mexico's health care system. Even a modest increase in access to MVA would provide additional cost savings of over US$ 50,000. Key to these scenarios is that the cost of providing abortion services declines as access increases at smaller public and private health facilities that can provide abortion care efficiently and at less cost than large hospitals.
(Pillai, Welsh et al. 2015) [United Kingdom]	To assess the applicability, acceptability and cost implications of introducing the MVA technique with local anaesthesia for fully conscious first-trimester termination of pregnancy within the National	Women attending the Pregnancy Advisory Service	Analysis of routinely collected data	The main cost savings were realised by replacing surgical procedures in theatre with MVA. Within four months of introducing MVA, it was possible to replace one of three weekly theatre lists with MVAs. The saving on the theatre recharge was £92,000 per annum. The costs for setting up and running the MVA sessions amounted to £28,000 per annum. The main consumable cost was contraception. Owing to the high uptake of

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	Health Service and for our population			long-acting reversible contraceptives, particularly the 51% uptake of the intrauterine system, this averaged £235 per session of four cases. There were additional setup costs for purchase of dilator sets and theatre clothing. Overall, the difference in cost of the weekly theatre list against running two MVA sessions per week resulted in an annual saving of around £60,000.
(Rodriguez, Mendoza et al. 2015) [Colombia]	To compare the costs to the health system of three approaches to the provision of abortion care in Colombia: PAC for complications of unsafe abortions, and for legal abortions in a health facility, misoprostol-only MA and vacuum aspiration abortion	Women who sought abortion care at all three sites in 2012 (n=1,411)	Cost analysis	Legal abortion would need to cost more than $734 per case for PAC to be a cost-saving strategy. If we assume a 9% spontaneous abortion rate, and if the remainder of PAC cases currently observed were replaced with legal abortion (medical or MVA), the health system would save an additional $163,000 dollars and prevent 16 complications per 1,000 abortions. The health system could save an additional $177,000 (per 1,000 women) from baseline, by replacing D&C with MVA.
(Schaff and Schaff 2010) [United States]	To review evidence relating to mifepristone ten years after its legalization in the United States	Evidence on mifepristone across the United States	Review	The FDA recommended mifepristone dose of 600mg is expensive, and some facilities require four visits before administering, which reduces cost benefits. Medical liability insurance for medical abortion has been reported to be denied or is cost-prohibitive for non-specialists, the result being that primary care physicians are unable to afford the costs of insurance to practice.
(Sjostrom, Kopp Kallner et al. 2016) [Sweden]	To calculate the cost-effectiveness of early MA performed by nurse-midwifes in comparison to physicians in a high resource setting where ultrasound dating is part of the protocol	Healthy women seeking treatment for abortion at an outpatient clinic of a university hospital	Cost effectiveness analysis	Task shifting of MA generated direct economic benefits associated with the shorter time spent in the clinic by providers and patients and nurse-midwives' lower salaries. Costs were also reduced due to shorter waiting time for subsequent patients and a possible lower cost for the treatment of complications. The intervention was superior in efficacy and cheaper than the standard treatment. In addition, the costs of the intervention are expected to decrease over time.
(Thapa, Poudel et al. 2004) [Nepal]	To assess and evaluate the safety, acceptability, and effectiveness of MVA services	Two groups of patients were compared: 529 patients treated in the MVA unit and 236 patients who were clinically eligible for treatment in the MVA unit but were	Cohort analytic	OT patients spent, on average, 33.42 hours in the facility, whereas the MVA patients spent only 19.75 hours. Thus, OT patients would have stayed 58.6% fewer hours in the hospital had they been treated in the MVA unit. Since the hospital usually has an overflow of patients, the freed-up beds would have been put to use

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
		treated instead in the main operation theatre (OT) owing to the unavailability of services in the MVA unit during the hours of their admission		by other patients. In addition, the hospital would have been able to use the physicians and anaesthetists for other major surgical cases. Switching eligible patients to the MVA unit and, thereby, shortening their stay in hospital, however, would not necessarily have reduced the cost to those patients. The cost of treatment in the MVA unit was about the same as treatment in the OT. We also estimated the potential use of the MVA unit if its service hours could be extended from 7 to 24 hours per day. Of the total number of patients with post-abortion complications, nearly three quarters could be treated in the MVA unit.
(Upadhyay, Johns et al. 2017) [United States]	To examine the association between distance travelled for an abortion and site of PAC among low-income women	Women seeking abortion services who were beneficiaries of the California Medicaid program	Retrospective observational cohort study	This study supports fully reimbursing abortion providers for all forms of follow-up care (e.g., low-sensitivity or semiquantitative urine pregnancy tests, phone calls, or internet communication) after medication abortion. Encouraging these alternative forms of follow-up care will likely result in cost-savings because women may be less likely to seek such care at emergency departments.
(Winocur 2006) [Mexico]	To analyse abortion laws and access to justice in the light of individual cases	Women of different ages who sought abortion services because of rape incidents and who faced several barriers to access the service and who obtained different results	Legal analysis and interviews	Authorities put up multiple barriers for women who come to request a legal interruption of their pregnancy, leading these women to look for clandestine procedures. An investigation by Lara, Strickler, Ellertson and Tsuyuki (2003) showed that 18% of "clandestine" abortions are performed for reasons considered legal and another 20% of these abortions are done for economic reasons, a circumstance that is only decriminalized in Yucatán.

Appendix Q. Summary of study reporting abortion-related stigma and meso-economic costs

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Bennett 2001) [Indonesia]	To examine the experience of premarital pregnancy and induced abortion among young, single women in Lombok, Eastern Indonesia	Single women and their families, and health care providers in Mataram, the capital city of Lombok, between August 1996 and February 1998	Ethnography	This study has found that the inflated fees from providers, unregulated because abortion procedures are clandestine, is a significant barrier to services. To ensure confidentiality, unmarried women will present to private medical providers for treatment. Costs of service can range from 60,000 – 300,000 rupiah, with purchase of drugs as an additional, separate cost. The high price point for confidentiality is often beyond the independent financial resources of most single women.
(Brack, Rochat et al. 2017) [Colombia]	To identify the key barriers to legal abortion, and to explore the ways they may work separately and together to delay the receipt of high quality, legal abortion care	Women who had obtained a legal abortion in Bogotá, Colombia in the last 12 months; were aged 18 or older; and exhibited verbal proficiency in Spanish (n=17)	In-depth interviews	In general, insurance companies acted as a barrier to timely access to legal, safe abortion care, even though they are legally obligated to authorize the procedure. Religious sentiments appeared to underlie the behavior of company representatives.
(Chełstowska 2011) [Poland]	To describe the economic consequences of the stigmatisation and illegality of abortion and its almost complete removal from public health services in Poland since the late 1980s.	Polish women	Review	In the private sector, illegal abortion must be cautiously arranged and paid for out of pocket. The more abortion is stigmatised in the public sphere, the more women depend on the private sector for solutions. In Poland it is common for doctors to deny abortion care to women whose health or life is in danger, because doctors count on them to “cope” with health problems privately. A pregnant woman cannot be sure whether a doctor who issues an opinion about her pregnancy is guided by what is good for her, or by their own apprehension, prejudice or interest. Some of the same doctors will refuse to perform abortions in public hospitals just to take that risk when a woman comes to their private practice. Private practice of abortion services is a vast, untaxed source of income. That is why the medical profession is not interested in changing the abortion law.
(Coast and Murray 2016) [Zambia]	To analyse the details of pathways to care, barriers and delays, and the role of others in influencing these pathways.	Females aged 15-43 years seeking either safe abortion or PAC at University Teachig	Qualitative cross-sectional	Stigma and the false perception that abortion is illegal contribute to steering women towards clandestine methods, and reinforce women's silence and isolation. Abortion stigma gives providers leverage to extort unofficial and illegal fees, knowing that women are desperate for the service and unlikely

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
		Hospital, Lusaka [n=112]		to expose these financial demands for fear of revealing an abortion. There was also a difficult-to-quantify undercurrent of unofficial private practice that exploited the stigma surrounding abortion and women's lack of clarity on their entitlement to services. Women can find it difficult to find out how much abortion care will cost; even legal service providers do not advertise their abortion service charges openly, unlike other sexual health services. When unofficial payments are paid, secrecy means that there can be substantial gaps between expected and actual costs.
(Díaz-Olavarrieta, Cravioto et al. 2012) [Mexico]	To identify the perceptions and opinions of people who provide abortion services in Mexico City, three years after implementation of elective abortion legal reforms.	Key informants: clinic health providers [n=10], hospital health providers [n=9]		A study reported that 38% of providers were opposed to provide abortion services for free because they needed to compensate the high costs of the program and create a dissuasive element to avoid abuses. In this study, the mechanism suggested by the participants was to implement a payments system in the rest of the public services that provide this service.
(Ganatra and Hirve 2002) [India]	To explore adolescent women's access to abortion services, decision-making on abortion, determinants of provider choice and extent of morbidity experienced.	Women (primarily those currently married) who had undergone an induced abortion in the study area in an 18-month reference period during 1996–1998	Questionnaires and a qualitative in-depth time-line of sequence of events	Providers routinely referred to unmarried adolescents as ‘‘illegal’’ cases because their pregnancies did not occur within the context of marriage. While we did not ask them about the costs of services for unmarried clients, a few providers did mention that unmarried young women are charged three to five times the normal rate. Some 40% selectively refused services to unmarried and separated young women even though they offered them to other women.
(Gober 1997) [United States]	Investigate the role of access in explaining the variation in state abortion rates	U.S. state policies and abortion rates	Regression analysis	Each year a growing number of clinicians are unwilling to perform abortions, citing as reasons poor pay, low prestige, harassment and intimidation, suboptimal working conditions, the tedium of performing largely repetitive operations, and emotional stress surrounding unwanted pregnancies and families in crisis. The public controversy surrounding abortion renders it unlike other medical procedures. Clinic personnel are stalked and taunted by antiabortion demonstrators. Doctors who perform abortions risk their physical safety, the loss of hospital privileges, and vigorous scrutiny by state licensing boards. The result is to isolate the practice of abortion from other aspects of reproductive health and to recast the public perception of abortion from a routine, safe, and inexpensive medical procedure to a burdensome, socially stigmatized act.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Henshaw 1995) [United States]	To provide information on the percentage of women who travel long distances to obtain abortion services, the availability of abortion providers for second trimester services, the need to make more than one trip to the abortion facility and the amount abortion providers charge for services. In addition, it presents a measure of antiabortion harassment.	Abortion providers in the United States (n= 1,525)	Cohort	Another type of problem faced by facilities, named by 6% or provider respondents, concerned regulation and legislation at the national and state level, especially the denial of Medicaid payment for abortion. 6% identified business problems, including reduced demand, competition and rising costs, and 1% cited insurance problems.
(Marlow, Wamugi et al. 2014) [Kenya]	To understand the methods married women aged 24–49 and young, unmarried women aged ≤ 20 used to induce abortion, the providers they utilized and the social, economic and cultural norms that influenced women's access to safe abortion services in Bungoma and Trans Nzoia counties in western Kenya.	Focus groups [n=10] conducted in Trans Nzoia and Bungoma county with un/married and younger/older women in rural and urban settings.	Qualitative cross-sectional descriptive	The secrecy and perceived illegality of abortion as a stigmatized, illicit, back-door activity, keeps it out of the public purview. When study participants were asked about community-based stigma towards abortion, all the focus groups discussed how women are ostracized, labelled and stigmatized as killers or murderers, are perceived to be a bad influence on others, are called prostitutes and accused of being unfaithful to their husbands or boyfriends. One study participant said that some providers can help but you cannot openly ask them for an abortion; you have to ask them to do it outside of the hospital. Married women from Bungoma and Trans Nzoia discussed arranging an abortion as a negotiable financial transaction that depends on the demand on a given day and whether the woman looks like she has money.
(Upadhyay, Johns et al. 2017) [United States]	To examine the association between distance travelled for an abortion and site of PAC among low-income women	Women seeking abortion services who were beneficiaries of the California Medicaid program	Retrospective observational cohort study	This study found that post-abortion visits to the emergency room (ED) as opposed to other facility types or visits may be driven by stigma, worry, or distrust of providers.

Appendix R. Summary of studies reporting abortion-related stigma and meso-economic impact

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Contreras, van Dijk et al. 2011) [Mexico]	To examine the experiences and opinions of health care	64 semi-structured interviews with obstetricians/gynaecologists,	Qualitative study using semi-	The number of conscientious objections was problematic for hospitals and health centres providing legal abortions; reports noted that these objections were not for moral or

	professionals after the legalization of abortion in Mexico City in 2007	nurses, social workers, key decision makers at the Ministry of Health, and others	structured interviews	ethical reasons but rather to avoid extra workloads. Objectors also reported providing abortions in their private practices, suggesting financial incentives. Objecting professionals created hostile environments for care seekers, including making them wait longer for their services.
(Foster, LaRoche et al. 2017) [Canada]	To document women's experiences obtaining abortion care in New Brunswick (NB) before and after the Regulation 84-20 amendment; identify the economic and personal costs associated with obtaining abortion care; and examine the ways in which geography, age and language-minority status condition access to care.	New Brunswick residents who received abortion services (n=36).	Qualitative: semi-structured interviews	One study participant explained: I went to my doctor and my doctor at the time flat out said [he was] not willing to help me in any way because it was not [his] beliefs...I've heard of other people…they can't get referrals from doctors to get it done in a regular hospital setting, where Medicare would pay for it because of the doctor's personal beliefs.
(Gerdts, DeZordo et al. 2016) [United Kingdom]	To better understand the experiences of non-resident women who travel to the United Kingdom (UK) seeking abortion services.	Non-UK residents seeking abortions at three British Pregnancy Advisory Service (BPAS) clinics (n=58).	Cross-sectional survey	Four women in this study reported not seeking abortion in their country of residence due to clinician refusal to provide abortion. Some participants in this study were forced to travel because they faced procedural barriers to legal abortion care, in particular conscientious objection, in their country of residence. How refusals to provide abortion care are defined and understood by providers, how they are communicated to women, and how such refusals shape women's decisions to travel requires further exploration.
(White, Adams et al. 2019) [United States]	To compare pregnancy options counseling and referral practices at state- and Title X-funded family planning organizations in Texas after enforcement of a policy restricting abortion referrals for providers participating in state-funded programs, which differed from Title X guidelines to provide referrals for services upon request.	Publicly funded family planning organizations in Texas.	Qualitative: semi-structured interviews	Despite none of the study respondents expressing personal views opposing abortion, their perceptions of anti-abortion sentiment in the community may have contributed to staff reluctance to provide women with more information about available services. Some respondents were concerned that providing any information about abortion beyond the name of a provider would threaten their state family planning funding. Therefore, despite examples of permissible practices in the proposed Title X guidelines, providers may censor themselves from offering any abortion-related information.

Appendix S. Summary of studies reporting macro-economic costs

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Aantjes, Gilmoor et al. 2018) [Eastern and Southern Africa]	To identify and synthesize the literature on PAC in the ESA region with the aim of reporting on the reach, quality and costs of these services	Varied by studies on PAC, health workers in PAC, incidence and abortion-related service reviews	Systematic review of studies on PAC	Treatment costs for abortion morbidity represented three times the annual per capita health expenditure in Uganda and five times that in Ethiopia.
(Adamczyk and Valdimarsdóttir 2018) [United States]	Examines the role of the local religious context for shaping attitudes and the presence of a county abortion clinic	U.S. residents 18 years of age or over	Regression analysis	Since 2011 the number of abortion clinics in the US has declined, which some have attributed to TRAP's effectiveness, as well as other factors like fewer unintended pregnancies. As the level of county religious engagement rises, religious and secular residents alike develop more conservative attitudes. Conversely, as the county Catholic rate increases, moderate and liberal Protestants become more prochoice. While the county conservative Protestant rate has no influence on residents' attitudes, it is the only religious contextual measure that shapes the likelihood that a county has an abortion clinic.
(Agadjanian 2002) [Kazakhstan]	This study shows how abortion-related views reflect the long-standing ethnocultural differences between the indigenous Kazakhs and Kazakhstan's residents of European roots	Women in Kazakhstan	Regression analysis	The bivariate comparisons suggest that for all three groups, abortion is associated with greater financial problems and especially with greater health problems than either the IUD or the pill. At the same time, non-Russified Kazakhs appear more concerned about financial costs of any of the three choices, whereas Europeans seem particularly preoccupied with potential negative side effects to health of abortion and, to a much lesser degree, of contraception. Indicators of greater modernization and affluence are inversely associated with the perception of monetary costs as a problem.
(Almond, Edlund et al. 2013) [Canada]	The study of South and East Asian immigrants in Canada, a rich OECD country, can potentially cast light on the role of culture in sex selection	Census data from Canada	Descriptive statistics	Since the overwhelming majority of Asian immigrants live in large cities, however, access to facilities can be assumed for the population under study. Although cost is another consideration, abortions in Canadian hospitals are covered by the universal public health plan in every province and territory, as are abortions in private clinics almost everywhere.
(Ananat, Gruber et al. 2009) [United States]	Provide a framework for understanding selection mechanisms and use that framework to address inconsistent past methodological approaches and provide evidence on	Individuals born in the United States and observed in the 2000 Census at ages 21 to 35 in that year (born between 1965 and 1979)	Regression analysis	Our results indicate that lower-cost abortion brought about by legalization altered young adult outcomes through selection. In particular, it increased likelihood of college graduation, lower rates of welfare use, and lower odds of being a single parent. Higher abortion costs reduce the pregnancy rate: nonrepeal states had lower pregnancy rates during the 1971–1973 period; among nonrepeal states, those with higher latent social costs of abortion experienced lower pregnancy rates. The same pattern continues in 1974–1975 and 1976–1979. As expected, the negative relationship between latent costs and

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	the long-run impact on cohort characteristics			the pregnancy rate becomes more pronounced after legalization: once the legal constraints are removed, the underlying latent costs of abortion become the primary determinant. Higher abortion cost predicts higher birth ratios (or equivalently, fewer abortions) and higher birth rates.
(Ayanore, Pavlova et al. 2017)[Ghana]	To explore what direction do women perceive gender roles to influence their reproductive choice and care	Data from women with records of recent birth (max 2 years prior to study) (n=90), health staff (n=16), policymakers (n=6)	Qualitative ethnographic study using focus groups and in-depth interviews	Policymakers responded that post-abortion fee costs and clinical treatments for post-abortion care were minimally covered under fee exemptions.
(Azize-Vargas and Avilés 1997) [Puerto Rico]	This paper examines the current practice of abortion and the hurdles women face to obtain this service, taking into consideration the impact of colonial subordination	Women attending 10 of the 13 private abortion clinics in Colombia 1991-2	Mixed methods	Lack of government and health professional support has meant that about 93 per cent of all abortions in Puerto Rico are carried out by individual doctors in private, profit-making providers. The absence of any public health or other non-profit abortion services means that there is little motivation to keep prices down. The US funded program Medicaid is supposed to cover the costs of abortion in cases of rape, incest and when a woman's life is in danger. Although the Puerto Rican government receives Medicaid funding, abortion is not covered, even in these extreme cases. Since private health insurance does not include abortion among its benefits either, a woman must attend a clinic with cash in hand when she needs an abortion. Hence cost is a barrier for obtaining abortions in Puerto Rico for poor women.
(Babigumira, Stergachis et al. 2011) [Uganda]	Perform a comprehensive assessment of the economic burden of induced abortion in Uganda in terms of its costs	Providers, untrained providers, and abortion-seekers	Cost analysis	The average societal cost per induced abortion (95% credibility range) was $177 ($140–$223). The average direct medical cost was $65 ($49–$86) and the average direct non-medical cost was $19 ($16–$23). The average indirect (productivity) cost was $92 ($57–$139). Patients incurred an average of $62 ($46–$183), 73% of the healthcare costs of induced abortion while government incurred an average of $14 ($10–$20), 17% of the healthcare costs of induced abortion. The annual incidence of induced abortion in Uganda is 362,000 cases. Therefore the national annual expenditure on induced abortion is projected to be $23.6 million in direct medical costs, $7.0 million in direct non-medical costs, $33.5 million in indirect/productivity costs, $5.1 million in costs to the government, $22.3 million in costs to patients, and $64.2 million in societal costs.
(Baird 2015) [Australia]	This paper considers the context through which it (medical abortion) has become available (in Australia) since 2013	Documentary sources, secondary literature, and expert opinions from health professionals and	The paper draws on documentary sources and oral history interviews	In the context of the ongoing absence of any central public health coordination of abortion services in all jurisdictions, and in the face of the slow uptake of medical abortion by general practitioners, telemedicine stands out as a method of materializing access, particularly for rural women. Marie Stopes have started a modest trial to offer medical abortion via telemedicine but the most

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
		managers who have worked in abortion services, researchers, educators, public servants, advocates and activists	conducted in 2013 and 2015.	significant development in this respect has been the launch of the Tabbott Foundation in September 2015. This new body pioneers an innovative business model for abortion provision. It has been established by an existing private provider to offer "an Australia-wide telephone consultation home medical termination of pregnancy service", although women in the jurisdictions which require abortion to be performed in a hospital will not be served.38 Women in rural and regional locations are the foundation's main focus.
(Baird 2017) [Australia]	Argues that while decriminalization is consistent with feminist goals, it will make little or no challenge to the sources of inadequate access to abortion in Australia	Documentary evidence and an oral history project in 4 Australian jurisdictions	Review of documents and oral history interviews conducted with key insiders	The nation has a comprehensive public health system, albeit one that struggles under the trends and pressures characteristic of neoliberal policy approaches. Australia has a strong tradition of social democracy but at the level of everyday cultural practice and of government social and economic policy, individualism, choice, and market-based solutions in all areas of life have become common sense. The role of the state is to facilitate markets.4 Health is understood largely as an individual responsibility, and the public health system (including public hospitals) negotiates competing principles in the context of ongoing pressure to privatize, limited resources, and constant restructuring.
(Battistelli, Magnusson et al. 2018) [United States]	Qualitative analysis examines how organizations participating in HWPP implemented changes to their provision of abortion care following the law's implementation in California	Health providers employed by six organizations located in California	Interviews	Several respondents cited the state's low Medicaid reimbursement rate for abortion services as a key driver of the maldistribution of care. Instead of trying to spread abortion services throughout the regions they serve to make care more geographically accessible, some organizations had consolidated such services into just a few high-volume clinics to be economically sustainable.
(Benson, Gebreselassie et al. 2015) [Malawi]	This study estimates current health system costs of treating unsafe abortion complications and compares these findings with newly-projected costs for providing safe abortion in Malawi	Malawi health system costs	Estimation study based on survey and costing data	Within the study facilities, the estimated median per-case cost of treatment for all PAC cases was $40 The median cost per D&C case ($63) was 29 % higher than an MVA case ($49) for every PAC treatment category. This difference was especially marked for simple cases as the median cost of care for a simple PAC case with D&C, $19, was 46 % higher than with MVA ($13) and 58 % higher than misoprostol ($12). Although few in number, cases with severe surgical complications were especially costly to treat ($128), almost 10 times higher than a simple case.
(Berer 2000) [Global]	This article examines the changes in policy and health service provision required to make abortions safe	It is based on a wide-ranging review of published and unpublished sources.	Review	Where abortion is clandestine and unsafe, women (or their partners and families) are buying drugs and other means of self-induced abortion and/or paying clandestine providers, while public health services and women are paying for the treatment of abortion complications, often in tertiary level hospitals, where costs are highest. Unsafe abortion situations are characterized by a lack of equity in cost, safety and quality of care. Covering the cost of safe abortions in public health services is therefore not about incurring entirely new costs, but

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				about shifting expenditure away from complicated cases in tertiary level hospitals to safe, simple procedures which can be provided in primary clinics. Women may or may not be charged a fee at the point of service, but safety means affordability for the poorest of women as well as for those who can pay, with one high standard of care for all.
(Berer 2005) [Global]	This paper discusses choice and acceptability of medical abortion from the perspective of both women and abortion providers and argues that choice of method is important for both	Recent papers found on Medline on these issues from a range of countries, and information presented at a 2004 conference on medical abortion	Review	Misoprostol alone is very low cost and has ease-of-access advantages for developing country settings. According to most of the developing country participants at the ICMA conference in 2004, misoprostol is likely to be used on its own for early medical abortion in settings where registration of mifepristone in the foreseeable future is unlikely. On the other hand, as one clinician from Latin America noted, if women take repeat doses of misoprostol, it may end up being more expensive than one 200mg pill of mifepristone and a smaller dose of misoprostol. Similar cost reduction studies for surgical methods are needed. Unless the costs of surgical and medical abortions are broadly similar, many women will feel they need to choose the cheaper option, which limits choice. Where the health service is covering the cost, or health insurance companies control treatment options, similarly, clinicians and managers will also tend towards the cheaper option. However, neither method should be forced on women for this reason. At the same time, because medical abortion does not require the use of an operating theatre or surgical skills, except in a small minority of cases, thereby drastically reducing the number of clinicians with these skills involved, all health systems may tend towards medical abortion in future.
(Bessett, Gorski et al. 2011) [United States]	The aim is to learn about women's experiences applying for subsidized insurance and to identify barriers to obtaining insurance or its use for abortion services	Women of childbearing age in Massachusetts.	Interviews	Applying for subsidized insurance was also associated with long delays. Although pregnant women's applications are supposed to be expedited, it often took several weeks to become enrolled even if everything went smoothly. Unnecessary delays should also be a matter of concern to policy makers in Medicaid states, because procedures at later gestational ages are more expensive and delays may increase costs to the state.
(Blanchard, Meadows et al. 2017) [United States]	We studied women's experiences seeking and receiving second-trimester abortion care in two geographically and legislatively different settings to inform ways to improve abortion care access and services	Women with estimated gestational age of ≥14.0 weeks LMP; age 18 or older; English fluency; ability to give informed consent	Mixed methods: descriptive statistics and qualitative	Interviewees generally opposed all restrictions, especially Medicaid restrictions, saying they failed to consider individual circumstances and infringed on the ability to make one's own decisions. Opinions about bans on abortions 22 weeks LMP, restrictions on Medicaid coverage, and mandatory waiting periods did not vary significantly between regions. There were differences in opinions about mandatory counseling: almost half of the women in the Midwest versus less than a third of the women in the Northeast disagreed with the law. Even if the information was inaccurate, more women in the Northeast than the Midwest still agreed with the law. More participants reported being negatively impacted by abortion restrictions than being positively impacted. Commonly cited negative

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				impacts included delayed care, significant travel, and having to take work leave. The most commonly cited positive outcome was feeling more informed.
(Blank, George et al. 1996) [United States]	This paper investigates the impact of public policy, provider availability, the political environment, and demographic and economic factors on the determinants of state abortion rates between 1974 and 1988	Number of abortions, abortion-related legislations	Regression analysis	Restrictions on Medicaid funding for abortion are strongly correlated with decreases in the abortion rate within states and with increased travel of women across states for abortions, while restrictions on teenagers have little effect on aggregate rates.
(Brown and Jewell 1996) [United States]	To estimate directly the responsiveness of abortion demand to county-level variations in travel-cost component of the full cost of abortion services	Abortion providers in Texas	Log-linear regressions using data that were obtained from health facilities on each abortion performed and data on the localities of these facilities	Counties with providers have higher time costs, due to higher median household incomes.
(Bullard, Shaffer et al. 2018) [United States]	To estimate the effect of 20-week abortion bans on maternal and consequent neonatal health outcomes and costs in the setting of fetal congenital diaphragmatic hernia	Women in their mid-second trimester of pregnancy with a prenatal diagnosis of congenital diaphragmatic hernia	Cohort analytic	With a 20-week abortion ban in place, 60 women traveled out of state to obtain an abortion. In terms of cost, having a 20-week abortion ban in place cost an additional $159,419,623 for this cohort of 921 women. This additional cost came with a reduction of 674 QALYs. Overall, 20-week bans were a dominated strategy; the policies resulted in higher costs and decreased effectiveness, thereby deeming the absence of a 20-week ban to be the optimal strategy.
(Calkin 2019) [Global]	This article makes the case for a political geography of abortion that moves beyond a state-based framework to account for changing patterns of resistance and restriction on abortion	Two case studies: mobile abortion clinics at sea and telemedicine abortion technology	Case study, literature review	Abortion restrictions continue to close clinics and restrict their operation: for example, there are twenty-seven cities in the US that qualify as “abortion deserts” because their nearest clinic is over 100 miles away. In practice, these geographical barriers become class-based obstacles: the absence of public transport in rural areas, for instance, means that travel to a far-away clinic requires an abundance of money and time that poor and rural women disproportionately lack.
(Chevrette and Abenhaim 2015) [United States]	Assess whether US state-level policies regarding	National teen birth and teen abortion rates	Regression analysis	In the states where deterrents to abortion were present, the teen abortion rate was 11.7 of 1000, compared with 19.1 of 1000 in the other states. When access to public or private insurance was prohibited for abortions (or limited to cases of

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	abortion and sexual education are associated with different teen birth and teen abortion rates			rape or a woman's life being endangered), teen abortion rate was 13.8 of 1000 compared with 18.8 of 1000 in the other states.
(Coast, Norris et al. 2018) [Global]	Present a new conceptual framework for studying trajectories to obtaining abortion-related care	Global review paper	Review	A pregnancy has short- and long-term economic and opportunity costs for women; these may be exacerbated when the pregnancy is unintended. In Latin American countries where abortion is illegal, access to economic resources and emotional support were critical for accessing a medically supervised medical abortion in a clandestine clinic.
(Coles, Makino et al. 2010) [United States]	Examine the relationship between adolescent pregnancy intention and policies affecting abortion access: mandatory waiting periods, parental involvement laws, and Medicaid funding restrictions	Women under 18 years of age at 3 months gestation	Bivariate analyses	Those living in states with either Medicaid funding restrictions or mandatory waiting periods reported higher percentages of both unwanted and mistimed birth compared to minors living in states without these statutes. Black and Hispanic teens were most strongly affected by mandatory waiting periods. These findings likely reflect resources availability more than cultural differences, as minors with Medicaid were also more likely to report an unintended birth when exposed to mandatory waiting periods.
(Cook 1999) [United States]	To estimate the funding effects on abortion rates and birth rates	Women who received abortions in North Carolina and data on the number of pregnancies	State level data analysis	In financial year 1989, 60% of people receiving a state-funded abortion were aged between 18 and 25. 75% were Black and 80% were unmarried. An additional 16% were separated or divorced. Overall, 7.1% of pregnant Black people received state funds for their abortion, whereas 1.1% of pregnant White people received state funds for their abortions.
(Creinin 2000) [United States]	To examine in a randomized trial the clinical efficacy and patient acceptance of medical abortion using oral methotrexate and vaginal misoprostol compared to surgical manual vacuum aspiration in women with pregnancies up to 49 days' gestation.	People aged 18 years and older requesting to have an abortion (n=50)	Randomized trial [no control]	The estimated staff costs in different provider scenarios. Based on a physician's hourly wage being 3 times that of a physician assistant and 8 times that of a research assistant / counselor, the estimated that surgical abortion would be 10% more expensive than medical abortion. However, where the physician's hourly wage is 2 times that of a physician assistant, surgical and medical abortion costs are identical.
(Crighton and Ebert 2002) [Europe]	Explore the impact of RU486 on abortion rates and practices in Europe	Abortion rates, policies, and practices for each nation state	Policy analysis from published literature	Finds no evidence that access to medical abortion with RU 486 has increased abortion rates in Europe. Study does find large national differences in the use of medical versus surgical abortions. These abortion practices are shaped by economic incentives, the organization of medical services, bureaucratic accounting rules, and physicians' choices. Effective implementation, with

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				governmental support, has a critical impact on access to medical abortion services.
(Davey 2005) [United Kingdom]	To present results of a review of the sexual health situation in the UK and to outline the challenges remaining in order for the UK to meet ICPD goals by 2015	UK residents	Situational review	Access to abortion services has improved in recent years. In 2003, 80% of abortions in England and Wales were funded by the NHS (National Health Service) compared with 67% in 1994. The vast majority (87%) were carried out under 13 weeks of pregnancy. In Scotland, in 2003, 99% of abortions were NHS-funded, and 92% were carried out within 13 weeks. However, within England, Wales and Scotland, access to an NHS abortion varies considerably according to where an individual lives. 2002 figures show that while in some Primary Care Trust areas almost all abortions were NHS-funded, in others less than two-thirds were.
(Dawson, Bateson et al. 2016) [United Kingdom, United States, Russia, Australia, New Zealand, Canada]	To identify quality studies of abortion services to provide insight into how access to services can be improved in Australia	Systematic review with included studies looking at multiple populations	Systematic review	Some of the studies included in this review examined costs from the perspective of the health system, health professionals and the individual women. For example, recent research in the UK examining a local anaesthetic outpatient STOP service found that a cost savings was made of approximately £60,000 per year and that the operating theatre use was reduced by one termination list per week.
(de Bruyn 2003) [Global]	Conduct literature review on unwanted pregnancy and induced abortion among women with HIV	women living with HIV	Literature review	This paper describes the difficulties faced by HIV-positive women in obtaining safe legal, affordable abortion services. It shows that voluntary HIV counselling and testing for women seeking induced abortions and post-abortion care may not be provided. HIV-positive women may have a greater risk of morbidity following unsafe abortions than HIV-negative women. Studies in Zimbabwe and Thailand show that when information and access to legal pregnancy termination are lacking, HIV-positive women may be prevented from terminating a pregnancy.
(Dennis, Manski et al. 2015) [United States]	Explore low-income women's experiences accessing abortion in Massachusetts	Low-income women age 18 or older, have had an abortion after January 2009, and, at the time of the abortion, resided in Massachusetts	Interviews	Most women described having access to timely, conveniently located, affordable, and highly acceptable abortion care. However, a sizable minority of women had difficulty enrolling in or staying on insurance, making abortion expensive. Some limited data also suggest that young women and immigrant women face specific barriers to care. There is a need for state-level policies that support access to health insurance and comprehensive abortion coverage. Such policies, along with a well-functioning health care environment, help to ensure that low-income women have access to abortion.
(Dennis, Manski et al. 2014) [United States]	Address 1) What do women know about the cost of abortion and the availability of Medicaid coverage for abortion? 2) Where do women obtain this	Low-income women age 18 or older, have had an abortion within the past two years, and resided in one	Interviews	Women's impressions about abortion costs and the availability of Medicaid coverage are generally accurate and that women rely predominantly on abortion facilities for confirmatory cost and coverage information. Additionally, when abortion is out of financial reach, women and the people in their lives experience numerous emotional and financial harms. Policies that aim to ensure abortion is

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	information? and 3) What are women's experiences paying for care?	of the four study states at the time of the abortion		affordable largely prevent these harms, though the availability of Medicaid coverage does not always guarantee access to affordable care.
(Díaz-Olavarrieta, Cravioto et al. 2012) [Mexico]	Identify the perceptions and opinions of people who provide abortion services in Mexico City, three years after implementation of elective abortion legal reforms	Health workers assigned to the legal abortion programs at a clinic and a hospital in Mexico's Federal District	Interviews	Participants favored the abortion law for the rest of the country to replicate the reforms made in the Federal District as this would prevent mobilization of women from other states, which is very expensive for them and increases the workload in the services. To this respect, from all abortion procedures up to March 2010, 25% corresponded to women who reside in other states.
(Donohoe 2005) [United States]	To present barriers to abortion in the US policy context, and the impact of US policies on abortion access elsewhere	US abortion-related policies	Descriptive study of barriers to abortion	Title X Family Planning Clinics cover women in low-income households, and predominantly serve BIPOC, but are prohibited from using federal and non-federal funds for any abortion.
(Drovetta 2015) [Latin America & Caribbean]	Describes the implementation of five Safe Abortion Information Hotlines (SAIH), a strategy developed by feminist collectives in a growing number of countries where abortion is legally restricted and unsafe	Participatory observation of activities of the SAIH, and in-depth interviews with feminist activists who offer these services, and with 14 women who used information provided by these hotlines to induce their own abortions	Qualitative study: participant observation, interviews, and review of documents	In general, the hotline constitutes an easily accessible tool, especially in urban contexts, for anyone with a landline or cellphone. If a woman cannot cover the cost of the call, she can ask to be called back, leaving her number. With a cellphone, the first contact can be made via text message.
(Duggal and Ramachandran 2004) [India]	To synthesize findings and reports from the Abortion Assessment Project – India	380 facilities in six states in India	Review of studies: policy reviews, multicentred facility surveys, 8 qualitative studies, community-based studies	The abortion economy was estimated as worth Rs. 6,950 million (154 million USD) in 2001, which is 0.58 of the total out-of-pocket expenditure for health care

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Duggal 2004) [India]	Examination of the political economy of abortion care in India by reviewing cost and expenditure patterns for abortion care in India	Population of India	Descriptive analysis of the political economy	In the public sector, abortion services are usually free, but in recent years some states have introduced user fees or have allowed private practice by public providers. Hence, such charges were being reported in the six-state study. Further, in some states, even if abortion services per se are free, there is a policy of charging for the abortion if a family planning method is not also accepted by the woman. Overall in the six states, the average charges for an induced abortion were Rs.615. This is equivalent to more than three weeks of average per capita income for all- India. The overall charges in the public sector averaged Rs.115 (or four days of per capita income) and in the private sector Rs.801 (or 30 days of per capita income). Public providers were the least expensive, and among the private providers, the certified ones were charging substantially higher fees than the uncertified ones.
(Dzuba, Winikoff et al. 2013) [Latin America & Caribbean]	Present evidence of medical abortion (MA)'s contributions to reduced complications, describe strategies to enhance safe MA, and highlight existing barriers to access in LAC	Women seeking abortion in Latin American and the Caribbean	Review of existing evidence	Medical abortion conserves the resources of public healthcare systems in treating serious and largely preventable complications. An estimated US$94.00 per-patient cost to treat post-abortion complications in LAC implies an annual cost of US$108,000,000 to healthcare systems throughout the region. The cost of treating abortion complications could exceed 50% of a healthcare system's expenditures on all obstetric emergencies. In 2005, in Mexico City, before first trimester abortion became legal, this cost to the system was estimated to be US$2.6 million. Ensuring access to safe medical abortion reduces abortion complications and allows scarce resources to be directed to other urgent health needs.
(Ely, Hales et al. 2017a) [United States]	Use a trauma-informed lens to explore abortion-related hardships in a previously understudied group	Status as abortion seeker and inability to pay for abortion care procedure	Descriptive, exploratory, cross- sectional analysis of administrative health care data	Patients from states that do not use state Medicaid funds to exceed coverage of abortions (outside of instances of rape or incest) had a higher average reporting of hardships related to abortion and abortion care. This finding was also true for patients from states that restrict the private insurance coverage of abortion, with patients from these restrictive states experiencing a higher average number of hardship experiences. This is also not surprising, given that states must elect to use their own Medicaid funds to cover the procedure, and the states not covering it are most often located in the South or Midwest, where the greatest numbers of hardships were found. Even when these states should be covering abortion in cases of rape or incest, problems getting the procedure paid for by Medicaid are common.
(Ely, Hales et al. 2017b) [United States]	Discuss the results of a secondary data analysis of NNAF's Tiller Memorial Fund cases that represent patients who received funding pledges to assist	Status as abortion seeker and inability to pay for abortion care procedure	Descriptive, exploratory, cross- sectional analysis of administrative health care data	Patients in the current study on average received almost $250 per case in NNAF funding assistance pledges and almost $800 in additional funding assistance from other sources. This extensive funding assistance from various sources demonstrates the significant impact of NNAF and the other funding organizations, and highlights the tremendous financial need that these women were facing when trying to access an abortion. This finding also highlights the effort these patients had to put in to piece together the funding for an abortion

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	them with paying for an abortion			procedure from more than one source, and the findings demonstrate the public health costs that are being picked up by these advocacy-oriented organizations. Perhaps most importantly, results from the current study are the first to demonstrate that funding pledges for second trimester abortions increased over time. This demonstrates that more women are seeking to fund procedures in the second trimester, which are more expensive and involve greater risk. This increased need for funding for second trimester procedures suggests that it may be becoming increasingly more difficult for women to gather the funding needed early enough to obtain the procedure in the first trimester.
(Ely, Hales et al. 2017c) [United States]	Examine Location and Travel Distance in U.S. Abortion Fund Patients	Status as abortion seeker and inability to pay for abortion care procedure	Descriptive, exploratory, cross-sectional analysis of administrative health case data	These findings suggest that patients with pledges from states restricting private insurance coverage expected to travel greater distances than patients from non-restrictive states. Restricting insurance coverage forces individuals to procure abortion costs privately. For low-income persons, obtaining costs for a procedure may take weeks or months, forcing patients to travel greater distances to providers who offer services for late stage procedures. However, contrary to expectations, patients in Medicaid expansion states expected to travel further distances than those in non- expansion states. The reason for this finding needs to be explored in future research, but a possible explanation may be that states in this region are larger (i.e. California) which results in the need to travel farther to access the procedure. Another possibility is that the expansion states have higher numbers of rural patients, who must travel greater distances to access providers, since 89% of U.S. counties do not have an abortion provider.
(Ely, Hales et al. 2018) [United States, Republic of Ireland, Northern Ireland, Isle of Man]	Compare abortion fund patient experiences across these developed nations for the first time	Selected abortion funds in each country	Cross-section descriptive analysis	The current study suggests that abortion fund use is increasing yearly across these nations and that abortions are costly and difficult to pay for. The assistance given by these abortion funds is an essential piece in bridging the gap to abortion access across these nations. While existing policy continues to ban or restrict abortion in these nations, steps should be taken to promote the resources offered by abortion funds and to increase financial support for abortion funds.
(Erim, Resch et al. 2012) [Nigeria]	We synthesize the best available data, adapt a model of pregnancy and pregnancy-related morbidity and mortality to the Nigerian context, and conduct national and regional analyses that quantify the payoffs from investing in safe pregnancy and childbirth	National level estimates	Mixed methods	Estimates of costs under current standard of care (2008 US$): post-abortion complications (US$50.73); elective abortion (US$21.87)

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Felkey and Lybecker 2014) [United States]	Measure whether young women are less careful in using contraception if abortions are less costly, both in the context of financial and opportunity costs.	Women under the age of 25	Regression analysis	The effects of abortion restrictions for minors are largest and the most significant for women aged 18 and younger, and the effect of these restrictions decrease in magnitude and significance gradually as women age. As the percent of the state's women without a provider increases, abortions are more difficult to obtain, and women are more likely to use the pill. When a larger percentage of women have a provider, abortions are more easily obtained, and there is a negative effect on pill usage. These results indicate that young women are forward thinking when making their contraceptive decisions, relative to the direct and indirect restrictions on abortion access.
(Felkey and Lybecker 2018) [United States]	Analysis of state abortion legislation and proxying how the cost of obtaining an abortion varies across states, then assessing the implications of legislative changes on women's contraceptive choices	US women making observable contraceptive choices	Regression analysis	Examining women by race/ethnicity, income, age, and religious affiliation, the results show that women respond to increased restrictions on abortion availability and cost but that the effects are very small. This study demonstrates that legislation restricting women's access to abortions fails to promote greater use of more effective contraceptive methods, increasing the likelihood of unwanted births and illegal abortion procedures.
(Fischer, Royer et al. 2018) [United States]	Seek to understand the impact of family planning and abortion clinic access on abortions, births, and contraceptive purchases	Women in designated Texas counties	Regression analysis	Findings suggest that restrictions in abortion access have economically-significant effects on fertility-related outcomes. Having no abortion provider within 50 mi reduces the observed number of abortions by 16.7%. Although the estimate may not capture the effect on the total number of abortions, the estimates suggest that these policies increase the cost of seeking an abortion. It is possible some women may travel to another state or country for an abortion or self-administer one (i.e., they receive the abortion they intended to obtain) — behaviors we cannot observe in our data. These actions can be costly and thus, should be considered part of the burden of these policies.9 For this reason, the impact of the reduction in abortion access on births, a 1.3% increase, is more informative of the total effect on fertility-related behaviors. The effect of reduced family planning access on births, as measured by whether or not there is a funded clinic within 25 mi, is similar. Overall, not having a funded clinic within 25 mi increases births by 1.2%. Back-of-the-envelope calculations imply that by the end of 2015, the abortion clinic restrictions led to 1570 additional births and the changes in funding to family planning clinics increased births by 929. These calculations, however, miss other important costs of reduced access — most importantly, the increased travel cost for women seeking abortion or family planning services.
(Forrest and Samara 1996) [United States]	To estimate the annual numbers of unplanned pregnancies, births and abortions averted by use of	Women using contraception who had recently visited a publicly	Analysis of 4 hypothetical scenarios of contraceptive	The public sector spent an estimated $412 million on publicly funded contraceptive services for FY1987. In contract, according to the average estimates from Scenarios I-III, if publicly funded services were

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	publicly funded family planning services in the United States	funded family planning service provider	behavior using survey data	not available, the federal and state governments would spend an additional $1.2 billion annually in their Medicaid pro- grams to cover costs associated with un-planned births ($1.2 billion) and abortions ($22 million). Thus, for every dollar spent to provide publicly funded contraceptive services, the public saved an average of $3.00 on Medicaid costs for pregnancy-related and newborn medical care. Using the gross numbers of pregnancies, births and abortions averted from Scenario IV, we arrive at savings of $7.80 per dollar spent.
(Foster, Jackson et al. 2008) [United States]	Examine and report on factors associated with abortion delay	Female patients at the San Francisco General Hospital Women's Options Center	Secondary data analysis of a cross-sectional study	For women in our study, we found that difficulty with getting MediCal to pay for the abortion was significantly associated with delay during the second step of the abortion process. Several factors may contribute to difficulty with getting MediCal to pay for the abortion including women's lack of knowledge about available coverage, difficulty negotiating the MediCal application process or difficulty locating an abortion provider that accepts the MediCal payment. Although the state Medicaid program covers abortion care for poor women, not all providers accept that coverage and even those who accept MediCal do not accept it for abortions at all gestational durations. California is unusual in its public funding of abortion. Thirty-seven states ban Medicaid funding for abortion unless the pregnancy is a result of rape or incest or poses a risk to the woman's life. Medicaid- eligible women in other states could face longer delays as they seek to finance their medical care with their own funds. In the step between calling a provider and obtaining the abortion, many women report being delayed by financial factors. Reducing the delay related to an inability to pay could be carried out through interventions aimed at helping women finance their abortions. These interventions may include grassroots efforts like expanding the network of abortion funds which currently provide support for low- income women or policy efforts like working to increase private and public insurance coverage of abortion. A final intervention may be encouraging abortion clinics located in states where Medicaid covers abortion to accept Medicaid for abortions at all gestational durations.
(Foster and Kimport 2013) [United States]	To analyze data on women who sought and received an abortion at or after 20 weeks' gestation for reasons other than fetal anomaly or life endangerment	People who were seeking abortions after 20 weeks gestation across 16 sites (n=272) and people who presented for first trimester abortions (n=169)	Mixed methods – qualitative data from interviews and quantitative data for logistic regression	Medi-Cal, the California Medicaid program, covers abortion costs for women with low-incomes. Delays in coverage leads to later abortion and increased costs.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Franzini, Marks et al. 2004) [United States]	To assess the potential economic costs that result when adolescents do not seek reproductive health care services because their confidentiality is compromised	Adolescents in Texas	Regression analysis	Reporting and consent requirements were estimated to result in an additional 11.45 pregnancies, 7.44 births, and 2.29 abortions per 100 teenagers currently receiving reproductive health care services. The cost of the additional births and abortions was estimated at $60 952 per 100 teenagers. Among Texas girls younger than 18 years currently receiving publicly funded reproductive health services, an estimated 5372 additional births and 1654 additional abortions cost $44 007.
(French, Anthony et al. 2016) [United States]	To assess the association of clinician referral with decision-to-abortion time.	English-speaking women aged 19 years and older presenting for an abortion for all indications at the three abortion clinics in Nebraska [n=263]	Cross-sectional survey	Most abortions in the United States are paid for out of pocket (57%) or Medicaid coverage (20%). In Nebraska and 31 other states, Medicaid funds may be used to pay for abortion only in cases of life endangerment, rape or incest. Consequently, even more women pay for their abortions out of pocket, creating hardships for themselves and their families
(Furedi 1999) [United Kingdom]	Estimate the effect of increased unintended pregnancies, births and abortions after the 1995 birth control "pill scare"	UK population	Review study	The unanticipated increase in births and abortions led to increased expenditure on maternity and abortion services. Answers to Parliamentary Questions have recently confirmed the cost to the National Health Service (NHS) of a first-trimester abortion to be between £289 and £443 and the average cost of childbirth to be £1698. If, as suggested in para. 3.4 of the Hansard document, there were about 12 400 additional births and 13 600 additional abortions (70% paid for by the NHS) in 1996, the cost to the NHS would have been about £21 million for maternity care and from £46 million for abortion provision. In the long term there will be continuing costs to the Government from social security payments and from the provision of extra school places.
(Gerber Fried 1997) [United States]	This paper gives a picture of the status of legal abortion from the vantage point of those women who bear the brunt of restricted access	Low-income women, women of colour (who comprise a disproportionate number of the poor), and young women	Review	Within the system of privatised health care in the US, a large majority of abortions are paid for by the patients themselves. About one-third of women do not have employment-linked health insurance. One-third of private plans do not cover abortion services, or only cover these for certain medical indications. At least 37 million Americans have no health care coverage at all, including nine million women of childbearing age. Abortion is the only reproductive health care service for which Medicaid does not pay. Medicaid is a publicly funded programme that covers 'necessary medical services' for people whose combined income and resources are considered insufficient to meet the costs of medical care. However, because the eligibility ceilings are set so low, Medicaid covers fewer than half of those who live in poverty. Federal Medicaid coverage was available for abortion from the time that state-level abortion laws began to be liberalised in the late 1960s until 1977, four years after Roe v. Wade made abortion legal nationwide. Since then, each year the US Congress has passed

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				different versions of the Hyde Amendment, which prohibits federal funding of abortion.
(Gerdts, DeZordo et al. 2016) [United Kingdom]	Better understand the experiences of non-resident women who travel to the UK seeking abortion services	58 non-UK residents seeking abortions at three British abortion clinics	Small-scale survey	Abortion travel represents a financial cost that is difficult to cover for many women. It is well known that travel in pursuit of health care services creates problematic cost, access and resource distribution in health care systems, and stratifying consequences for populations and individuals. The issue of cross-country abortion care is especially significant considering the 2013 EU Cross-Border Health Directive which would allow women to receive abortions abroad and be reimbursed by their home nations.
(Gober 1997) [United States]	Investigate the role of access in explaining the variation in state abortion rates	U.S. state policies and abortion rates	Regression analysis	Greater accessibility leads to higher abortion rates. Public demand variables affect abortion rates both directly and indirectly through access conditions. The number of women at risk of unintended pregnancies leads to higher abortion rates directly and indirectly through its effects on medical access. Per capita income, percent Catholic, and percent of the population born outside the state affect abortion rates indirectly through the access variables. High per capita income leads directly to greater availability of hospital abortions, higher levels of state funding of abortions for poor women, less restrictive state abortion laws, and indirectly to higher abortion rates. States with large non-native populations have less restrictive abortion laws and higher abortion rates. The presence of a large Catholic population reduces the number of hospitals offering abortion services and leads indirectly to lower abortion rates. The interaction of public demand and access at the state level creates geographically varying environments in which abortion decisions are made.
(Goldie, Sweet et al. 2010) [India]	We estimate the clinical and population-level benefits associated with strategies to improve the safety of pregnancy and childbirth in India	Country- and region-specific data were synthesized	The best available data were synthesized using a computer-based simulation model	An integrated and stepwise approach (increased family planning and safe abortion combined with consecutively increased skilled birth attendants, improved care before and after birth, reduced home births, and improved emergency obstetric care) could eventually prevent nearly 80% of maternal deaths. All the steps in this strategy either saved money or involved an additional cost per year of life saved of less than US$500; given one suggested threshold for cost-effectiveness in India of the per capita GDP (US$1,068) per year of life saved, these strategies would be considered very cost-effective. While the initial strategy was cost saving in both urban and rural India, incremental cost-effectiveness ratios ranged from US$150 to US$300 per YLS in rural India and from US$150 to US$350 per YLS in urban India. Cost-effectiveness ratios are also expressed as percent of the per capita GDP (US$1,068). Even the most intensive and effective strategic package was well below 50% of the per capita GDP. In contrast to these integrated strategies, implementing only the stepwise intrapartum care upgrades—without family planning and safe abortion—was less effective and less cost-effective. The incremental cost-effectiveness ratios

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				ranged from US$490–US$1,060 in rural India and US$200–US$990 per YLS in urban India.
(Graff and Amoyaw 2009) [Ghana]	Identify barriers to sustainable MVA supply	Key stakeholders	Situational assessment with interviews from key stakeholders and review of evidence	The findings of this study highlight the importance of establishing a low-cost and high-quality sustainable supply of MVA, especially for the low-volume, low-income providers. There were great accomplishments by the Government of Ghana, but otherwise there was little effort to scale-up MVA supply, which would have required an investment by donors that was not forthcoming at the time. Training activity provided by Ipas, the lead supplier of MVA equipment in Ghana, essentially ceased in 2001 with the imposition of the Mexico City Policy/Global Gag Rule. Other than free equipment obtained from trainings, MVA was available from limited private retailers in urban areas who imported equipment from outside of the country. Barriers to MVA availability in Ghana are experienced on both the supply and demand side.
(Gresh and Maharaj 2011) [South Africa]	To examine the acceptability of medical abortion among young people in Durban, South Africa. To investigate the potential demand for and applicability of the method among women in South Africa	Sexually active women at the University of Durban and under 30 years of age (n=20)	Qualitative in-depth interviews	Abortion services are free in public hospitals, however few people are aware of this legislation and seek costlier private providers or less safe abortions.
(Grossman, Grindlay et al. 2016) [Global]	Investigate public funding policies for abortion in countries with liberal or liberally interpreted laws	Public funding policies for abortion	Survey questionnaire	Among the world's female population aged 15 – 49 in countries with liberal/liberally interpreted abortion laws, 46% lived in countries with full funding for abortion (34 countries), 41% lived in countries with partial funding (25 countries), and 13% lived in countries with no funding or funding for exceptional cases only (21 countries). Thirty-one of 40 high-income countries provided full funding for abortion (n =20) or partial funding (n=11); 28 of 40 low- to middle-income countries provided full (n=14) or partial funding for abortion (n=14). Of those countries that did not provide public funding for abortion, most provided full coverage of maternity care.
(Guttmacher, Kapadia et al. 1998) [South Africa]	Examine the policies that have regulated accessibility of abortion and assesses their impact on reproductive health	National level policies and health outcomes	Review of policies and related evidence on health outcomes	Availability of state-funded abortions is limited. Such abortions are not available at many local clinics because of a shortage of trained providers and adequate technology. Currently, state funded terminations are only available at secondary or tertiary facilities, where the necessary resources are not as scarce. A woman can get an appointment at such a facility only after being referred by a community clinic or local day hospital. If it is economically feasible, a woman can

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				arrange to have an abortion at a private freestanding clinic or with a private doctor, as long as these providers are registered with the state.
(Haas-Wilson 1996) [United States]	Estimate the impact of enforced abortion restrictions on minors' demand for abortion services between 1978-1990	Minors who sought an abortion	Regression analysis	This paper includes estimates of the impact of the enforced abortion restrictions on minors' demand for abortions between 1978 and 1990. Using four estimation methods that account for difficult-to-measure variables, such as anti-abortion sentiment, the results suggest that parental involvement laws decrease minors' demand for abortions by 13 to 25 percent and state restrictions on Medicaid funding of abortions decrease minors' demand for abortions by 9 to 17 percent.
(Haas-Wilson 1997) [United States]	Determine whether Medicaid funding restrictions affect women's reproductive health outcomes	Women of reproductive age	Regression analysis	Results indicate that abortion rates in states with Medicaid funding restrictions are 2% lower than rates in states with no such restrictions. However, when the supply of abortion providers and the demographic characteristics of the state population are taken into account, the difference is no longer statistically significant. Medicaid funding restrictions have no impact on birthrates, and the result is the same regardless of whether the empirical model takes into account provider availability, demographic characteristics and state sentiment toward women and reproductive rights.
(Henshaw 1995) [United States]	Provide a range of descriptive statistics on abortion access and availability in the United States	Abortion providers	Survey	Although abortion services are readily available in large urban areas to those able to pay, a 1993 survey of U.S. abortion providers shows that access to service is still problematic for many women because of barriers related to distance, gestation limits, costs and harassment. The exclusion of abortion from Medicaid coverage in most states is perhaps the most severe legislative restriction now in effect.
(Henshaw and Finer 2003) [United States]	Document the current status of abortion service accessibility in the United States	Abortion providers	Survey	As of December 2000, four states† of the 34 that do not fund abortions under Medicaid had legislation prohibiting private insurance from covering abortions except under an optional rider at additional cost, but these could not account for much of the difference between Medicaid-funding and non-funding states. Evidently, some of the same state characteristics that influence states to cover abortion under Medicaid influence private insurers to cover abortion. The proportion of providers that bill private insurance for their clients' abortions is higher than average for nonhospital providers performing fewer than 30 abortions per year and for physicians' offices. Direct billing of private insurance is most common in the Northeast (27%) and is least common in the South (5%).
(Hu, Bertozzi et al. 2007) [Mexico]	To conduct a cost effectiveness analysis of alternative strategies to reduce maternal mortality and morbidity in Mexico	A computer-based model that simulates the natural history of pregnancy and pregnancy-related complications in a cohort of 15-year-	An empirically calibrated model that simulates the natural history of pregnancy and pregnancy-	Under base case assumptions, the incremental cost-effectiveness ratio associated with provision of safe abortion for all women desiring elective termination of pregnancy, but with no other changes or improvements in any dimension of safe motherhood relative to standard care, was approximately $1,400 per YLS, less than 25% of the GDP per capita. If the underlying rate of abortion in a pregnant woman is increased by 1.5, the case fatality rate due to unsafe abortion is increased to 0.002 or greater, the proportion of unsafe abortion to safe abortion is increased by 12.5%, and/or if the rate of attributable

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
		old women followed over their lifetime	related complications	morbidity and costs of that morbidity are more than 2 times higher, the incremental cost-effectiveness ratio associated with provision of safe abortion is less than 10% of the GDP and in many cases less than 5% of the GDP (corresponding to cost-effectiveness ratios of $100 to $500 per YLS or DALY averted)
(Hu, Grossman et al. 2010) [Sub-Saharan Africa]	To explore the policy implications of increasing access to safe abortion in Nigeria and Ghana	Women seeking abortion	Decision analytic model	Examined hospital - based dilatation and curettage, hospital - and clinic - based manual vacuum aspiration (MVA), and medical abortion using misoprostol (MA). Assuming all modalities are equally available, clinic - based MVA is the most cost - effective option in Nigeria. If clinic - based MVA is not available, MA is the next best strategy. Conversely, in Ghana, MA is the most cost - effective strategy, followed by clinic - based MVA if MA is not available.
(Hyman, Baird et al. 2008) [Nepal, Viet Nam, South Africa]	To describe the experiences and lessons learned in Nepal, Viet Nam and South Africa, and make recommendations for delivering safe and effective second trimester abortions	Technical assistance provided by Ipas to the three governments	Reflections (evaluations) of the technical assistance provided	In Viet Nam, the government does not regulate patient fees, so the cost of abortion varies: In early 2008, MVA for first trimester abortion averaged around US$4–7 compared to about US$20–25 for medical abortion; D&E cost about US$80–100 The Nepal Strategic Plan specifies that the cost of second trimester abortions should be the same as first trimester abortions. Second trimester abortions cost an estimated 1,000 rupees (16 USD) for D&E or medical induction). In South Africa, all facilities are free.
(Jewell and Brown 2000) [United States]	This paper applies a model of fertility control to estimate the responsiveness of teenage demand for abortion to travel distance	Teenagers in Texas	Regression analysis	The results indicate that counties with higher travel costs have lower teenage abortion rates: the coefficient sizes imply that a $1.00 increase in travel cost would decrease abortions per woman by 0.86% and per pregnancy by 0.67%, other factors constant. To the degree that abortion services are available at non-licensed facilities within a county, these coefficients may overestimate the true impact of travel cost on abortion demand–as licensed providers become less available, teenage women may substitute toward having abortions at non-licensed facilities. The mean travel cost in a county that currently has abortion providers is $3.61. Suppose that abortion services were no longer available in such a county. This reduction in abortion availability increases the travel cost of acquiring an abortion to $15.48, the mean travel cost for counties without abortion providers. The increase of $11.87 in travel cost would reduce teenage abortion rates by 10.2% per woman and by 8.0% per pregnancy, translating into approximately 20 fewer abortions per year.
(Johnston, Gallo et al. 2007) [Uganda]	Establish the utility of the model and assess the order of magnitude of the difference in costs of care	Cost data	Estimations of costs for unsafe abortions	The mean per-case cost of abortion care (in US dollars) was $45 within the setting that placed heavy restrictions on elective abortion and used a conventional approach to service delivery; $25 within the restrictive legal setting that used recommended interventions for treating complications; $34 within the

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	when different service delivery approaches are used			legal setting that allowed elective abortion and relied on a conventional approach to service delivery; and $6 within the liberal legal setting that used recommended interventions. Using recommended technical interventions substantially reduced costs regardless of the legal setting. The greatest reduction in costs (86%) occurred from using recommended interventions within a liberal legal setting rather than using conventional interventions within a restricted setting. These findings should support policy and practice efforts to reform abortion laws and to offer accessible, safe abortion services.
(Johnston, Oliveras et al. 2010) [Bangladesh]	Estimate comparative costs to the health system of providing menstrual regulation and care for abortion complications	Government health facilities that provide menstrual regulation or care for abortion complications	Cost estimates	The incremental costs per case of providing menstrual regulation care in 2008 were 8-13% of those associated with treating severe abortion complications, depending on the level of care. An estimated 263,688 menstrual regulation procedures were provided at public-sector facilities in 2008, with incremental costs estimated at US$2.2 million, and 70,098 women were treated for abortion-related complications in such facilities, with incremental costs estimated at US$ 1.6 million. The provision of menstrual regulation averts unsafe abortion and associated maternal morbidity and mortality, and on a per case basis, saves scarce health system resources. Increasing access to menstrual regulation would enable more women to obtain much-needed care and health system resources to be utilized more efficiently.
(Jones and Weitz 2009) [United States]	A set of laws directly target abortion providers, make the provision of abortion more difficult and costly, and provide strong incentives for physicians not to offer abortion services. We addresses this set of laws, which have a significant capacity to reduce access to and quality of abortion care in the United States	Entire US population	Legal review	Combined with the public controversy over abortion, confusion over insurance coverage prompts many women to pay out of pocket rather than seek coverage clarification. Women who choose to pay for their abortions themselves also cite concerns about confidentiality and privacy. Finally, some abortion clinics do not accept third-party payers. Together, these factors cause three quarters of women receiving outpatient abortions to pay for the procedure with their own funds.24 Women with limited financial resources can find themselves in an vicious cycle: by the time they have secured the money for an abortion performed at one gestational limit, their pregnancy has advanced into the next. Studies continue to demonstrate that lack of financial support for abortion results in delays that push the procedure into the second trimester.
(Kahane 2000) [United States]	Estimate the effects of anti-abortion activity on the demand and supply of abortion services in 1992	Abortion rates at the state level.	Regression analysis	Anti-abortion activities (measured as picketing with physical contact or blocking of patients) have decreased the market equilibrium abortion rate by an estimated 19 percent and raised the price of an abortion by approximately 4.3 percent. Taken together, the empirical results show that anti-abortion activities have been successful in making abortion services scarcer.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Kay, Katzenellenbogen et al. 1997) [South Africa]	Analyze the medical costs incurred in treating women for incomplete abortion	Women with incomplete abortions	Cost estimates	A conservative estimate of the total cost of treating women is R18.7 million ± R3.5 million for 1994. An estimated R9.74 million ± R1.3 million of this was spent treating women with 'unsafe' incomplete abortions.
(Le, Connolly et al. 2015) [South Africa]	To evaluate the likely costs of unintended pregnancy in South Africa using a deterministic modeling approach	Model estimates based on contraception prevalence and failure rates among women of reproductive age.	A decision analytic model to estimate costs of unintended pregnancies	Estimated costs of miscarriages and abortion for a single year were 287 million and 282 million RAND respectively.
(Limacher, Daniel et al. 2006) [Canada]	Compares the costs of four options for early medical and surgical abortion in Ontario. Costs are considered from the perspectives of society, the health care system, and the patient	Abortion providers	Cost estimates	The medical options for early abortion compare favorably with the surgical options in terms of total cost to society, the health care system, and the patient. For society and the health care system, the direct costs of medical abortion are also less than those of surgical abortion, but for patients the direct costs of medical abortion are higher. Although the procedures and outcomes for early surgical abortion are essentially identical in the hospital and clinic settings, the clinic has a cost advantage from the perspectives of both society and the health care system because of its lower overhead and its greater efficiency, which is due to specialization in a single procedure.
(Lince-Deroche, Harries et al. 2018) [South Africa]	To estimate the costs of public-sector abortion provision in South Africa and to explore the potential for expanding access at reduced cost by changing the mix of technologies used	Public-sector abortion provision in South Africa	A budget impact analysis using public sector abortion statistics and published cost data	The public sector performed an estimated 20% of the expected total number of abortions in 2016/17; 26% and 54% of all abortions were performed illegally or in the private sector respectively. Costs were lowest in scenarios where method mix shifting occurred. Holding the proportion of abortions performed in the public-sector constant, shifting to more cost-effective service provision (more first-trimester services with more medication abortion and using the combined regimen for medical induction in the second trimester) could result in savings of $28.1 million in the public health service over the 10-year period. Expanding public sector provision through elimination of unsafe abortions would require an additional $192.5 million...South Africa can provide more safe abortions for less money in the public sector through shifting the methods provided.
(Medoff 2008b) [United States]	Examines if state restrictive abortion laws increase the price providers charge for supplying abortion services	State level data on number and prices of abortions	Regression analysis	The empirical results find that the enforcement of a parental notification law and a mandatory counseling law causes an increase in the price charged by abortion providers by over 13% and 9%, respectively. Based on previous estimates of the price elasticity of abortion demand, this implies that the spillover effect of a parental notification law and a mandatory counseling law is to reduce the demand for abortion, through their increase on the price of an abortion, by between 9.4% and 13.6% for a parental notification law and between 6.5% and 9.4% for a mandatory counseling law.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Medoff 2015) [United States]	Examines two questions: Do restrictive state abortion laws increase the price charged by abortion providers? And, if so, Does the increase in the price charged by abortion providers have a significant negative impact on abortion demand	Abortion providers and women of reproductive age	Regression analysis	Over the period 2000-2011, state enforcement of a two-visit law and a TRAP law are associated with an increase in the real price charged by abortion providers of 19% for a two-visit law and 25% for a TRAP law. These empirical results suggest that these two restrictive state abortion laws reduce the demand for an abortion in a state by between 13% and 15% for a two-visit law and between 17% and 19% for a TRAP law.
(Monea and Thomas 2011) [United States]	Estimates the costs of unplanned pregnancies	Women in the U.S. of reproductive age	Cost estimates	Lower-bound, mean and upper-bound estimates of the annual cost of unintended pregnancy are, respectively, $9.6 billion, $11.3 billion and $ 12.6 billion. Corresponding estimates of the savings that would accrue to taxpayers by preventing unintended pregnancies are $4.7 billion, $5.6 billion and $6.2 billion. The mean estimate of the taxpayer cost per publicly subsidized unintended pregnancy is $9,000; the prevention of such a pregnancy would save taxpayers about half that amount. CONCLUSIONS: The prevention of unintended pregnancy represents an important opportunity for the public to reap substantial savings, especially given the current fiscal climate. The enactment or expansion of cost-effective policies to prevent unintended pregnancies is therefore a timely and sensible strategy.
(Montouchet, Trussell et al. 2013) [United Kingdom]	We estimate the direct medical costs to the National Health Service (NHS) of unintended pregnancies in 2010 and identify populations at risk for unintended pregnancies	UK population of women who had pregnancies	Estimate of the number of unintended pregnancies and costing using direct medical costs associated with these pregnancies	Proportion of pregnancy outcomes stemming from unintended pregnancies and cost of each outcome to the NHS: Cost per induced abortion = £919 ($1422); cost to the NHS of induced abortions: £142.8 ($221.2) million.
(Murthy and Creinin 2003) [Global]	A complete review of the history and incidence of abortion, who chooses to get an abortion, who provides that service and at what cost. The cost issue is discussed using three different viewpoints: cost to the patient, cost to the	Women choosing to have medical abortions	Literature review	Cost to society: For every dollar spent on abortions for poor women, > US$4 was saved in medical and social welfare costs on pregnancy-related and newborn care over the next 2 years. This is directly translated to the taxpayers, who would have to give millions of dollars to subsidise the cost of prenatal and delivery services, as well as the cost for the mothers to continue to be on medical assistance. There is additional data of this nature in the article for the UK, France, Sweden, India, and China. Main conclusion: Medical abortion, as performed currently, is an expensive process both for providers and for the

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	provider, cost to society – mainly in the form of government expenditure and savings			patient. However, the actual cost is commonly in the same range as surgical abortion.
(Parmar, Leone et al. 2017) [Zambia]	We estimated the costs of providing safe abortion and PAC services at the University Teaching Hospital, Lusaka and then projected these costs to generate indicative cost estimates for Zambia	University Teaching Hospital, Lusaka	We used multiple data sources: key informant interviews, medical records and hospital logbooks	The unit cost of safe abortion lies between US$37 and U$39, and for PAC after unsafe abortion between US$47 and US$56. The national estimates have wider ranges. The annual cost of safe abortion ranges from US $221,000 to US$701,000; and for PAC after unsafe abortion, from US$403,000 to US$3.5 million. Overall, the annual cost savings lie between US$66,000 and US$1.2 million, with a base estimate of US$375,000.
(Prada, Maddow-Zimet et al. 2013) [Colombia]	This study has multiple aims: estimate the costs incurred by health care facilities in treating complications of unsafe abortion; estimate the total annual cost to the health system of providing post-abortion care; compare the cost of treating complications of unsafe abortion with the cost of providing legal abortion services	Estimates based on a sample of facilities	Cost estimations	Cost to the National Health System. By applying the median direct cost per case to the estimated number of women receiving post-abortion care in tertiary and secondary facilities in 2012, we estimate that approximately $14.4 million was spent that year on the treatment of abortion complications (not shown). This does not include indirect costs, which, as stated previously, account for around two-thirds of the cost to Colombia's health system. Including these indirect costs, we estimate that approximately $44 million was spent in 2012 on postabortion care in Colombia.
(Prata, Sreenivas et al. 2010) [34 sub-Saharan African countries]	To guide policy-decision makers in prioritizing the different components of safe motherhood programs in resource-scarce settings.	Different cost models for 34 different countries	Cost effectiveness models	Estimates three levels of costs – low, medium and high. The most cost-effective interventions are family planning and safe abortion, as well as anc-miso. The major contributor to variance for deaths due to unsafe abortions was cost of family planning per client and contraception prevalence.
(Shearer, Walker et al. 2010) [Global]	Evaluate the quality of costing studies of post-abortion care from low- and middle-income countries and to describe costs in various settings	Post-abortion care facilities across countries	Systematic review and regression analysis	Data indicate that the cost (in 2007 international dollars) of post-abortion care in Africa and Latin America is $392 and $430, respectively, per case. Differences in post-abortion care costs were associated with region, procedure, facility level, case severity, and whether the study was operations research.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Sheldon and Fletcher 2017) [United Kingdom]	To provide a detailed reassessment of the relevant law and the clinical evidence that supports this assumption (that vacuum aspiration for induced abortion could be safely and legally performed by nurses and midwives)	Medically-trained abortion providers (doctors, nurses, midwives)	Reassessment of relevant law and clinical evidence	At a time of extreme budgetary restraint within the NHS, the current understanding of the law has resulted in the (relatively expensive) time of doctors being devoted to work that might safely be done by nurses and midwives. The latter are also likely to constitute a more stable workforce than junior doctors, who will move around during their career progression. Allowing nurses to provide this service thus potentially offers a more sustainable and economically efficient basis for the long-term development of excellent care. It would free up doctors to focus on those aspects of service provision where their specific expertise is needed. It might also improve the job satisfaction of nursing and midwifery staff, potentially impacting positively on sickness absence and staff retention rates.
(Singh 2010) [Global]	Review the scientific evidence on the consequences of unsafe abortion, highlight gaps in the evidence base, and suggest areas where future research efforts are needed.	Women who obtained unsafe abortions	Literature review	The total annual cost of providing postabortion care including overhead and capital costs in Latin America and Africa was estimated to range between $227 and $320 million in 2006 (and the average cost was $274 million). Rough estimates were made for Asia assuming that the average cost was similar to that in sub-Saharan Africa and Latin America, resulting in an estimated total annual cost of postabortion care in the developing world of just over $500 million.
(Thomas, Schmid et al. 2010) [United Kingdom]	To determine whether it is worth paying more for ulipristal acetate (UPA), a new method of emergency contraception, in order to avoid an additional unintended pregnancy	Women who present to NHS after having unprotected sexual intercourse	Cost-effectiveness analysis	Looking specifically at women who become pregnant following EHC (emergency hormonal contraception) in the clinical trials (HRA Pharma, data on file, June 2010) the percentage of unintended pregnancies that end in delivery is 18%, induced abortion 66% and miscarriage 16%. Applying these percentages to the average cost of a delivery (£2380), induced abortion (£672) and miscarriage (£474) gives an average cost of an unintended pregnancy of £948.
(Tunc 2008) [United States]	Review the vacuum aspirator's history and why, in less than a decade, electric vacuum suction became American physicians' abortion technology of choice	Americans involved in the provision/ receipt of abortion	Historical review	This article examines why, In less than a decade, electric vacuum suction became American physicians' abortion technology of choice. It focuses on factors such as political and professional feasibility (the technology was able to complement the decriminalization of abortion in the US and the interests, abilities, commitments, and personal beliefs of physicians); clinical compatibility (it met physician/patient criteria such as safety. simplicity and effectiveness); and economic viability (it was able to adapt to market factors such as production. cost, supply/demand, availability, and distribution).
(Vach, Bishop et al. 1998) [Vietnam]	To determine the proportion of unnecessary procedures being performed…. And estimate the costs and savings of using pregnancy testing	Women seeking menstruation regulation	Cohort study and cost estimates	Of women seeking menstrual regulation, 17% had negative pregnancy tests. If this proportion is applicable to Vietnam as a whole, some 136,000 of the estimated 800,000 menstrual regulation procedures performed each year are unnecessary. Overall, these 800 000 procedures cost the Vietnamese government about $2.2 million a year and cost women about $7 million. By providing pregnancy tests for all women seeking menstrual regulation (at a fetal

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	before menstrual regulation			cost of $720,000), the government would avoid spending $380,000 for unnecessary procedures, for a net testing cost of $340,000. Assuming costs of more than $12.00 per menstrual regulation procedure for women with complications and $8.50 for those with none, the avoidance of un necessary procedures would save Vietnamese women an estimated total of $1.2 million.
(Vlassoff, Walker et al. 2009) [Global]	To estimate the health system costs of postabortion care in Africa and Latin America	Top down approach: PAC patients	Cost estimations	This study found that the health system costs of postabortion care in Africa and Latin America ranged from $159 million to $476 million per year, depending on the estimation method used. This study could not assess the cost of postabortion care in Asia or the developed world because no empirical data were available. If we apply our lower boundary figure of $68 per case, which assumes that all women seeking postabortion care have low-severity complications, to the annual number of cases treated in developing countries in Asia and the Pacific region (2,280,000), a very approximate minimum estimate of the cost of such care in this region would be $154 million per year. Adding this to the corresponding figure for Africa and Latin America ($187 million) yields a minimum annual estimate of $341 million for postabortion care in the developing world.
(Vlassoff, Fetters et al. 2012) [Ethiopia]	To address the knowledge gap that exists in costing unsafe abortion in Ethiopia, estimates were derived of the cost to the health system of providing postabortion care (PAC)	14 health facilities	Cost analysis	The average direct cost per client, across 5 types of abortion complications, was US $36.21. The annual direct cost nationally ranged from US $6.5 to US $8.9 million. Including indirect costs and satisfying all demand increased the annual national cost to US $47 million. PAC consumes a large portion of the total expenditure in reproductive health in Ethiopia.
(Vlassoff, Mugisha et al. 2014) [Uganda]	Presents estimates based on the research conducted in 2010 of the cost to the Ugandan health system of providing post-abortion care (PAC), filling a gap in knowledge of the cost of unsafe abortion	39 health facilities	Cost analysis	Our results show that the average annual PAC cost per client, across five types of abortion complications, was $131. The total cost of PAC nationally, including direct non-medical costs, was estimated to be $13.9 million per year. Satisfying all demand for PAC would raise the national cost to $20.8 million per year. This shows that PAC consumes a substantial portion of the total expenditure in reproductive health in Uganda.
(Vlassoff, Musange et al. 2015) [Rwanda]	estimate the cost to the Rwandan health-care system of providing post-abortion care (PAC) due to unsafe abortions	PAC in Rwanda	economic costing	We found that the average annual PAC cost per client, across five types of abortion complications, was $93. The total cost of PAC nationally was estimated to be $1.7 million per year, 49% of which was expended on direct non-medical costs. Satisfying all demands for PAC would raise the national cost to $2.5 million per year.
(Vlassoff, Singh et al. 2016) [Ethiopia,	The objective of this study is to expand the research findings of four previous studies on the cost of post-	Comparative study of costing studies from 4 countries	4 country comparative costing study	The labor cost component varies widely: in Ethiopia and Colombia doctors spend about 30–60% more time with PAC patients than do nurses; in Uganda and Rwanda an opposite pattern is found. Labor costs range from I$42.80 in Uganda to I$301.30 in Colombia. The cost of drugs and supplies does not vary greatly,

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
Uganda, Rwanda and Colombia]	abortion care (PAC), making use of their extensive datasets			ranging from I$79 in Colombia to I$115 in Rwanda. Capital and overhead costs are substantial amounting to 52–68% of total PAC costs. Total costs per PAC case vary from I$334 in Rwanda to I$972 in Colombia. The financial burden of PAC is considerable: the expense of treating each PAC case is equivalent to around 35% of annual per capita income in Uganda, 29% in Rwanda and 11% in Colombia. Providing modern methods of contraception to women with an unmet need would cost just a fraction of the average expenditure on PAC: one year of modern contraceptive services and supplies cost only 3–12% of the average cost of treating a PAC patient.
(Wilder 2000) [Israel]	This study uses data from the 1974-75 Israel Fertility Survey and the 1987-88 Study of Fertility and Family Formation to examine the changing determinants of abortion among Jewish women in Israel.	Women of reproductive age in Israel	Regression analysis	Sick funds typically cover the costs of the procedure for minors and for women who have medical grounds for abortion. Abortions due to rape are funded by government welfare agencies, although full payment has been provided only since October 1991. Otherwise, the woman pays the equivalent of US$250-400, depending on the hospital, for the procedure and associated care. Abortion is widely available in Israel, and 95% of Israeli women have access to moderately priced abortion.
(Winikoff, Hassoun et al. 2011) [United States, France]	To examine the commercial, political, regulatory, and legislative history of the introduction of mifepristone / misoprostol in France and the United States.	Abortion providers and seekers	Review	In the United States, a large majority of women (74%) pay for their abortions with their own money or with funds they obtain from their partners, family or others. Most abortion costs are paid out-of-pocket. The insurance situation in the United States has important implications for the use and accessibility of mifepristone. On the one hand, because few women use insurance to cover the procedure, insurance companies exert little influence over practice patterns or standards of care compared to other surgical or reproductive health procedures; clinics and providers have been free to develop innovative service models for provision of the service that ultimately may have reduced the overall cost of the procedure. On the other hand, the price of the procedure has a wide range. The adjusted cost of providing medical abortion care varies significantly depending upon the practice model used (from $252 to $460 per abortion, median $351). Consequently, the method may be more or less accessible or a more or less attractive alternative to surgical abortion depending upon the practice and pricing model in place.
(Wu, Maru et al. 2017) [Nepal]	To review abortion care in Nepal 15 years after it was legalized	This review paper talks about abortion in relation to practitioners, women seeking abortions, national policies, etc.	Review	While the landmark 2009 Supreme Court decision established the legal framework for the government to mandate free and accessible abortion services in the public sector, there was no policy to implement safe abortion services until the passage of the Safe Abortion Service Guidelines of 2016. Under these guidelines, all government facilities should provide free abortion services. However, the provider reimbursement scheme outlined in the guidelines is less profitable for providers than it was when women paid out of pocket. It remains to be seen whether these new guidelines thus create monetary incentives that

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				encourage providers to shift abortion provision from the public to the private sector, thereby adversely affecting access at public facilities. Despite the legal reforms, however, further improvement in protocols and infrastructure is necessary to ensure that all women truly have equal access to affordable services. Second-trimester services, for example, remain extremely limited, with many women still lacking access.

Appendix T. Summary of studies reporting macro-economic impacts

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Ananat and Hungerman 2012) [United States]	Considers how the diffusion of oral contraception to young unmarried women affected the number and parental characteristics of children born to these women	Children in national sample for U.S.	Regression analysis	Children whose births were avoided due to pill access may have had characteristics different, and along some dimensions more advantageous, from children whose births were avoided by abortion access. In the long-term, access led to negligible changes in fertility while increasing the share of children with college-educated mothers and decreasing the share with divorced mothers. The short-term effects appear to be driven by upwardly-mobile women opting out of early childbearing while the long-term effects appear to be driven by a retiming of births to later ages. These effects differ from those of abortion legalization, although we find suggestive evidence that pill diffusion lowered abortions. Our results suggest that abortion and the pill are on average used for different purposes by different women, but on the margin some women substitute from abortion towards the pill when both are available.
(Anandhi 2007) [India]	To contextualize the decision to abort in terms of local cultural practices, women's employment in newly emerging peri-urban informal sector, and new forms of encoding masculinities in four villages in northern Tamil Nadu where the fertility rate is rapidly declining	Women aged between 45-65 and 25-45 who live in the study villages that are marked by high incidence of abortion and industrial estates for pharmaceutical companies	Interviews	Women's decision to abort is often a process of accommodating the pressures of cultural values and beliefs. Women's decision to abort seems to be linked to a vector of factors like childcare as their exclusive responsibility, marital conflicts, son preference and belief in astrology and local religion. Since women do not have control over these social conditions, their "choice" of abortion is basically to deal with these situations. The logic of family limitation through abortion as promoted by the state population policy might be influencing women's consciousness on abortion. But how women arrive at the decision to abort is not based on the received notions of family planning or birth control, but on the basis of local, social and cultural conditions and relations that define their lives.
(Angrist and Evans 2000) [United States]	Examine effect of teen fertility and marital status on the schooling and labor market outcomes of women who were exposed to state abortion reforms as teenagers	Women born 1949-54	Regression analysis	The first-stage teen marriage effects experienced by white women did not lead to detectable schooling or labor market consequences. In contrast the teen fertility consequences of abortion reform for black women translated into large and statistically significant increases in high school graduation rates, college attendance rates, and employment rates. The increase in schooling for black women is not reflected in an increase in earnings, most likely because the effects on earnings are too far down the causal chain that began with abortion reform.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Averett, Rees et al. 2002)[United States]	To estimate the determinants of being sexually active and using contraceptives at last intercourse	The National Survey of Family Growth (NSFG) Cycle V – a nationally representative survey of 10,847 women between ages 15-44 years in 1995	Secondary data analysis	There is little indication that changes at a policy level of the cost of abortion impacts sexual behaviour, nor prevalence of family planning services.
(Azarnert 2009) [Sub-Saharan Africa]	Analyze the relationship between abortion and female education	school enrollment rates in secondary school	Regression analysis	More liberal abortion policies are associated with a higher female secondary school enrollment. It is assumed in the model that easier access to abortion decreases probability of dropping out of school for a female child in the case of an occasional pregnancy. As a consequence, it enhances parental investment in human capital of their female offspring and helps to reduce the gender gap in education.
(Bailey and Lindo 2017) [United States]	Chronicles changes in childbearing, provides descriptive evidence regarding trends in use, and reviews the literature linking them to changes in childbearing and women's economic outcomes	Women of reproductive age and children	Literature review	Legalized abortion led to decreases in completed childbearing—largely due to increases in childlessness— and improvements in the material living circumstances of children.... the effects of greater access to family planning and abortion services vary by age, demographic group, type of policy intervention, and context. Third, these policy changes seem to have contributed to women's longer term economic advancement. Studies of the Pill find effects on cohabitation, age at first marriage, educational attainment, occupational choice, and the gender wage gap. Fourth, large policy changes have increased the likelihood that children are born into households with greater material resources, likely leading to improved outcomes for children. Some of the improvements in the material resources of children reflect the greater earnings capacity of both men and women, and some reflect changes in the population who select into parenthood at different times.
(Bendavid, Avila et al. 2011) [Sub-Saharan Africa]	Investigate the association between a country's exposure to the Mexico City Policy and the odds of abortion among women of reproductive age between 1994 and 2008	Women of reproductive age in 20 Sub-Saharan African countries	Regression analysis	Women living in highly exposed countries had 2.73 times the odds of having an induced abortion after the policy's reinstatement than during the period from 1994 to 2000 or than women living in less exposed countries. After adjustments for place of residence, educational attainment, use of contraceptives and funding for family planning and reproductive health from sources other than the United States, the estimated OR dropped to 2.55. The increase in contraceptive use proceeded at a slower pace after 2002 in countries with a high level of exposure, whereas in countries with a low exposure the increase continued at the same pace.
(Berer 2000) [Global]	This article examines the changes in policy and health	It is based on a wide-ranging review of	Review	Most authors agree that treating abortion complications in sub-Saharan Africa consumes a disproportionate amount of hospital resources. In Bangladesh, up to 50% of hospital gynaecology beds are

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	service provision required to make abortions safe	published and unpublished sources.		reported to be taken up with abortion complications. Women tend to wait until complications become severe before seeking help, increasing both the cost and complexity of treatment. Furthermore, women attending untrained providers have been found to make more visits for care and spend more overall than women attending trained providers in the first place. A Tanzanian study estimated that the cost per day of treating abortion complications, including the costs of drugs, meals, staying costs and surgical procedures, was more than seven times the Ministry of Health's annual per capita budget.
(Billings and Benson 2005) [Latin America & Caribbean]	This article reviews results from 10 major PAC operations research projects conducted in public sector hospitals in seven Latin American countries, completed and published between 1991 and 2002	All were operations research, that is, studies designed to measure the effectiveness of an intervention in achieving service delivery outcomes	Review	Following relatively modest interventions, the majority of eligible patients were being treated with manual vacuum aspiration (MVA), a method preferred for safety and other reasons over the method conventionally used in the region, sharp curettage (SC). A number of studies showed improvements in contraceptive counselling and services when these were integrated with clinical treatment of abortion complications, resulting in substantial increases in contraceptive acceptance. Finally, data from several studies showed that, in most settings, reorganizing services by moving treatment out of the operating theatre and reclassifying treatment as an ambulatory care procedure substantially reduced the resources used for PAC, as well as the cost and average length of women's stay in the hospital.
(Bloom, Canning et al. 2009) [Global]	Estimate the effect of fertility on female labor force participation in a panel of countries using abortion legislation as an instrument for fertility	Women ages 20-44	Regression analysis	Removing legal restrictions on abortion significantly reduces fertility and estimate that, on average, a birth reduces a woman’s labor supply by almost 2 years during her reproductive life. Results imply that behavioral change, in the form of increased female labor supply, contributes significantly to economic growth during the demographic transition when fertility declines.
(Bloomer and O'Dowd 2014) [Ireland]	To consider abortion tourism in Ireland, both north and south, and how the moral conservatism present in both jurisdictions has impacted on attitudes and access to abortion	Women seeking abortion serves in restricted setting, (Ireland)	Mixed methods	The moral conservatism in the Republic of Ireland and Northern Ireland is apparent in the role of religious and political institutions. Both fail to acknowledge the repeated evidence of the public and professional support for abortion law reform and the evidence of the continuance of abortion tourism. Their comments on abortion demonstrate that they fail to grasp the complex set of circumstances women find themselves in when faced with a crisis pregnancy. In denying women their agency, these comments reinforce perceived traditional feminine roles as fertile, caring and inevitable mothers, in effect forcing them into ‘reproductive labor.’
(Bowmaker and Emerson 2013) [Europe]	Presents an alternative theory of abortion access and marriage based on the cost of search which	Women of reproductive age	Regression analysis	A switch to a more liberal abortion law regime is associated with an increase in marriage rates for nonteenage females. the results reported in Tables 4 and 5 for the ‘twenty-somethings’ reveal a remarkably consistent story. Across all specifications, the coefficient

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	suggests that more liberal abortion laws may actually promote young marriage			on the liberal abortion law dummy is positive and strongly statistically significant.
(Brown and Jewell 1996) [United States]	To estimate directly the responsiveness of abortion demand to county-level variations in travel-cost component of the full cost of abortion services	Abortion providers in Texas	Log-linear regressions using data that were obtained from health facilities on each abortion performed and data on the localities of these facilities	A higher travel cost for abortion services significantly lowers county-level abortion rates.
(Bullard, Shaffer et al. 2018) [United States]	To estimate the effect of 20-week abortion bans on maternal and consequent neonatal health outcomes and costs in the setting of fetal congenital diaphragmatic hernia	Women in their mid-second trimester of pregnancy with a prenatal diagnosis of congenital diaphragmatic hernia	Cohort analytic	Twenty-week bans were associated with both poorer health outcomes from the maternal perspective and increased costs across all ranges used for the costs, probabilities, and utilities.
(Buonanno, Drago et al. 2011) [United States and Europe]	Studies the causal impact of demographic changes, incarceration, abortion, unemployment and immigration on crime	Crime and abortion rates	Regression analysis	Does not find evidence that abortion rates reduce crime rates in Europe as much as previously found for the United States. Understanding why is beyond the scope of this paper, but future research should investigate this different response of crime rates to abortion in Europe. A possible explanation is that in Europe a strong welfare state, easy access to good education and strong family ties work as risk reducing factors that weaken the link between unwanted childbearing and crime. Overall, one of the key elements explaining the drop in crime rates in the United States seems to be ineffective in Europe.
(Coast, Norris et al. 2018) [Global]	Present a new conceptual framework for studying trajectories to obtaining abortion-related care	Global review paper	Review	International institutions can shape the availability of abortion in other national and sub-national contexts, both ideologically and financially. Health system financing (e.g. free, subsidised, insurance, co-payments) affects how abortion-related care is sought and paid for. There is increased recognition of the scale and consequences of unsafe abortion, including the costs for both women and health systems, in a range of legal settings.
(Comendant 2005) [Moldova]	Presents information on the current abortion law, policy and services in Moldova	National-level for Moldova	Mixed methods	Since 1994, to reduce the number of complications, the Ministerial Order said that all abortions should be performed in hospitals by obstetrician–gynaecologists. This centralisation of services and their

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				relatively higher cost has reduced the accessibility of abortion. Still the implementation of medical abortion in Moldova faces problems. There are difficulties in the organisation of service delivery as most abortions are currently being provided on an inpatient basis, and the fees include payment for a hospital stay. The cost of a medical abortion, including the cost of the pills, is much higher than for vacuum aspiration. Thus, many women will not have access to this method, preferring the cheaper option.
(Cook 1999) [United States]	To estimate the funding effects on abortion rates and birth rates	Women who received abortions in North Carolina and data on the number of pregnancies	State level data analysis	In months when state funding is not available there are fewer abortions and more unacceptable births.
(Crane and Dusenberry 2004) [Global]	To examine the effect of the Global Gag Rule on family planning organizations in countries receiving American assistance	Family planning organizations within multiple countries	Literature review	Some organizations were forced to close clinics, terminate staff and cut not only family planning programs but also programs for maternal health and well-baby care, sexual health education, youth outreach, and the prevention and treatment of sexually transmitted infections and HIV/AIDS. The Gag Rule also led to the termination of all American contraceptive supply shipments to leading family planning organizations in 29 countries.
(Dennis, Manski et al. 2014) [United States]	To answer the following questions: (1) What do women know about the cost of abortion and the availability of Medicaid coverage for abortion? (2) Where do women obtain this information? (3) What are women's experiences paying for care?	Low-income women aged 18 years or older who had an abortion within the past two years and who resided in one of the four study states at the time of the abortion	Interviews	Findings suggest that policies regarding Medicaid coverage of abortion affect the lives of women and their families in numerous ways. Restrictive coverage policies appear to force women to take measures to raise money for an abortion that may put their health and wellbeing at risk, promote short and longer-term financial instability, and increase the difficulty of implementing an abortion decision, thereby interfering with women's reproductive life plans. Restrictive Medicaid coverage policies also appear to have ripple effects on children, partners, and parents of women seeking abortion services.
(Donohue and Levitt 2001) [United States]	Provide evidence that legalized abortion has contributed significantly to recent crime reductions	Crime and abortion rates	Regression analysis	Offers evidence that legalized abortion has contributed significantly to recent crime reductions. Crime began to fall roughly eighteen years after abortion legalization. The five states that allowed abortion in 1970 experienced declines earlier than the rest of the nation, which legalized in 1973 with Roe v. Wade. States with high abortion rates in the 1970s and 1980s experienced greater crime reductions in the 1990s. In high abortion states, only arrests of those born after abortion legalization fall relative to low abortion states. Legalized abortion appears to account for as much as 50 percent of the recent drop in crime.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Donohue and Levitt 2004) [United States]	This paper is an extension of the original Donohue 2001 paper following a critique by Foote 2008	Crime and abortion rates	Regression analysis	We demonstrate that Joyce's failure to uncover a negative relationship between abortion and crime is a consequence of his decision to focus almost exclusively on one nonrepresentative six-year period during the peak of the crack epidemic. We provide empirical evidence that the crack-cocaine epidemic hit the high-abortion early-legalizing states earlier and more severely than other states.
(Donohue and Levitt 2008) [United States]	This paper corrects an analysis error to their original Donohue 2001 paper based on a critique by Foote 2008	Crime and abortion rates	Regression analysis	Correcting our mistake does not alter the sign or statistical significance of our estimates, although it does reduce their magnitude. Using a more carefully constructed measure of abortion that better links birth cohorts to abortion exposure (by using abortion data by state of residence rather than of occurrence, by adjusting for cross-state mobility, and by more precisely estimating birth years from age of arrest data), we present new evidence that abortion legalization reduces crime through both a cohort-size and a selection effect.
(Dragoman and Davis 2008) [United States]	Synthesis of published literature and current practices for adolescent abortion care.	Literature on national abortion statistics and evidence for adolescents.	Literature review	The availability of affordable abortion services determines if a young woman can obtain an abortion at all and how quickly. Compared with adults, barriers to care may particularly affect adolescents with limited resources. Obtaining an abortion may require significant travel because most counties in the United States (more than 80%) have no abortion provider. In most states, abortion is not covered by state Medicaid programs and poor teens may have difficulty funding the cost of care. Delays experienced by adolescents lead to increased costs and risk, as later abortions are more technically difficult and expensive.
(Duggal 2004) [India]	Examination of the political economy of abortion care in India by reviewing cost and expenditure patterns for abortion care in India	Population of India	Descriptive analysis of the political economy	This review shows that it is imperative for the state to regulate the abortion economy in India, both services and the medical profession, in order to rationalise costs and assure safe abortions for women. It would make good sense to expand the base of certified and registered abortion providers to include nurses, midwives and auxiliary nurse–midwives to provide early abortion services, as it would eliminate many of the quacks. This is more easily said than done because it will involve large-scale investment in training, strong resistance from the medical profession, require strengthening of support systems in public health services and a change in the state's perspectives on abortion. However, such an option in terms of financing would be cost-effective and simultaneously could help to increase the credibility of the public health system and rebuild women's willingness to use public abortion services.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Elias, Lacetera et al. 2017) [Global]	Analysis of differences and changes in the regulation of taboo activities around the world, including abortion	100 countries between 1960 and 2015	Regression analysis	In the case of abortion, higher income per capita is strongly associated with the adoption of formal legislation with increasingly permissive rules. Regression estimates also indicate that democratic regimes and more economic and political rights for women are associated with more permissive abortion legislation and with the legalization of non-organized forms of prostitution. In the case of abortion, the prevailing religion affects the rate at which higher income associates with more liberal legislation. The correlation is weaker in countries with a majority of Muslim citizens, although we estimate more liberal regulation at lower levels of income; where Catholicism is prevalent, we estimate restrictive laws at low levels of income but a faster adoption rate of permissive rules as income increases.
(Ely, Hales et al. 2017a) [United States]	Use a trauma-informed lens to explore abortion-related hardships in a previously understudied group	Status as abortion seeker and inability to pay for abortion care procedure	Descriptive, exploratory, cross- sectional analysis of administrative health care data	Over one-third of patients report receiving some form of public assistance, which includes a range of programs such as SNAP, which stands for Supplemental Nutrition Assistance Program, formerly known as Food Stamps, Women Infants Children vouchers (food assistance for pregnant or nursing women and young children), or unemployment benefits. This finding point to the broader economic hardships experienced by abortion fund patients in the United States, and is consistent with other findings suggesting that women already on public assistance are more likely to get an abortion when faced with unintended pregnancy. This is also consistent with findings indicating that public assistance recipients already experience a wide range of “megastressors” that are difficult to address.
(Foote and Goetz 2008) [United States]	Revisits 2001 paper by Donohue and Levitt that linked the unexpected decline in crime during the 1990s to the legalization of abortion	Crime and abortion rates	Regression analysis	Placing these results alongside those from the corrected concluding regressions and our expanded cross-state analysis, we find no compelling evidence that abortion has a selection effect on crime.
(Foster, LaRoche et al. 2017) [Canada]	To document women's experiences obtaining abortion care in New Brunswick (NB) before and after the Regulation 84-20 amendment; identify the economic and personal costs associated with obtaining abortion care; and examine	New Brunswick residents who received abortion services	Semi-structured interviews	Although the 2015 changes to Regulation 84-20 represent an important step in aligning New Brunswick with the rest of Canada, the amendment does little to mitigate the challenges imposed by the province's refusal to fund clinic-based abortion care within or outside of the province. This study’s findings indicate that even if the elimination of the two-physician requirement were to be fully implemented, this would have only marginal impact on women's ability to access affordable and timely abortion care.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	the ways in which geography, age and language-minority status condition access to care.			
(Foster, Biggs et al. 2018a) [United States]	To examine the association of women receiving or being denied a wanted abortion with their children's health and well-being	Children and mothers	Regression analysis	Perinatal and child health outcomes were not different between subsequent and index children, and there was no clear pattern of delayed child development. However, mixed-effects models adjusting for clustered recruitment and multiple observations per child revealed that poor maternal bonding was more common for index children compared with subsequent children. Index children lived in households with lower incomes relative to the federal poverty level than did subsequent children (101% vs 132% of federal poverty level), and were more likely to live in households without enough money to pay for basic living expenses (72% vs 55%).These findings suggest that access to abortion enables women to choose to have children at a time when they have more financial and emotional resources to devote to their children.
(Foster, Biggs et al. 2018b) [United States]	To determine the socioeconomic consequences of receipt versus denial of abortion	Women seeking abortion services	Regression analysis	In analyses that adjusted for the few baseline differences, women denied abortions who gave birth had higher odds of poverty 6 months after denial than did women who received abortions; women denied abortions were also more likely to be in poverty for 4 years after denial of abortion. Six months after denial of abortion, women were less likely to be employed full time and were more likely to receive public assistance than were women who obtained abortions, differences that remained significant for 4 years. Women denied an abortion were more likely than were women who received an abortion to experience economic hardship and insecurity lasting years. Laws that restrict access to abortion may result in worsened economic outcomes for women.
("Fourteenth Amendment" 2016) [United States]	To review the Whole Woman's Health v. Hellerstedt case on abortion restrictions	State-level and national policy/law	Review	By explicitly and precisely requiring future courts to consider the burdens a law imposes on abortion access together with the benefits [that law] confer[s], the Court added clarity in at least three ways. First, it translated the undue burden inquiry into a framework with which all government branches have become intimately familiar in recent decades: cost-benefit analysis. Cost-benefit analysis is certainly a far cry from the rule-like trimester framework established in Roe and subsequently rejected by Casey. But it is a standard to which courts are more accustomed, and it will thus likely be applied with greater consistency than the undue burden standard has been applied in the past.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Gruber, Levine et al. 1997) [United States]	Examine the impact of increased abortion availability on the average living standards of children through a selection effect	National sample of children born immediately after abortion was legalized	Regression analysis	The study finds evidence of sizable positive selection: the average living circumstances of cohorts of children born immediately after abortion became legalized improved substantially relative to preceding cohorts, and relative to places where the legal status of abortion was not changing. Results suggest that the marginal children who were not born as a result of abortion legalization would have systematically been born into less favorable circumstances if the pregnancies had not been terminated: they would have been 60 percent more likely to live in a single-parent household, 50 percent more likely to live in poverty, 45 percent more likely to be in a household collecting welfare, and 40 percent more likely to die during the first year of life.
(Haddad, Yanow et al. 2009) [United States]	To explore provider responses to the ban in one state in order to identify important indicators for a national study	Facilities that provided abortions in Massachusetts	Descriptive statistics from key informant surveys	The 2007 SCOTUS decision to uphold the Partial-Birth Abortion Act (2003) three hospitals increased their chargers for later-trimester abortion services. Medicaid-eligible people must rely on hospitals to obtain abortions at 19 weeks to receive funding under state guidelines.
(Hodorogea and Comendant 2010)[Armenia, Azerbaijan, Belarus, Bulgaria, Croatia, Czech Republic, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Republic of Moldova, Romania, Russian Federation, Slovakia, Tajikistan, Ukraine, Uzbekistan, Commonwealth of Independent States (CIS), Central Asian Republics]	To discuss progress made in various contexts toward safe and legal pregnancy termination	Macro, national level data from the WHO and Guttmacher Institute	Descriptive statistics	Legal barriers have made access to abortion in Central and Eastern Europe and Central Asia more difficult. Long distances due to clinic closures and the increased cost of abortions, not covered by medical insurance or the state, are significant barriers.
(Johnston, Oliveras et al. 2010) [Bangladesh]	Estimate comparative costs to the health system of providing menstrual	Government health facilities that provide menstrual regulation or	Cost estimates	If all women experiencing abortion- related complications were able to access the care they needed (and that Bangladesh has committed to providing in international agreements), the total annual health system costs of providing care for abortion-related com- plications

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	regulation and care for abortion complications	care for abortion complications		would be much higher. The Bangladesh health system could better meet the re- productive health needs of women by making menstrual regulation more accessible, further reducing recourse to unsafe abortion. For example, the health system could ensure that each facility that is meant to provide menstrual regulation services has a provider trained and equipped to offer menstrual regulation care, increase the allowed limit for menstrual regulation from 10 to 12 weeks since last menstrual period and address the socioeconomic barriers to safe menstrual regulation services. On a national level, the incremental costs of providing essential care to women with abortion-related complications amounted to roughly US$1.6 million in 2008. It is possible that these costs of treating abortion complications could be reduced and quality of care maintained or improved through shifting of care strategies.
(Johnston, Akhter et al. 2012) [Bangladesh]	Assess incremental health system costs of service delivery for abortion-related complications in the Bangladesh public health system	Health facilities across Bangladesh	Interview and survey analysis	The study findings show that despite the presence of a decentralized MR program, designed in part to reduce complications of unsafe abortion, abortion complications remain a frequent event in Bangladesh. According to the data, on average, each tertiary facility received more than 4 patients with abortion-related complications every day; this is consistent with previously generated estimates that suggest the public health system treats roughly 70,000 such patients annually. These numbers are inexcusably high. Nonetheless, it should be noted that in a 13-country analysis of hospitalizations related to abortion complications, Bangladesh – the only country in the analysis to have an established MR or abortion program – had the lowest hospitalization rate for abortion complications per 1000 women.
(Jones and Weitz 2009) [United States]	Examine effect of set of laws on access to and quality of abortion care in the United States	Legal review for whole of USA	Review article	The costs and burdens stemming from the imposition of ASC requirements have hindered or prevented physicians in some states from providing abortions. In 2004, a state law went into effect requiring that abortions after 16 weeks' gestation be performed in ASCs or hospitals.93 Accordingly, existing abortion providers had to meet the state ASC regulations and become licensed as ASCs to continue providing abortions after 16 weeks. Compliance with the state's ASC requirements was difficult, particularly with respect to the physical plant, and existing facilities could not meet the standards without undertaking major renovations or moving into new buildings. For example, the physical renovations alone at one facility would cost $750,000.
(Jones and Finer 2012)[United States]	To examine the characteristics of women	A national sample of 9493 women obtaining abortions in 2008	Regression analyses. Data analyses of the	One=third of abortion-care seekers relied on health insurance. Black women were twice as likely as White women to have obtained an abortion at 16+ weeks than at 13-15 weeks.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	having abortions at 13 weeks or later		2008 Abortion Patient Survey	Women with family incomes 200+% of poverty were more likely than poor women to be obtaining abortions at 16+ weeks. Women using health insurance to pay were more than twice as likely to have an abortion at 16+ weeks than were women out of pocket.
(Jones 2017) [United States]	To determine which characteristics and circumstances were associated with obtaining very early and second-trimester abortions	8380 non-hospital abortion patients from the 2014 Abortion Patient Survey	Regression analyses	45% of patients paid for out of pocket care for abortion, Medicaid was the second most common method of payment – the overwhelming majority of people lived in one of the 15 states that use their own Medicaid funds to cover abortion. 14% of women used private insurance, 13% used financial assistance, which refers to discounts provided by clinics or subsidies available at some facilities.
(Jones, Ingerick et al. 2018) [United States]	To determine which characteristics are associated with prior abortion	8380 non-hospital abortion patients from the 2014 Abortion Patient Survey	Regression analyses	The odds of having a prior abortion were higher for those who paid for the procedure using public or private health insurance (OR: 1.47; 95% CI: 1.29– 1.69) / received financial assistance (OR: 1.32; 95% CI: 1.15–1.52), compared to patients who paid for the abortion out of pocket.
(Kahane 2000) [United States]	Estimate the effects of anti-abortion activity on the demand and supply of abortion services in 1992	Abortion rates at the state level	Regression analysis	With an estimated coefficient of -7.713, this means that a 1 percent increase in anti-abortion activities (as defined) leads to a decrease in the supply of abortion services (also, as defined) by approximately 0.08. This result thus supports the hypothesis set out above that anti-abortion activities have been successful in reducing the supply of abortion services.
(Kalist 2004) [United States]	Examine whether the liberalization of state abortion laws affects female labor force participation	Women of reproductive age	Regression analysis	Results indicate that abortion, by reducing unwanted pregnancies and hence fertility rates, has increased the labor force participation rates of females, especially of single black women. The data suggest that the probability a woman works (40 or more weeks a year) increases by almost 2.0 percent in states adopting legalized abortion prior to Roe v. Wade. Furthermore, abortion had a greater effect on the participation rates of black women than white women. The probability that a black woman works in the labor force increases by almost 6 percent in states adopting legalized abortion pre-Roe v. Wade.
(Kalsi 2015) [Taiwan]	Investigate whether the ability to prenatally sex select through legal abortion	Households that have had abortions for family planning	Regression analysis	Finds evidence supporting the substitution hypothesis that prenatal gender discrimination reduces postnatal discrimination for girls later in life. Once abortion is made legal, families with a strong preference for a boy at a higher birth order (or a strong distaste for a girl at a higher birth order) choose to abort the higher order female fetus. Hence, girls born at higher birth orders after the legalization of

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				abortion are born into families with, on average, a higher preference for girls. I find results consistent with this compositional change, with abortion legalization resulting in an increase in the average rate of university attendance of higher birth order girls by about 4.5 percentage points. It is important to realize that these results do not imply that abortion legalization increased any one girl's likelihood to attend a university but rather increased the average rate of attendance because girls who would have experienced less education, hence driving the average rate of university attendance down, were never born.
(Levine and Staiger 2002) [United States, Romania, Russia, German Democratic Republic, Czech Republic, Slovak Republic]	Examine the impact on fertility-related behavior of changes in abortion access	Cross country data on abortion rates and fertility	Regression analysis	The model predicts that legalized abortion should lead to a reduction in the likelihood of giving birth. It also predicts that if abortion access becomes relatively inexpensive (including both monetary and psychic costs), then pregnancies would rise and births would remain unchanged or may even rise as well. We review the evidence on the impact of changes in abortion policy mainly from the United States and find support for both predictions. Then we test these hypotheses using recent changes in abortion policy in several Eastern European countries. We find that countries which changed from very restrictive to liberal abortion laws experienced a large reduction in births, highlighting the insurance value. Changes from modest restrictions to abortion available upon request, however, led to no such change in births despite large increases in abortions, indicating that pregnancies rose as well.
(Lin and Pantano 2015) [United States]	Quantify the impact of abortion legalization on the incidence of unintended births	National-level U.S. data	Regression analysis	Paper finds a strong decline in the prevalence of unintended births. Moreover, it finds that this decline is mainly driven by "pro-choice" women. It then proposes an empirical strategy to recover the effect of being "unintended" on life cycle outcomes. It uses the differential timing of abortion legalization across states interacted with the mother's religion (which facilitates or hinders legal abortion take up) to instrument for endogenous pregnancy intention. It finds that being unintended causes negative outcomes (higher crime, lower schooling, lower earnings) over the life cycle.
(Lince-Deroche, Harries et al. 2018) [South Africa]	To estimate the costs of public-sector abortion provision in South Africa and to explore the potential for expanding access at	Public-sector abortion provision in South Africa	A budget impact analysis using public sector abortion statistics	The total estimated costs over the projected 10-year period for abortion service provision in the public sector, assuming no changes to the current share or method mix, are estimated to be $163.6 million. Total costs are lower in scenarios with the method mix adjustments. When the proportion of procedures performed in the

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	reduced cost by changing the mix of technologies used		and published cost data	public sector is held constant at 20% of all abortions, shifting to a more cost-effective method mix could result in savings of $28.1 million in the health service over the 10-year period. Similarly, shifting to more cost-effective methods while increasing the share of abortions provided in the public sector to 80% of total abortions could result in savings of $91.2 million in the public health service over the 10-year period. Expanding service provision in the public sector, to potentially eliminate unsafe abortions, together with shifts to more cost-effective approaches, would require an additional $192.5 million over the next 10 years at base case costs and service volume estimates. Savings through technical efficiency gains represent an opportunity to improve service quality or expand abortion access or both. Expanding public-sector provision to 80% of all abortions would require an additional $192.5 million over the next 10 years, or $19.2 million per year, even with cost savings from shifting the method mix. However, this is a small portion of the overall public health budget, which was roughly $12 billion (140.9 billion Rands) in 2014/15.
(Lott and Whitley 2007) [United States]	The study aims to calculate the effect of abortion on crime and out-of-wedlock-births	National-level U.S. data	Regression analysis	Legalizing abortion can either increase or decrease investments in children's human capital. This article finds that abortion increases the number of out-of-wedlock births. Using data that more directly links the criminal with age when the crime was committed, not age when arrested, and fixing the assumption in previous research that no abortions took place prior to the Roe v. Wade decision in the 45 states affected by that decision, we find consistent significant evidence that legalizing abortions increased murders by over 7%. Linear estimates indicate that legalization increased total annual victimization costs by at least $3.2 billion.
(Malamud, Pop-Eleches et al. 2016) [Romania]	Asks if the benefit of access to better schools is larger for children who experienced better family environments because their parents had access to abortion	Romanian administrative data	Regression analysis	Although paper finds that access to abortion and access to better schools each have positive impacts, it does not find evidence of significant interactions between these shocks. While these results suggest the absence of dynamic complementarities in human capital formation, survey data suggest that they may also reflect behavioral responses by students and parents.
(Matthews, Ribar et al. 1997) [United States]	Investigate the determinants of annual abortion rates and birthrates	State-level data	Regression analysis	The incidence of abortion is found to be lower in states where access to providers is reduced and state policies are restrictive. Calculations indicate that decreased access may have accounted for about one-quarter of the 5% decline in abortion rates between 1988 and 1992. In addition, birth-rates are elevated where the costs of contraception

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				are higher because access to obstetrician-gynecologists and family planning services is reduced. Economic resources such as higher wages for men and women and generous welfare benefits are significantly and consistently related to increased birthrates; however, even a 10% cut in public assistance benefits would result in only one birth fewer for every 212 women on welfare. Economic factors showed no consistent relationship with abortion rates.
(Medoff 1999) [United States]	To estimate the demand for abortion by teenagers	Teenagers in the United States	Regression analysis	The empirical results found teenage abortion demand was inelastic with respect to price and a normal good with respect to income. Teenage abortion demand was also found to be positively related to state Medicaid funding and labor force participation. Parental involvement laws, welfare benefits, educational attainment, and state abortion attitudes are found to have no statistically significant impact on teenage abortion demand. Teenage abortion demand was found to be coincident with the business cycle.
(Medoff 2000) [United States]	Analyze the demand for abortion by black women	Black women in the United States	Regression analysis	The empirical results find that black abortion demand is price inelastic, negatively related to unemployment conditions, and positively related to the presence of state Medicaid and a college education. These results are consistent with the findings in prior studies of all childbearing women. The only two findings at odds with those of all childbearing women were that black women's abortion demands are considerably more responsive to changes in income and do not depend on marital status.
(Medoff 2007) [United States]	Estimates abortion demand using data about price and restrictive laws or policies	Women of reproductive age in the United States	Regression analysis	State Medicaid funding is found to increase the abortion demand of women of childbearing age; while the price of an abortion, parental involvement, parental consent, and parental notification laws all have a negative effect on the demand for abortions. State mandatory waiting periods have no statistically significant impact on abortion demand. The empirical results remain robust for the abortion demand of teen minors.
(Medoff 2008a) [United States]	Estimate the impact of various restrictive abortion laws on the demand for abortion	Women of reproductive age in the United States	Regression analysis	Women in the labor force or who have a higher income, have a statistically significantly greater demand for abortion. Educated women are associated with a decreased likelihood of having an unwanted pregnancy terminated, presumably due to their lower search costs of identifying and utilizing effective birth control methods. The Evangelical Christians variable has a significantly negative impact on the abortion ratio, but no statistically significant impact on the abortion rate. This result is consistent with previous research that finds that Evangelical religiosity has a strong influence on the decision not to terminate an unwanted pregnancy (in order to

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				avoid community disapproval and social ostracism), but a much smaller role in the decision to be sexually active.
(Medoff 2008b) [United States]	Examines if state restrictive abortion laws increase the price providers charge for supplying abortion services	State level data on number and prices of abortions	Regression analysis	The empirical results find that two types of state restrictive abortion laws—parental notification and mandatory counseling—have a spillover effect on abortion demand due to the increase in the price of an abortion that results from the higher costs imposed on abortion providers as a result of complying with each restrictive abortion law. State enforcement of a parental notification law and a mandatory counseling law causes an increase in the price charged by abortion providers by over 13% and 9%, respectively. Based on previous estimates of the price elasticity of abortion demand of between -.68 and -.99, this implies that the spillover effect of the enforcement of a parental notification law and a mandatory counseling law is to reduce the demand for abortions, through their increase in the price of an abortion, by between 9.4% and 13.6% for a parental notification law and between 6.5% and 9.4% for a mandatory counseling law.
(Medoff 2008) [United States]	To address whether the direct (price) and indirect (restriction abortion laws) costs of abortion affect the pregnancy rates	Cross-sectional state data pooled over 1982, 1992 and 2000	Cost analysis of abortions	A 10% increase in the real price of an abortion will cause a decrease in ten pregnancy rate by over 8%. An increase in the price of obtaining an abortion induces women to engage in ex ante pregnancy avoidance methods. A 10% increase in the real price of obtaining an abortion will cause a 6.5% decrease in the pregnancy rate of women of childbearing age.
(Meier and McFarlane 1994) [United States]	Examine whether state family planning expenditures and abortion funding for Medicaid-eligible women affect different kinds of births	State abortion rates	Regression analysis	For each additional abortion funded by a state, the number of abortions increases by 0.42. In states that funded abortions for one or more of the 7 years under analysis, there were an additional 563 900 abortions, 151 900 fewer births to teen mothers, 21 300 fewer low-birthweight babies, 23 900 fewer premature births, and 232 600 fewer births with late or no prenatal care. States that did not fund abortions had 503 800 fewer abortions, 136 500 more births to teen mothers, 18 500 more low-birthweight babies, 20 800 more premature births, and 201 900 more births with late or no prenatal care. The cumulative impact of funding or not funding abortions for Medicaid-eligible women over this time period, therefore, could be substantial.
(Myers 2017) [United States]	Provide new evidence on the relative "powers" of contraception and abortion policy in effecting the dramatic social	Women of reproductive age	Regression analysis	Trends in sexual behavior suggest that young women's increased access to the birth control pill fueled the sexual revolution, but neither these trends nor difference-in-difference estimates support the view that this also led to substantial changes in family formation. Rather, the estimates robustly suggest that it was liberalized access to

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	transformations of the 1960s and 1970s			abortion that allowed large numbers of women to delay marriage and motherhood. Relative to the adjusted predictions, these are very large effects: liberalized abortion policy predicts a 34 percent decline in motherhood, a 20 percent decline in marriage, and a 63 percent decline in shotgun marriages prior to age 19. As an additional means of gauging the magnitude of these estimates, I use the regression coefficients to predict outcomes for the 1940 and 1958 cohorts had abortion reforms and legalization not occurred. This exercise suggests that the liberalization of abortion policy explains about 80 percent of the decline in the probability of birth and 25 percent of the decline in the probability of marriage prior to age 19 observed between these birth cohorts.
(Oreffice 2007) [United States]	Estimates the impact of abortion legalization on spouses' labor supplies to test whether legalization increased women's household bargaining power	Married couples	Regression analysis	Abortion legalization significantly decreased the labor supply of married women in their fertile age by 83 annual hours and significantly increased their husbands' labor supply by 34 annual hours. In addition, the theory provides a number of other predictions. First, abortion legalization should have no effect on couples with strongly held religious beliefs against abortion. Second, abortion legalization should have little impact on couples who regularly use contraceptives. Third, to the extent that households from the upper part of the income distribution would have been able to obtain abortions more readily even when they were illegal, the effects of legalization should be less evident. The empirical evidence is consistent with these predictions.
(Parmar, Leone et al. 2017) [Zambia]	We estimated the costs of providing safe abortion and PAC services at the University Teaching Hospital, Lusaka and then projected these costs to generate indicative cost estimates for Zambia	University Teaching Hospital, Lusaka	We used multiple data sources: key informant interviews, medical records and hospital logbooks	It costs the Zambian public health system 2.5 times more to provide PAC for unsafe abortions than to provide safe abortion. If women requiring PAC following unsafe abortion instead had a safe abortion, we estimate that Zambia's public health system would incur a cost saving of approximately US$375,000 per year. We estimate that the projected costs for PAC for unsafe abortion in 2030 alone could be nearly US$11million if the number of abortions, contraceptive prevalence and health budget were to remain constant. The overall financial burden of PAC on the health expenditure budget could potentially increase to 0.9% (currently 0.2%). The annual cost of safe abortion ranges from US $221,000 to US$701,000; and for PAC after unsafe abortion, from US$403,000 to US$3.5 million. Overall, the annual cost savings lie between US$66,000 and US$1.2 million, with a base estimate of US$375,000.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Pop-Eleches 2006) [Romania]	Examines educational and labor outcomes of children affected by a ban on abortions	All children born between January and October 1967	Regression analysis	On average, children born after abortion became illegal display better educational and labor market achievements, and this outcome can be explained by a change in the composition of families having children: urban, educated women working in good jobs were more likely to have abortions prior to the policy change, so a higher proportion of children were born into urban, educated households. Moreover, the analysis shows that after I control for this type of compositional changes, the children born after the abortion ban had significantly worse schooling and labor market outcomes. I interpret this result as evidence of the existence of a negative unwantedness effect.
(Shah, Åhman et al. 2014) [Global]	To review the evidence on abortion laws and policies, and trends in the incidence of safe and unsafe abortion and in mortality due to unsafe abortion	Abortion seekers, countries with abortion policies	Review	Globally, the number of induced abortions (safe and unsafe) per 1000 women aged 15–44 years declined from 35 in 1995 to 28 in 2008. The number of deaths due to unsafe abortion declined from 69,000 in 1990 to 47,000 in 2008, as safe and effective methods of abortion, including manual vacuum aspiration and medical abortion, became more widely available. During the same period, there was a slight increase in the number of countries where abortion is permitted on request, and 70 countries made grounds for abortion more liberal. Since ICPD, the decline in unsafe abortion was slower than that in safe abortion, and unsafe-abortion-related mortality continued to be a problem. Nearly all unsafe abortions and mortality occur in developing countries.
(Tunc 2008) [United States]	Review the vacuum aspirator's history and why, in less than a decade, electric vacuum suction became American physicians' abortion technology of choice	Americans involved in the provision/ receipt of abortion	Historical review	The electric vacuum suction technique triumphed because it was politically and professionally feasible (Le., it was able to complement the decriminalization of abortion in the US, as well as the interests, abilities, commitments, and personal beliefs of physicians); clinically compatible (Le., it met physician/patient criteria such as safety, simplicity, and effectiveness); and economically viable (Le., able to adapt to market factors such as production, cost, supply/demand, availability, and distribution). The entry of the electrical vacuum aspiration machine into the medical mainstream was clearly facilitated by the fact that abortion was being decriminalized on a state-by-state basis just as physicians such as Margolis and Nathanson were discovering the apparatus.
(Vlassoff, Walker et al. 2009) [Global]	To estimate the health system costs of postabortion care in Africa and Latin America	Top down approach: PAC patients	Cost estimations	This study found that the health system costs of postabortion care in Africa and Latin America ranged from $159 million to $476 million per year, depending on the estimation method used. The average estimates from the two approaches largely coincide: $280 million using the top-down approach, and $274 million using the bottom-up approach (averaging actual and standard practice estimates). These

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				sums are considerable and impose an added burden on the already overstretched health resources of developing countries. A new United Nations estimate of maternal and newborn health expenditures places the cost of unsafe abortion in context: Obstetric complications cost health care systems in Africa and Latin America around $490 million annually.
(Whitaker 2011) [United States]	Examines whether the legalization of abortion changed high school graduation rates among the children selected into birth	High school graduation rates	Regression analysis	Unless women in all socio-economic circumstances sought abortions to the same extent, increased use of abortion must have changed the distribution of child development inputs. Higher abortion ratios are associated with higher graduation rates for black males, but not other demographic groups. Regression results indicate abortion ratios are linked with the fertility differences between ethnicities, which suggests this is a channel of influence. Overall, the relationship between abortion exposure and educational attainment is small. There is evidence for positive selection due to legalized abortion but among only one subpopulation, black males. The results seem to point to negative selection in aggregate. As with all social phenomena, abortion availability interacted with evolving economic, cultural, and legal institutions. It was certainly part of a bundle of changing sexual practices and attitudes toward family life. It appears that abortion was used disproportionately by black women in difficult circumstances, and therefore fewer of the women's potential sons became high school dropouts. However, more economically advantaged white women seem to have lowered their fertility even more, possibly in response to rising opportunity costs. This reduced the share of children raised with the child development inputs necessary to complete high school.
(Wu, Maru et al. 2017) [Nepal]	To review abortion care in Nepal 15 years after it was legalized	This review paper talks about abortion in relation to practitioners, women seeking abortions, national policies, etc.	Review	While the landmark 2009 Supreme Court decision established the legal framework for the government to mandate free and accessible abortion services in the public sector, there was no policy to implement safe abortion services until the passage of the Safe Abortion Service Guidelines of 2016. Under these guidelines, all government facilities should provide free abortion services. However, the provider reimbursement scheme outlined in the guidelines is less profitable for providers than it was when women paid out of pocket. It remains to be seen whether these new guidelines thus create monetary incentives that encourage providers to shift abortion provision from the public to the private sector, thereby adversely affecting access at public facilities. Despite the legal reforms, however, further improvement in protocols and infrastructure is necessary to ensure that all women truly have equal access to affordable services. Second-trimester services, for

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				example, remain extremely limited, with many women still lacking access.

Appendix U. Summary of studies reporting macro-economic value/benefit

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Aksoy 2007) [United Kingdom]	Discusses the rationale behind doing antenatal screening and the actual and potential problems that it may cause	General population	Review	The costs of providing amniocentesis for all expectant mothers over the age of 40 years, and maternal serum AFP screening for all pregnant women, would be more than offset by the economic benefits in terms of savings of expenditure on children and adults with down's Syndrome and spina bifida.
(Almond, Edlund et al. 2013) [Canada]	The study of South and East Asian immigrants in Canada, a rich OECD country, can potentially cast light on the role of culture in sex selection	Census data from Canada	Descriptive statistics	High and rising sex ratios lead one to ask what causes parents to prefer sons over daughters. One strand of argument emphasizes socioeconomic and institutional factors. Absent couples' ability to save or to rely on national pensions, the poor count heavily on children for old-age support, a task that under patriarchal norms falls on sons. In India, high and rising dowry payments are argued to place families with daughters at a disadvantage, and it has also been argued that families depend on males for physical protection. In both India and China, however, sex ratios are highest in the richest areas, and for India a strong education gradient is evident, with better-educated parents favoring sons more extensively. These observations cast doubt on sex selection being the result of economic necessity alone.
(Ananat, Gruber et al. 2009) [United States]	Provide a framework for understanding selection mechanisms and use that framework to address inconsistent past methodological approaches and provide evidence on the long-run impact on cohort characteristics	Individuals born in the United States and observed in the 2000 Census at ages 21 to 35 in that year (born between 1965 and 1979)	Regression analysis	The results on education are perhaps most striking, with a large negative effect on the percentage of the cohort that did not graduate from college (column 5), indicating that abortion legalization shifted the distribution of education upward. But these results provide no evidence of convergence; coefficients on repeal 1974–1975 and repeal 1976 1979 are generally of the same sign and larger than the coefficient on repeal 1971–1973. This lack of convergence supports the possibility that continued growth in both the pregnancy and abortion rates in early legalization states caused greater positive selection in the composition of births in those states, even after abortion was legalized nationally and birth rates converged.
(Benson, Okoh et al. 2012) [Nigeria]	To add more recent cost estimates of PAC in Nigeria to the existing body of literature	79 PAC providing public hospitals	Cost analysis	The World Bank calculates a per capita health expenditure cost of US $69, with more than one-third of total health expenditures borne by the public sector in Nigeria. Just 1 PAC case over the 3 states consumes an estimated US $79, which is illustrative of the stress that current practices place on public health system budgets and the hidden effect on competing obstetric and gynecologic needs that may go unmet.
(Benson, Gebreselassie et al. 2015) [Malawi]	This study estimates current health system costs of treating unsafe abortion complications and compares	Malawi health system costs	Estimation study based on survey and costing data	Treating 18,600 women for PAC in public health facilities annually represents a significant and preventable burden on the public health system. The median cost of treating one PAC case in public facilities, $40, is markedly higher than the 2011 per capita spending by the Malawi government on

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	these findings with newly-projected costs for providing safe abortion in Malawi			health, $23. A liberalized abortion law and access to safe abortion in public health facilities yielded a 20-30% decrease in current PAC costs. This drop would occur even though a high-quality first-trimester legal abortion with MVA (with appropriate use of supplies and pain management drugs) costs somewhat more than the current treatment of a simple PAC case.
(Bullard, Shaffer et al. 2018) [United States]	To estimate the effect of 20-week abortion bans on maternal and consequent neonatal health outcomes and costs in the setting of fetal congenital diaphragmatic hernia	Women in their mid-second trimester of pregnancy with a prenatal diagnosis of congenital diaphragmatic hernia	Cohort analytic	Whereas the model was conducted from a societal standpoint, the payers for much of these costs would be insurers and the most prominent payer would be Medicaid, because that is the largest single payer for neonatal and maternal care.
(Cheng, Zhou et al. 2012) [China]	To investigate providers' knowledge and attitudes about medical abortion	Abortion service providers	Survey with multistage stratified cluster sampling design	Even though SA is generally available in China under medically safe conditions, MA provides a low-cost, very low-risk alternative with other advantages that include avoidance of surgery and anesthesia.
(Comendant 2005) [Moldova]	Presents information on the current abortion law, policy and services in Moldova	National-level for Moldova	Mixed methods	Providers are pleased with the MVA services which, they say, are not only safe and effective but also save time and costs. Women who have MVA are also pleased: ongoing monitoring during 2003–04 at the MVA Centre found that more than 90% were very satisfied with their care and would recommend it to others needing an abortion.
(Elias, Lacetera et al. 2017) [Global]	Analysis of differences and changes in the regulation of taboo activities around the world, including abortion	100 countries between 1960 and 2015	Regression analysis	Our main finding of a positive association between income and liberal legislation for abortion and prostitution is consistent with the idea that cost-benefit considerations affect attitudes toward repugnant transactions. Economic development could affect the regulation of morally disputed transactions through three channels: direct effects on efficiency and repugnance; and an indirect effect through the change in the individuals' relative valuation of the two policy options (legalization versus prohibition) due for example to income effects.
(Erim, Resch et al. 2012) [Nigeria]	We synthesize the best available data, adapt a model of pregnancy and pregnancy-related morbidity and mortality to the Nigerian context, and conduct national and regional analyses that quantify the payoffs from investing in safe pregnancy and childbirth	National level estimates	Mixed methods	Paper provides robust insight into the importance of investing in all three domains of family planning, safe abortion and intrapartum care – any approach that focuses on only one of these, to the exclusion of the other, will be less effective and cost-effective.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Fletcher 2000) [Ireland]	Tease out what might be gained or lost from the categorisation of abortion as a service regulated by European Community law	Abortion law	Feminist legal analysis	This paper addresses the implications of categorising abortion as a supranational economic service for feminist legal strategy. The advantages of categorising abortion as a service to which women have access as consumers are that it legitimates abortion and it provides a new strategy for making abortion claims. The disadvantages are that a woman's legal interest in abortion is based on her capacity to buy the service, fetal life is rendered devoid of value, and the service supplier has as much say about the abortion transaction as the woman consumer. If feminist legal strategy is to successfully use the legal construction of abortion as an economic service, it must work to minimise such negative implications.
(Foster, Biggs et al. 2018a) [United States]	To examine the association of women receiving or being denied a wanted abortion with their children's health and well-being	Children and mothers	Regression analysis	Although our study improved on the previous literature by observing women seeking abortion, we may not have captured the full benefits for children of the mother receiving a wanted abortion. The study included data on index children for a mean of3.4 years and subsequent children for a mean of2.2 years; outcomes such as physical growth or school performance may not be apparent in that time frame. We were able to capture data only on subsequent children born within 5 years after the abortion. Children born beyond 5 years after the abortion may have outcomes that further diverge from those of index children, because the woman may have more time to establish the life circumstances in which she desires to parent, such as stable relationships, completed education, and/or secure financial footing. Being able to delay childbearing even for a few years and thus have a child at a time that the woman feels is better may result in closer relationships between mother and child and children raised in better economic circumstances.
(Foster, Biggs et al. 2018b) [United States]	To determine the socioeconomic consequences of receipt versus denial of abortion	Women seeking abortion services	Regression analysis	Differences over time in employment, poverty, and receipt of public assistance suggest that public assistance programs served an important role in mitigating the loss of full-time employment for women denied an abortion. However, public assistance was not sufficient to support the increase in household size resulting from a new baby, and did not keep households of women denied an abortion from living in poverty. Differences in economic outcomes gradually converged over the 5 years. At the time of seeking an abortion, more than a quarter of all women in the study were living in a household as the only adult with children, and this increased significantly for women who were denied an abortion, indicating that the burden of raising a child often falls to women alone rather than to couples or an extended family.
(Gruber, Levine et al. 1997) [United States]	Examine the impact of increased abortion availability on the average living	National sample of children born immediately after	Regression analysis	We find evidence of sizable positive selection: the average living circumstances of cohorts of children born immediately after abortion became legalized improved substantially relative to preceding cohorts, and relative to places where the legal status of abortion was not changing. Our results

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
	standards of children through a selection effect	abortion was legalized		suggest that the marginal children who were not born as a result of abortion legalization would have systematically been born into less favorable circumstances if the pregnancies had not been terminated: they would have been 60 percent more likely to live in a single-parent household, 50 percent more likely to live in poverty, 45 percent more likely to be in a household collecting welfare, and 40 percent more likely to die during the first year of life.
(Hammel and Galloway 2000) [Europe]	To examine short-term responses to scarcity in the context of medium and long-term historical change	Parish residents in the Northwest Balkans in 18th and 19th Centuries	Mixed methods	Fertility responses in the year of a price shock come to dominate those in the year following, suggesting a shift from contraception to abortion as economic and social conditions apparently worsened and strategies of control intensified. Analysis of monthly responses supports the conjecture based on the annual responses. The shift to the preventive check and strength of the preventive check in the same year as the price shock is unusual in Europe and beyond.
(Haas-Wilson 1996) [United States]	Estimate the impact of enforced abortion restrictions on minors' demand for abortion services between 1978-1990	Minors who sought an abortion	Regression analysis	Abortions appear to be a normal good. A 1 percent increase in per capita income results in a 1.35 to 2.07 percent increase in minors' demand for abortions. Labor force participation is associated with higher abortion rates. A 1 percent increase in the labor force participation rate of women results in a 0.56 to 1.35 percent increase in minors' demand for abortions. Education is associated with lower abortion rates. A 1 percent increase in the percentage of women who are high school graduates results in a 0.48 to 1.19 percent decrease in minors' demand for abortion.
(Hu, Bertozzi et al. 2007) [Mexico]	To conduct a cost effectiveness analysis of alternative strategies to reduce maternal mortality and morbidity in Mexico	A computer-based model that simulates the natural history of pregnancy and pregnancy-related complications in a cohort of 15-year-old women followed over their lifetime	An empirically calibrated model that simulates the natural history of pregnancy and pregnancy-related complications	A combined approach that improves access to safe abortion and increases effective coverage for family planning is synergistic in reducing unwanted pregnancies, reducing maternal morbidity and mortality, and increasing health returns for investments using public health dollars. The cost savings from providing these two interventions together, over the long-term, exceeds $11 million per 100,000 women of reproductive age followed over their lifetime. Using current census data from Mexico, our most effective strategy that included enhanced family planning and safe abortion as two of its three main components, would save approximately $116 million on average, over the lifetime of a single birth cohort. The savings in high-marginality states ($49,572,000) would be greater than those with medium marginality ($39,579,000) or lower marginality ($26,530,000).
(Hu, Grossman et al. 2010) [Sub-Saharan Africa]	To explore the policy implications of increasing access to safe abortion in Nigeria and Ghana	Women seeking abortion	Decision analytic model	Transitioning from unsafe to safe abortion, regard- less of modality, is the most influential factor on saving both lives and societal costs. For example, provision of safe abortion for 60% of women that would otherwise get an unsafe abortion has a large impact on years of life saved (~11,000 years life saved per 100,000 procedures in Nigeria and ~ 17,500 years life saved per 100,000 procedures in Ghana). Furthermore, if access to medical abortion

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				provides a feasible and acceptable option, such that all women are assured access to safe abortion, years of life gained per 100,000 procedures are more than 18,300 and 29,000 in Nigeria and Ghana, respectively, compared with unsafe abortion. In contrast, a transition in practice pattern from one where 50% of women that would other- wise receive D&C to clinic-based MVA, with- out changing the percentage that pursue un- safe abortion, provides very small incremental health benefits (~3 years life saved per 100,000 procedures) although does save substantial costs. Results underscore the importance of enhancing access to safe abortion in Nigeria, Ghana, and similar countries in sub-Saharan Africa.
(Jarlenski, Hutcheon et al. 2017) [United States]	To estimate association between state Medicaid coverage of medically necessary abortion and severe maternal morbidity and in-hospital maternal mortality	Pregnancy-related hospitalizations	Regression analysis	Across both Medicaid and private paid hospitalizations, state Medicaid coverage of medically necessary abortion was associated with an adjusted average of 9.5 per 10,000 fewer cases of severe maternal morbidity, which translates to an average 16% risk reduction. Among women with Medicaid, the unadjusted rate of in-hospital mortality was 9.1 per 100,000 pregnancy-related hospitalizations, which did not differ significantly by state Medicaid abortion coverage status. The average predicted risk of in-hospital maternal mortality was not different among Medicaid-paid hospitalizations in states with or without Medicaid coverage of medically necessary abortion. Likewise, there was no significant difference in in-hospital mortality among private insurance-paid hospitalizations in states with or without Medicaid coverage of medically necessary abortion.
(Kelly and Grant 2007) [United States]	Using state-level data, this study analyzes the effects of state policies enacted in the wake of welfare reform on reproductive health	State level abortion rates and birth rates	Regression analysis	The authors find that economic-based incentives have only minor, and inconsistent, influence on statewide rates of abortion and nonmarital births in 2000. Results are consistent with feminist scholarship proposing that noneconomic considerations are more central in women's decision making about reproduction than economic factors.
(Meier and McFarlane 1994) [United States]	Examine whether state family planning expenditures and abortion funding for Medicaid-eligible women affect different kinds of births	State abortion rates	Regression analysis	All other things being equal, an increase of one funded abortion per 1000 women of childbearing age is associated with 0.673 fewer teen births per 1000 teenage women, 0.024 percentage points fewer low-birthweight babies, 0.027 percentage points fewer premature births, and 0.263 percentage points fewer births with late or no prenatal care. Two comments about the size of these coefficients are in order. First, funded abortions are associated with a major drop in births to teen mothers--perhaps as many as 0.67 teen births for every abortion funded. Second, many other impacts of abortion funding or family planning appear modest; however, even small changes in these variables can have a major impact.
(Rodriguez, Mendoza et al.	To compare the costs to the health system of three	Three sites in Colombia that were high-volume	Cost analysis	Sensitivity analysis demonstrated that legal abortion would need to cost more than $734 per case for PAC to be a cost-saving strategy. If we assume a 9% spontaneous abortion rate (based on population level estimates), and if

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
2015) [Colombia]	approaches to the provision of abortion care in Colombia	institutions that offer legal abortions and PAC		the remainder of PAC cases currently observed were replaced with legal abortion (medical or MVA), the health system would save an additional $163,000 dollars and prevent 16 complications per 1,000 abortions. We also evaluated how changing hospital practice to eliminate sharp curettage would affect health outcomes and costs. We ran the model replacing D&C with either medical abortion or MVA, and estimated outcomes for a population of 1,000 women. The health system could save an additional $177,000 (per 1,000 women) from baseline, by replacing D&C with MVA.
(Sethe and Murdoch 2013) [United Kingdom]	We consider two clinical procedures, abortion and IVF treatment, which have similar ethical and political sensitivities	Anyone considering abortion or IVF	Literature review	In the UK, the provision of the NHS treatment can be a proxy for social acceptance: Abortion is free on the NHS but women may decide to pay privately to avoid GP referral or waiting times. NHS abortion provision ranges from more than 90% to less than 60% of local demand. From 2002 to 2009, the number NHS funded abortions increased from 78 to 94%.
(Sutton 2017) [Argentina]	Explore how several clandestine zones build women's bodies in vital ways to the sovereign power of the State, both in dictatorship and in democracy	Women in Argentina	Meta-analysis	In the case of women who have clandestine induced abortions, women affirm their rights as human beings, but at the cost of their exclusion from the political body. Instead of being able to exercise their rights in the protection of the law, in the field of law and on the margins of institutions. The criminalization of abortion creates a contradiction for the state: on the one hand, the state has an interest in the bodies of individual women in a punitive sense, but on the other hand, it also has a biopolitical interest in a healthy population.
(Thomas 2007) [India]	Sets out a conceptual framework to clarify the process by which the demand and supply continuum that underpins the market for reproductive services is sustained by repeated and frequent abortions	Supply and demand for sex-selective abortions	Literature review	By 2005, ultrasound scanning for sex determination had become a Rs.5 billion industry. The upward trend in sex-selective abortions and the flourishing abortion business are linked. The regulatory framework established by the MTP underpins this linkage. The evidence that the sex-selective abortion business is flourishing even after the practice has been criminalised indicates two things: there is a demand for sex-selective abortions and the medical practitioners and abortion seekers are strategically avoiding the law to meet this demand. If the latter does not, then the PCPNDT will criminalize both her and her family. This mutual, strategic, avoidance is not only necessary to sustain the proliferating business of sex-selective abortions but it reveals a fissure between legal ordering or the formal law (which by all accounts has failed) and the underground system of private orderings (in which the sex-selective abortion business flourishes).
(Tunc 2008) [United States]	Review the vacuum aspirator's history and why, in less than a decade, electric vacuum suction became American physicians' abortion technology of choice	Americans involved in the provision/ receipt of abortion	Historical review	Legalized pregnancy termination inspired many physicians to try new abortion technologies, such as the Karman cannula, which won converts to electrical vacuum aspiration by making it a great deal cheaper and safer. Thus, this critical juncture not only facilitated the diffusion of electrical vacuum suction, but also reinforced the authority of specialized professionals as the sole purveyors of pregnancy termination, and its techniques.

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings

Appendix V. Summary of studies reporting abortion-related stigma and macro-economic cost

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Aiken, Johnson et al. 2018) [Ireland]	(1) to examine the factors affecting whether women in Ireland choose to access abortion by travelling or by using online telemedicine; and (2) to explore their experiences in accessing care through each pathway	Women (n=38) identified through three organisations: Women on Web, Abortion Support Network, For Reproductive Rights Against Oppression, Sexism and Austerity. Criteria: aged over 18, had an abortion within 8 years of study, lived in Ireland at time of abortion, had travelled or used telemedicine to access abortion care.	Qualitative in-depth interviews	This study found that the restricted legal environment as well as the concern of judgement in communities led people in Ireland to travel for their abortions.
(Chełstowska 2011) [Poland]	To describe the economic consequences of the stigmatisation and illegality of abortion and its almost complete removal from public health services in Poland since the late 1980s.	Polish women	Review	The situation in Poland seems to be similar in Ireland, where regulations regarding abortion are even more restrictive, and the monopolisation of abortion services by the private sector causes social inequality because commercialised abortion services are not affordable for everyone. However, this can be bypassed if one has the means to travel abroad. Women from the middle class, who are more likely to have an influence on the political situation, find these conditions bearable, while women from the working class lack the political capital to protest against the discrimination against them. The effort to change the law cannot succeed unless women from all social classes show solidarity."
(Gerber Fried 1997) [United States]	This paper gives a picture of the status of legal abortion from the vantage point of those women who bear the brunt of restricted access	Low-income women, women of colour (who comprise a disproportionate number of the poor), and young women	Review	Restricting access for young women and denying public funding for abortions are strategic ways to isolate and stigmatize the doctors who perform abortions, the hospitals and clinics where abortions are provided, abortion itself and ultimately, the women who have abortions. Adherents to the anti-abortion movement's agenda have made moral

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
				disapproval a key strategy in their efforts to restrict and re-criminalise abortion and have successfully used it as a vehicle for shaping Public opinion. For example, in the area of public funding, they have made appeals such as: 'Abortion may be legal, but why should we be forced to pay for something that is morally repugnant (to us)?'. The same contempt for women, especially those who have the fewest resources, pervades other aspects of the conservative political agenda, which calls for the restoration of the stigma of illegitimacy and a renewed emphasis on the connection between illegitimacy, poverty and social decay.
(Gober 1997) [United States]	Investigate the role of access in explaining the variation in state abortion rates	U.S. state policies and abortion rates	Regression analysis	The decision to terminate a pregnancy has been transformed from a private matter between a woman and her doctor into a more public decision, subject to public opinion, local discretion over the prosecution of antiabortion violence, local influence over hospital management, and public laws regulating abortion. These public realms vary from place to place. They define how easy, expensive, safe, and socially acceptable it is to obtain an abortion. They determine whether a young woman can obtain an abortion in a nearby facility, free of charge, and free from intimidation or whether she is required to obtain permission from a parent, travel hundreds of miles to the nearest clinic, wait 24 hr alter signing an informed consent form, pay $300, and then face demonstrators as she enters the abortion facility.

Appendix W. Summary of studies reporting abortion-related stigma and macro-economic impact

Author, year [country]	Aim/objective(s)	Population	Study type	Summary of main findings
(Chełstowska 2011) [Poland]	To describe the economic consequences of the stigmatisation and illegality of abortion and its almost complete removal from public health services in Poland since the late 1980s.	Polish women	Review	Stigmatisation of pregnancy termination enforces and obscures, at the same time, the commercialisation and privatisation of abortion in the postsocialist Polish state. The 1993 abortion law was only a part of that process, and a wider policy of limiting access to legal abortion to the minimum. Stigmatisation of abortion was the primary reason why it disappeared from public health services and for the emergence of a market for private abortion services. It is the interpretation and the political intent that pushed legal abortions out of public hospitals and more widely, the public sphere. The monopolisation of abortion services by the private sector causes social inequality because commercialised abortion services are not affordable for everyone. But because stigmatisation of abortion dominates the public discourse, the economic aspects are rarely discussed. Thus, the combined forces of right-wing Catholic ideology and neoliberal economic reforms have resulted in reproductive and social injustice.
(Crane and Dusenberry 2004) [Global]	To examine the effect of the Global Gag Rule on family planning organizations in countries receiving American assistance	Family planning organizations within multiple countries	Literature review	The result of this Global Gag Rule has been to institutionalise the stigmatisation of abortion in US foreign assistance for the last three decades.
(Felkey and Lybecker 2014) [United States]	The analysis seeks to measure whether young women really are less careful in using contraception if abortions are less costly, both in the context of financial and opportunity costs, and explore the impact of direct and indirect abortion restrictions,	Data on women under the age of 25 seeking abortions.	Regression analysis	The variable controlling for a state's pro-life sentiment was always negative and was significant for the youngest women in 2002 and both age groups in 1989. This indicates that states presenting an overall pro-life sentiment inhibit the use of oral contraceptives. In essence, the political climate and social stigma may make it harder for a woman to make the choice to use oral contraceptives. While not a cost in terms of money or time, social stigma increases the cost of oral contraceptives. A reduction of this and other costs may increase the use of oral contraception and reduce unwanted pregnancies.

References

"Fourteenth Amendment" (2016). "Fourteenth Amendment - Due Process Clause - Undue Burden - Whole Woman's Health v. Hellerstedt." Harvard Law Review **130**(1): 397.

Aantjes, C. J., A. Gilmoor, E. V. Syurina and T. L. Crankshaw (2018). "The status of provision of post abortion care services for women and girls in Eastern and Southern Africa: a systematic review." Contraception **98**(2): 77-88.

Acosta de Hart, H., C. Umaña and C. Villarreal (2002). "Oriéntame: Preventing and Solving Problems Related to Unwanted Pregnancy for 25 Years in Colombia." Reproductive Health Matters **10**(19): 138-142.

Adamczyk, A. and M. Valdimarsdóttir (2018). "Understanding Americans' abortion attitudes: The role of the local religious context." Social Science Research **71**: 129-144.

Afable-Munsuz, A., H. Gould, F. Stewart, K. A. Phillips, S. L. Van Bebber and C. Moore (2007). "Provider practice models for and costs of delivering medication abortion — evidence from 11 US abortion care settings." Contraception **75**(1): 45-51.

Agadjanian, V. (2002). "Is "Abortion Culture" Fading in the Former Soviet Union? Views about Abortion and Contraception in Kazakhstan." Studies in Family Planning **33**(3): 237-248.

Ahmed, S., A. Islam, P. A. Khanum and K. Barkat e (1999). "Induced abortion: What's happening in rural Bangladesh." Reproductive Health Matters **7**(14): 19-29.

Aiken, A., R. Gomperts and J. Trussell (2017). "Experiences and characteristics of women seeking and completing at-home medical termination of pregnancy through online telemedicine in Ireland and Northern Ireland: a population-based analysis." Bjog **124**(8): 1208-1215.

Aiken, A. R. A., K. A. Guthrie, M. Schellekens, J. Trussell and R. Gomperts (2018). "Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain." Contraception **97**(2): 177-183.

Aiken, A. R. A., D. M. Johnson, K. Broussard and E. Padron (2018). "Experiences of women in Ireland who accessed abortion by travelling abroad or by using abortion medication at home: a qualitative study." BMJ Sex Reprod Health.

Aiken, A. R. A., D. M. Johnson, K. Broussard and E. Padron (2018). "Experiences of women in Ireland who accessed abortion by travelling abroad or by using abortion medication at home: a qualitative study." BMJ Sexual & Reproductive Health **44**(3): 181.

Akin, A., G. O. Kocoglu and L. Akin (2005). "Study Supports the Introduction of Early Medical Abortion in Turkey." Reproductive Health Matters **13**(26): 101-109.

Aksoy, S. (2007). "Antenatal screening and its possible meaning from an unborn baby's perspective." Neonatal Intensive Care **20**(6): 35-42.

Almond, D., L. Edlund and K. Milligan (2013). "Son Preference and the Persistence of Culture: Evidence from South and East Asian Immigrants to Canada." Population and Development Review **39**(1): 75-95.

Alouini, S., M. Uzan, J. P. Meningaud and C. Herve (2002). "Knowledge about contraception in women undergoing repeat voluntary abortions, and means of prevention." Eur J Obstet Gynecol Reprod Biol **104**(1): 43-48.

Alouini, S., M. Uzan, J. P. Méningaud and C. Hervé (2002). "Knowledge about contraception in women undergoing repeat voluntary abortions, and means of prevention." European Journal of Obstetrics & Gynecology and Reproductive Biology **104**(1): 43-48.

Altshuler, A. L., A. Ojanen-Goldsmith, P. D. Blumenthal and L. R. Freedman (2017). "A good abortion experience: A qualitative exploration of women's needs and preferences in clinical care." Social Science & Medicine **191**: 109-116.

Ananat, E. O., J. Gruber, P. B. Levine and D. Staiger (2009). "Abortion and selection." The Review of Economics and Statistics **91**(1): 124-136.

Ananat, E. O., J. Gruber, P. B. Levine and D. Staiger (2009). "Abortion and Selection." Review of Economics and Statistics **91**(1): 124-136.

Ananat, E. O. and D. M. Hungerman (2012). "THE POWER OF THE PILL FOR THE NEXT GENERATION: ORAL CONTRACEPTION'S EFFECTS ON FERTILITY, ABORTION, AND MATERNAL AND CHILD CHARACTERISTICS." The Review of Economics and Statistics **94**(1): 37-51.

Anandhi, S. (2007). "Women, Work and Abortion: A Case Study from Tamil Nadu." Economic and Political Weekly **42**(12): 1054-1059.

Angrist, J. D. and W. N. Evans (2000). Schooling and labor market consequences of the 1970 state abortion reforms. Research in Labor Economics, Emerald Group Publishing Limited. **18:** 75-113.

Aniteye, P. and S. Mayhew (2011). "Attitudes and Experiences of Women Admitted to Hospital with Abortion Complications in Ghana." African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive **15**(1): 47-55.

Anjum, Z. K. (2000). "Termination of early pregnancy with a reduced oral dose of mifepristone and vaginal misoprostol." S Afr Med J **90**(9): 889-891.

Appiah-Agyekum, N. N. (2018). "Medical abortions among university students in Ghana: implications for reproductive health education and management." International Journal of Womens Health **10**: 515-522.

Appiah-Agyekum, N. N., C. Sorkpor and S. Ofori-Mensah (2015). "Determinants of abortion decisions among Ghanaian university students." Int J Adolesc Med Health **27**(1): 79-84.

Asplin, N., H. Wessel, L. Marions and S. Georgsson Öhman (2014). "Pregnancy termination due to fetal anomaly: Women's reactions, satisfaction and experiences of care." Midwifery **30**(6): 620-627.

Austin, N. and S. Harper (2018). "Assessing the impact of TRAP laws on abortion and women's health in the USA: a systematic review." BMJ Sex Reprod Health **44**(2): 128-134.

Averett, S. L., D. I. Rees and L. M. Argys (2002). "The impact of government policies and neighborhood characteristics on teenage sexual activity and contraceptive use." American Journal of Public Health **92**(11): 1773-1778.

Ayanore, M. A., M. Pavlova, R. Biesma and W. Groot (2017). "Stakeholder's experiences, expectations and decision making on reproductive care: An ethnographic study of three districts in northern Ghana." PLoS One **12**(11): e0186908.

Azarnert, L. V. (2009). "ABORTION AND HUMAN CAPITAL ACCUMULATION: A CONTRIBUTION TO THE UNDERSTANDING OF THE GENDER GAP IN EDUCATION." Scottish Journal of Political Economy **56**(5): 559-579.

Azize-Vargas, Y. and L. A. Avilés (1997). "Abortion in Puerto Rico: The limits of colonial legality." Reproductive Health Matters **5**(9): 56-65.

Babigumira, J. B., A. Stergachis, D. L. Veenstra, J. S. Gardner, J. Ngonzi, P. Mukasa-Kivunike and L. P. Garrison (2011). "Estimating the costs of induced abortion in Uganda: a model-based analysis." BMC Public Health **11**(1): 904-904.

Bailey, M. J. and J. M. Lindo (2017). Access and Use of Contraception and Its Effects on Women's Outcomes in the U.S, National Bureau of Economic Research, Inc, NBER Working Papers: 23465.

Bailey, P. E., Z. V. Bruno, M. F. Bezerra, I. Queiróz, C. M. Oliveira and M. Chen-Mok (2001). "Adolescent pregnancy 1 year later: the effects of abortion vs. motherhood in Northeast Brazil." Journal of Adolescent Health **29**(3): 223-232.

Baird, B. (2015). "Medical abortion in Australia: a short history." Reproductive Health Matters **23**(46): 169-176.

Baird, B. (2017). "Decriminalization and Women's Access to Abortion in Australia." Health & Human Rights: An International Journal **19**(1): 197-208.

Banerjee, S. K. and K. Andersen (2012). "Exploring the pathways of unsafe abortion in Madhya Pradesh, India." Global Public Health **7**(8): 882-896.

Banerjee, S. K., K. L. Andersen and J. Warvadekar (2012). "Pathways and consequences of unsafe abortion: a comparison among women with complications after induced and spontaneous abortions in Madhya Pradesh, India." International Journal of Gynecology & Obstetrics **118**: S113-120.

Banerjee, S. K., K. L. Andersen, J. Warvadekar, P. Aich, A. Rawat and B. Upadhyay (2015). "How prepared are young, rural women in India to address their sexual and reproductive health needs? a cross-sectional assessment of youth in Jharkhand." Reproductive Health **12**: 1-10.

Banerjee, S. K., R. Kumar, J. Warvadekar, V. Manning and K. L. Andersen (2017). "An exploration of the socio-economic profile of women and costs of receiving abortion services at public health facilities of Madhya Pradesh, India." BMC Health Serv Res **17**(1): 223.

Bankole, A., S. Singh, M. Vlassoff and V. Woog (2007). Estimating the cost of post-abortion care in Nigeria: a case study. Fertility Regulation Behaviors and Their Costs: Contraception and Unintended Pregnancies in Africa and Eastern Europe & Central Asia, . Washington, DC, World Bank**:** 65-92.

Barot, S. (2017). "The benefits of investing in international family planning and the price of slashing funding." Guttmacher Policy Review **20**: 1-4.

Barot, S. (2017). "When antiabortion ideology turns into foreign policy: how the Global Gage Rule erodes health, ethics and democracy." Guttmacher Policy Review **20**: 73-77.

Barua, A. and H. Apte (2007). "Quality of Abortion Care: Perspectives of Clients and Providers in Jharkhand." Economic and Political Weekly **42**(48): 71-80.

Battistelli, M. F., S. Magnusson, M. A. Biggs and L. Freedman (2018). "Expanding the Abortion Provider Workforce: A Qualitative Study of Organizations Implementing a New California Policy." Perspectives on Sexual & Reproductive Health **50**(1): 33-39.

Baum, S. E., K. White, K. Hopkins, J. E. Potter and D. Grossman (2016). "Women's Experience Obtaining Abortion Care in Texas after Implementation of Restrictive Abortion Laws: A Qualitative Study." PLoS One **11**(10): e0165048.

Baxerres, C., I. Boko, A. Konkobo, F. Ouattara and A. Guillaume (2018). "Abortion in two francophone African countries: a study of whether women have begun to use misoprostol in Benin and Burkina Faso." Contraception **97**(2): 130-136.

Bélanger, D. and A. Flynn (2009). "The Persistence of Induced Abortion in Cuba: Exploring the Notion of an "Abortion Culture"." Studies in Family Planning **40**(1): 13-26.

Belton, S. and A. Whittaker (2007). "Kathy Pan, sticks and pummelling: Techniques used to induce abortion by Burmese women on the Thai border." Social Science & Medicine **65**(7): 1512-1523.

Bendavid, E., P. Avila and G. Miller (2011). "United States aid policy and induced abortion in sub-Saharan Africa." Bulletin of the World Health Organization **89**(12): 873-880C.

Bennett, L. R. (2001). "Single women's experiences of premarital pregnancy and induced abortion in Lombok, Eastern Indonesia." Reproductive Health Matters **9**(17): 37-43.

Benson, J., H. Gebreselassie, M. A. Manibo, K. Raisanen, H. B. Johnston, C. Mhango and B. A. Levandowski (2015). "Costs of postabortion care in public sector health facilities in Malawi: a cross-sectional survey." BMC Health Serv Res **15**: 562.

Benson, J., L. A. Nicholson, L. Gaffikin and S. N. Kinoti (1996). "Complications of unsafe abortion in sub-Saharan Africa: a review." Health Policy Plan **11**(2): 117-131.

Benson, J., M. Okoh, K. KrennHrubec, M. A. Lazzarino and H. B. Johnston (2012). "Public hospital costs of treatment of abortion complications in Nigeria." Int J Gynaecol Obstet **118 Suppl 2**: S134-140.

Berer, M. (2000). "Making abortions safe: a matter of good public health policy and practice." Bull World Health Organ **78**(5): 580-592.

Berer, M. (2005). "Medical abortion: issues of choice and acceptability." Reproductive Health Matters **13**(26): 25-34.

Berer, M. (2020). "Reconceptualizing safe abortion and abortion services in the age of abortion pills: A discussion paper." Best Practice & Research Clinical Obstetrics & Gynaecology **63**: 45-55.

Bessett, D., K. Gorski, D. Jinadasa, M. Ostrow and M. J. Peterson (2011). "Out of Time and Out of Pocket: Experiences of Women Seeking State-Subsidized Insurance for Abortion Care in Massachusetts." Women's Health Issues **21**(3, Supplement): S21-S25.

Betala Belinga, J. F., A. Valence, A. Zaccabri and J. Fresson (2010). "[Voluntary abortion cost in France and prospective payment system: to raise the issue of so many misstatements]." J Gynecol Obstet Biol Reprod (Paris) **39**(7): 549-553.

Biggs, M. A., L. Ralph, S. Raifman, D. G. Foster and D. Grossman (2018). "Support for and interest in alternative models of medication abortion provision among a national probability sample of U.S. women." Contraception.

Billings, D. L. and J. Benson (2005). "Postabortion care in Latin America: policy and service recommendations from a decade of operations research." Health Policy Plan **20**(3): 158-166.

Blanchard, K., J. L. Meadows, H. R. Gutierrez, C. P. S. Hannum, E. F. Douglas-Durham and A. J. Dennis (2017). "Mixed-methods investigation of women's experiences with second-trimester abortion care in the Midwest and Northeast United States." Contraception **96**(6): 401-410.

Blank, R. M., C. C. George and R. A. London (1996). "State Abortion Rates: The Impact of Policies, Providers, Politics, Demographics, and Economic Environment." Journal of Health Economics **15**(5): 513-553.

Bloom, D. E., D. Canning, G. Fink and J. E. Finlay (2009). "Fertility, Female Labor Force Participation, and the Demographic Dividend." Journal of Economic Growth **14**(2): 79-101.

Bloomer, F. and K. O'Dowd (2014). "Restricted access to abortion in the Republic of Ireland and Northern Ireland: exploring abortion tourism and barriers to legal reform." Culture, Health & Sexuality **16**(4): 366-380.

Bowmaker, S. W. and P. M. Emerson (2013). "Still Waiting for Mister Right? Asymmetric Information, Abortion Laws and the Timing of Marriage." Applied Economics **45**(22-24): 3151-3169.

Brack, C. E., R. W. Rochat and O. A. Bernal (2017). "It's a Race Against the Clock: A Qualitative Analysis of Barriers to Legal Abortion in Bogot, Colombia." International Perspectives on Sexual and Reproductive Health **43**(4): 173-182.

Broen, A. N., T. Moum, A. S. Bodtker and O. Ekeberg (2005). "Reasons for induced abortion and their relation to women's emotional distress: a prospective, two-year follow-up study." Gen Hosp Psychiatry **27**(1): 36-43.

Brown, R. W. and R. T. Jewell (1996). "The Impact of Provider Availability on Abortion Demand." Contemporary Economic Policy **14**(2): 95-106.

Bullard, K. A., B. L. Shaffer, K. S. Greiner, A. E. Skeith, M. I. Rodriguez and A. B. Caughey (2018). "Twenty-Week Abortion Bans on Pregnancies With a Congenital Diaphragmatic Hernia: A Cost-Effectiveness Analysis." Obstetrics & Gynecology **131**(3): 581-590.

Buonanno, P., F. Drago, R. Galbiati and G. Zanella (2011). "Crime in Europe and the United States: Dissecting the 'Reversal of Misfortunes'." Economic Policy(67): 347.

Calkin, S. (2019). "Towards a political geography of abortion." Political Geography **69**: 22-29.

Campbell, M., N. N. Sahin-Hodoglugil and M. Potts (2006). "Barriers to Fertility Regulation: A Review of the Literature." Studies in Family Planning **37**(2): 87-98.

Cano, J. K. and A. M. Foster (2016). ""They made me go through like weeks of appointments and everything": Documenting women's experiences seeking abortion care in Yukon territory, Canada." Contraception **94**(5): 489-495.

Casas-Becerra, L. (1997). "Women prosecuted and imprisoned for abortion in Chile." Reproductive Health Matters **5**(9): 29-36.

Casas, L. and L. Vivaldi (2014). "Abortion in Chile: the practice under a restrictive regime." Reproductive Health Matters **22**(44): 70-81.

Chae, S., S. Desai, M. Crowell and G. Sedgh (2017). "Reasons why women have induced abortions: a synthesis of findings from 14 countries." Contraception **96**(4): 233-241.

Chełstowska, A. (2011). "Stigmatisation and commercialisation of abortion services in Poland: turning sin into gold." Reproductive Health Matters **19**(37): 98-106.

Cheng, Y., Y. Zhou, Y. Zhang, X. Jiang, M. Xi, K. Gan and S. Ren (2012). "Study of knowledge and attitudes on medical abortion among Chinese health providers." International Journal of Gynecology & Obstetrics **118**: S28-S32.

Chevrette, M. and H. A. Abenhaim (2015). "Do State-Based Policies Have an Impact on Teen Birth Rates and Teen Abortion Rates in the United States?" Journal of Pediatric and Adolescent Gynecology **28**(5): 354-361.

Chibber, K. S., M. A. Biggs, S. C. M. Roberts and D. G. Foster (2014). "The Role of Intimate Partners in Women's Reasons for Seeking Abortion." Women's Health Issues **24**(1): e131-e138.

Choobun, T., S. Khanuengkitkong and S. Pinjaroen (2012). "A comparative study of cost of care and duration of management for first-trimester abortion with manual vacuum aspiration (MVA) and sharp curettage." Archives of Gynecology & Obstetrics **286**(5): 1161-1164.

Chor, J., S. Garcia-Ricketts, D. Young, L. E. Hebert, L. A. Hasselbacher and M. L. Gilliam (2018). "Well-woman Care Barriers and Facilitators of Low-income Women Obtaining Induced Abortion after the Affordable Care Act." Women's Health Issues **28**(5): 387-392.

Chunuan, S., S. Kosunvanna, W. Sripotchanart, J. Lawantra, J. Lawantrakul, U. Pattrapakdikul and J. Somporn (2012). "Characteristics of Abortions in Southern Thailand." Pacific Rim International Journal of Nursing Research **16**(2): 97-112.

Coast, E. and S. Murray (2016). ""These things are dangerous": Understanding induced abortion trajectories in urban Zambia." Social Science & Medicine **153**: 201-209.

Coast, E. and S. F. Murray (2016). "“These things are dangerous”: Understanding induced abortion trajectories in urban Zambia." Social Science & Medicine **153**: 201-209.

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

Cockrill, K. and T. A. Weitz (2010). "Abortion patients' perceptions of abortion regulation." Womens Health Issues **20**(1): 12-19.

Coêlho, H. L. L., A. C. Teixeira, A. P. Santos, E. B. Forte, S. M. Morais, C. LaVecchia, G. Tognoni and A. Herxheimer (1993). "Misoprostol and illegal abortion in Fortaleza, Brazil." The Lancet **341**(8855): 1261-1263.

Cohen, J., O. Ortiz, S. E. Llaguno, L. Goodyear, D. Billings and I. Martinez (2005). "Reaching Women with Instructions on Misoprostol Use in a Latin American Country." Reproductive Health Matters **13**(26): 84-92.

Coles, M. S., K. K. Makino, N. L. Stanwood, A. Dozier and J. D. Klein (2010). "How Are Restrictive Abortion Statutes Associated With Unintended Teen Birth?" Journal of Adolescent Health **47**(2): 160-167.

Colman, S. and T. Joyce (2011). "Regulating Abortion: Impact on Patients and Providers in Texas." Journal of Policy Analysis and Management **30**(4): 775-797.

Comendant, R. (2005). "A project to improve the quality of abortion services in Moldova." Reproductive Health Matters **13**(26): 93-100.

Conkling, K., C. Karki, H. Tuladhar, H. Bracken and B. Winikoff (2015). "A prospective open-label study of home use of mifepristone for medical abortion in Nepal." International Journal of Gynaecology & Obstetrics **128(3)**(3): 220-223.

Contreras, X., M. G. van Dijk, T. Sanchez and P. S. Smith (2011). "Experiences and opinions of health-care professionals regarding legal abortion in Mexico City: a qualitative study." Stud Fam Plann **42**(3): 183-190.

Contreras, X., M. G. van Dijk, T. Sanchez and P. S. Smith (2011). "Experiences and Opinions of Health-Care Professionals Regarding Legal Abortion in Mexico City: A Qualitative Study." Studies in Family Planning **42**(3): 183-190.

Cook, P. J. (1999). "The Effects of Short-Term Variation in Abortion Funding on Pregnancy Outcomes." Journal of Health Economics **18**(2): 241-257.

Cook, S., B. de Kok and M. L. Odland (2017). "'It's a very complicated issue here': understanding the limited and declining use of manual vacuum aspiration for postabortion care in Malawi: a qualitative study." Health Policy & Planning **32**(3): 305-313.

Cooper, D., K. Dickson, K. Blanchard, L. Cullingworth, N. Mavimbela, C. von Mollendorf, L. van Bogaert and B. Winikoff (2005). "Medical abortion: the possibilities for introduction in the public sector in South Africa [corrected] [published erratum appears in REPROD HEALTH MATTERS 2006 May;14(27):5]." Reproductive Health Matters **13**(26): 35-43.

Costa, S. H. (1998). "Commercial availability of misoprostol and induced abortion in Brazil." International Journal of Gynecology & Obstetrics **63**: S131-S139.

Couteau, C., C. D'Ercole, F. Bretelle, L. Boubli, B. Guidicelli and C. Chau (2016). "Methods of induction of labor in termination of pregnancy after 22 weeks: About 3 procedures." Journal De Gynecologie Obstetrique Et Biologie De La Reproduction **45**(6): 652-658.

Crane, B. B., N. Daulaire and A. C. Ezeh (2017). "Reproductive health in culture wars crossfire." Science **358**(6360): 175.

Crane, B. B. and J. Dusenberry (2004). "Power and Politics in International Funding for Reproductive Health: the US Global Gag Rule." Reproductive Health Matters **12**(24): 128-137.

Creinin, M. D. (1997). "Medical abortion with methotrexate 75 mg intramuscularly and vaginal misoprostol." Contraception **56**(6): 367-371.

Creinin, M. D. (2000). "Randomized comparison of efficacy, acceptability and cost of medical versus surgical abortion." Contraception **62**(3): 117-124.

Creinin, M. D., E. Shore, S. Balasubramanian and B. Harwood (2005). "The true cost differential between mifepristone and misoprostol and misoprostol-alone regimens for medical abortion." Contraception **71**(1): 26-30.

Crighton, E. and M. Ebert (2002). "RU 486 and abortion practices in Europe: From legalization to access." Women & Politics **24**(3): 13-33.

Cunningham, S., J. M. Lindo, C. Myers and A. Schlosser (2017). How Far Is Too Far? New Evidence on Abortion Clinic Closures, Access, and Abortions, National Bureau of Economic Research, Inc, NBER Working Papers: 23366.

Davey, C. (2005). "Sexual and Reproductive Health and Rights in the United Kingdom at ICPD+10." Reproductive Health Matters **13**(25): 81-87.

David, H. P. and A. Baban (1996). "Women's health and reproductive rights: Romanian experience." Patient Education & Counseling **28**(3): 235-245.

Dawson, A., D. Bateson, J. Estoesta and E. Sullivan (2016). "Towards comprehensive early abortion service delivery in high income countries: insights for improving universal access to abortion in Australia." BMC Health Services Research **16**: 612-612.

de Bruyn, M. (2003). "Safe Abortion for HIV-Positive Women with Unwanted Pregnancy: A Reproductive Right." Reproductive Health Matters **11**(22): 152-161.

Dennis, A. and K. Blanchard (2012). "A Mystery Caller Evaluation of Medicaid Staff Responses about State Coverage of Abortion Care." Women's Health Issues **22**(2): e143-e148.

Dennis, A., R. Manski and K. Blanchard (2014). "Does Medicaid Coverage Matter? A Qualitative Multi-State Study of Abortion Affordability for Low-income Women." Journal of Health Care for the Poor & Underserved **25**(4): 1571-1585.

Dennis, A., R. Manski and K. Blanchard (2015). "A Qualitative Exploration of Low-Income Women's Experiences Accessing Abortion in Massachusetts." Women's Health Issues **25**(5): 463-469.

Díaz-Olavarrieta, C., V. M. Cravioto, A. Villalobos, N. Deeb-Sossa, L. García and S. G. García (2012). "Mexico City's Legal Abortion Program: health workers' experiences." Revista Panamericana de Salud Publica **32**(6): 399-404.

Diniz, S. G., A. F. P. L. d'Oliveira and S. Lansky (2012). "Equity and women's health services for contraception, abortion and childbirth in Brazil." Reproductive Health Matters **20**(40): 94-101.

Dobie, S. A., L. Gober and R. A. Rosenblatt (1998). "Family planning service provision in rural areas: a survey in Washington State." Fam Plann Perspect **30**(3): 139-142, 147.

Donohoe, M. (2005). "Increase in obstacles to abortion: the American perspective in 2004." Journal of the American Medical Women's Association **60**(1): 16-25.

Donohue III, J. J. and S. D. Levitt (2001). "The Impact of Legalized Abortion on Crime*." The Quarterly Journal of Economics **116**(2): 379-420.

Donohue, J. J., III and S. D. Levitt (2001). "The Impact of Legalized Abortion on Crime." Quarterly Journal of Economics **116**(2): 379-420.

Donohue, J. J. and S. D. Levitt (2004). "Further Evidence That Legalized Abortion Lowered Crime: A Reply to Joyce." The Journal of Human Resources **39**(1): 29-49.

Donohue, J. J. and S. D. Levitt (2008). "Measurement Error, Legalized Abortion, and the Decline in Crime: A Response to Foote and Goetz." The Quarterly Journal of Economics **123**(1): 425-440.

Doran, F. and J. Hornibrook (2014). "Rural New South Wales women's access to abortion services: highlights from an exploratory qualitative study." Aust J Rural Health **22**(3): 121-126.

Doran, F. and S. Nancarrow (2015). "Barriers and facilitators of access to first-trimester abortion services for women in the developed world: a systematic review." Journal of Family Planning & Reproductive Health Care **41**(3): 170-180.

Doran, F. M. and J. Hornibrook (2016). "Barriers around access to abortion experienced by rural women in New South Wales, Australia." Rural & Remote Health **16**(1): 3538-3549.

Dragoman, M. and A. Davis (2008). "Abortion care for adolescents." Clinical Obstetrics & Gynecology **51**(2): 281-289.

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

Duggal, R. (2004). "The political economy of abortion in India: cost and expenditure patterns." Reproductive Health Matters **12**: 130-137.

Duggal, R. and V. Ramachandran (2004). "The Abortion Assessment Project-India: Key Findings and Recommendations." Reproductive Health Matters **12**(24): 122-129.

Dzuba, I. G., B. Winikoff and M. Pena (2013). "Medical abortion: a path to safe, high-quality abortion care in Latin America and the Caribbean." Eur J Contracept Reprod Health Care **18**(6): 441-450.

Edejer, T. T.-T. (2003). Making choices in health: WHO guide to cost-effectiveness analysis, World Health Organization.

Elias, J. J., N. Lacetera, M. Macis and P. Salardi (2017). "Economic Development and the Regulation of Morally Contentious Activities." American Economic Review **107**(5): 76-80.

Ely, G. E., T. Hales, D. L. Jackson, E. A. Bowen, E. Maguin and G. Hamilton (2017a). "A trauma-informed examination of the hardships experienced by abortion fund patients in the United States." Health Care for Women International **38**(11): 1133-1151.

Ely, G. E., T. Hales, D. L. Jackson, E. Maguin and G. Hamilton (2017b). "The undue burden of paying for abortion: An exploration of abortion fund cases." Social Work in Health Care **56**(2): 99-114.

Ely, G. E., T. W. Hales and D. L. Jackson (2018). "A cross-cultural exploration of abortion fund patients in the USA and the Republic of Ireland, Northern Ireland and the Isle of Man." Culture, Health & Sexuality **20**(5): 560-573.

Ely, G. E., T. W. Hales, D. L. Jackson, E. Maguin and G. Hamilton (2017c). "Where are They from and How Far Must They Go? Examining Location and Travel Distance in U.S. Abortion Fund Patients." International Journal of Sexual Health **29**(4): 313-324.

Erfani, A. (2011). "Induced Abortion in Tehran, Iran: Estimated Rates and Correlates." International Perspectives on Sexual and Reproductive Health **37**(3): 134-142.

Erim, D. O., S. C. Resch and S. J. Goldie (2012). "Assessing health and economic outcomes of interventions to reduce pregnancy-related mortality in Nigeria." BMC Public Health **12**: 786.

Esia-Donkon, K., E. K. M. Darteh, H. Blemano and H. Asare (2015). "Who Cares? Pre and Post Abortion Experiences among Young Females in Cape Coast Metropolis, Ghana." African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive **19**(2): 43-51.

Felkey, A. J. and K. M. Lybecker (2014). "Utilization of oral contraception: The impact of direct and indirect restrictions on access to abortion." The Social Science Journal **51**(1): 44-56.

Felkey, A. J. and K. M. Lybecker (2018). "Do Restrictions Beget Responsibility? The Case of U.S. Abortion Legislation." The American Economist **63**(1): 59-70.

Fergusson, D. M., J. M. Boden and L. J. Horwood (2007). "Abortion among young women and subsequent life outcomes." Perspectives on Sexual & Reproductive Health **39**(1): 6-12.

Fernandez Lopez, M. I., F. Carrillo Navarro, M. Leal Hernandez, I. Carrillo Canaveras, E. Carrillo Navarro, M. L. Lozano Sanchez, S. Fernandez Riquelme and L. M. Pastor (2010). "[An approach to abortion and immigration in Spain. The social economic value of the human life]." Cuad Bioet **21**(73): 313-326.

Finer, L. B., L. F. Frohwirth, L. A. Dauphinee, S. Singh and A. M. Moore (2005). "Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives." Perspectives on Sexual and Reproductive Health **37**(3): 110-118.

Finer, L. B., L. F. Frohwirth, L. A. Dauphinee, S. Singh and A. M. Moore (2006). "Timing of steps and reasons for delays in obtaining abortions in the United States." Contraception **74**(4): 334-344.

Fischer, S., H. Royer and C. White (2018). "The Impacts of Reduced Access to Abortion and Family Planning Services on Abortions, Births, and Contraceptive Purchases." Journal of Public Economics **167**: 43-68.

Fletcher, R. (2000). "National crisis, supranational opportunity: the Irish construction of abortion as a European service." Reproductive Health Matters **8**(16): 35-44.

Flory, F., M. Manouana, E. Janky and P. Kadhel (2014). "Caractéristiques sociodémographiques et médicales des interruptions volontaires de grossesse des mineures en Guadeloupe." Gynécologie Obstétrique & Fertilité **42**(4): 240-245.

Font-Ribera, L., G. Perez, A. Espelt, J. Salvador and C. Borrell (2009). "Determinants of induced abortion delay." Gaceta Sanitaria **23**(5): 415-419.

Foote, C. L. and C. F. Goetz (2008). "The Impact of Legalized Abortion on Crime: Comment." Quarterly Journal of Economics **123**(1): 407-423.

Forrest, J. D. and R. Samara (1996). "Impact of publicly funded contraceptive services on unintended pregnancies and implications for Medicaid expenditures." Fam Plann Perspect **28**(5): 188-195.

Foster, A. M., K. J. LaRoche, J. El-Haddad, L. DeGroot and I. M. El-Mowafi (2017). ""If I ever did have a daughter, I wouldn't raise her in New Brunswick:" exploring women's experiences obtaining abortion care before and after policy reform." Contraception **95**(5): 477-484.

Foster, D. G., M. A. Biggs, S. Raifman, J. Gipson, K. Kimport and C. H. Rocca (2018a). "Comparison of Health, Development, Maternal Bonding, and Poverty Among Children Born

After Denial of Abortion vs After Pregnancies Subsequent to an AbortionHealth, Development, Maternal Bonding, and Poverty Among Children Born After Denial of AbortionHealth, Development, Maternal Bonding, and Poverty Among Children Born After Denial of Abortion." JAMA Pediatrics **172**(11): 1053-1060.

Foster, D. G., M. A. Biggs, L. Ralph, C. Gerdts, S. Roberts and M. M. Glymour (2018b). "Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States." American Journal of Public Health **108**(3): 407-413.

Foster, D. G., R. A. Jackson, K. Cosby, T. A. Weitz, P. D. Darney and E. A. Drey (2008). "Predictors of delay in each step leading to an abortion." Contraception **77**(4): 289-293.

Foster, D. G. and K. Kimport (2013). "Who Seeks Abortions at or After 20 Weeks?" Perspectives on Sexual & Reproductive Health **45**(4): 210-218.

Foy, R., G. C. Penney, J. M. Grimshaw, C. R. Ramsay, A. E. Walker, G. MacLennan, S. C. Stearns, L. McKenzie and A. Glasier (2004). "A randomised controlled trial of a tailored multifaceted strategy to promote implementation of a clinical guideline on induced abortion care." Bjog **111**(7): 726-733.

Franzini, L., E. Marks, P. F. Cromwell, J. Risser, L. McGill, C. Markham, B. Selwyn and C. Shapiro (2004). "Projected economic costs due to health consequences of teenagers' loss of confidentiality in obtaining reproductive health care services in Texas." Archives of Pediatrics & Adolescent Medicine **158**(12): 1140-1146.

Freeman, E., E. Coast and S. F. Murray (2017). "Men's Roles in Women's Abortion Trajectories in Urban Zambia." International Perspectives on Sexual and Reproductive Health **43**(2): 89-98.

French, V., R. Anthony, C. Souder, C. Geistkemper, E. Drey and J. Steinauer (2016). "Influence of clinician referral on Nebraska women's decision-to-abortion time." Contraception **93**(3): 236-243.

Friedman, J., B. Saavedra-Avendaño, R. Schiavon, L. Alexander, P. Sanhueza, R. Rios-Polanco, L. Garcia-Martinez and B. G. Darney (2018). "Quantifying disparities in access to public-sector abortion based on legislative differences within the Mexico City Metropolitan Area." Contraception.

Fuentes, L., S. Lebenkoff, K. White, C. Gerdts, K. Hopkins, J. E. Potter and D. Grossman (2016). "Women's experiences seeking abortion care shortly after the closure of clinics due to a restrictive law in Texas." Contraception **93**(4): 292-297.

Furedi, A. (1999). "The public health implications of the 1995 'pill scare'." Hum Reprod Update **5**(6): 621-626.

Gallo, M. F. and N. C. Nghia (2007). "Real life is different: a qualitative study of why women delay abortion until the second trimester in Vietnam." Social Science & Medicine **64**(9): 1812-1822.

Gan, K., Y. Zhang, X. Jiang, Y. Meng, L. Hou and Y. Cheng (2011). "Perspectives of Chinese healthcare providers on medical abortion." International Journal of Gynecology & Obstetrics **114**(1): 15-17.

Ganatra, B., C. Gerdts, C. Rossier, B. R. Johnson, Ö. Tunçalp, A. Assifi, G. Sedgh, S. Singh, A. Bankole, A. Popinchalk, J. Bearak, Z. Kang and L. Alkema (2017). "Global, regional, and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model." The Lancet.

Ganatra, B. and S. Hirve (2002). "Induced Abortions Among Adolescent Women in Rural Maharashtra, India." Reproductive Health Matters **10**(19): 76-85.

Ganatra, B., V. Manning and S. P. Pallipamulla (2005). "Availability of medical abortion pills and the role of chemists: a study from Bihar and Jharkhand, India." Reproductive Health Matters **13**(26): 65-74.

Garcete, N. U. and M. Winocur (2006). "El acceso al aborto por violación en la Ciudad de México: limitaciones, oportunidades y desafíos." Debate Feminista **34**: 162-184.

Gerber Fried, M. (1997). "Abortion in the US: Barriers to access." Reproductive Health Matters **5**(9): 37-45.

Gerdts, C., S. DeZordo, J. Mishtal, J. Barr-Walker and P. A. Lohr (2016). "Experiences of women who travel to England for abortions: an exploratory pilot study." European Journal of Contraception & Reproductive Health Care **21**(5): 401-407.

Gerdts, C., L. Fuentes, D. Grossman, K. White, B. Keefe-Oates, S. E. Baum, K. Hopkins, C. W. Stolp and J. E. Potter (2016). "Impact of Clinic Closures on Women Obtaining Abortion Services After Implementation of a Restrictive Law in Texas." American Journal of Public Health **106**(5): 857-864.

Gerdts, C., S. Raifman, K. Daskilewicz, M. Momberg, S. Roberts and J. Harries (2017). "Women's experiences seeking informal sector abortion services in Cape Town, South Africa: a descriptive study." BMC Women's Health **17**: 1-10.

Gerdts, C., D. Vohra and J. Ahern (2013). "Measuring Unsafe Abortion-Related Mortality: A Systematic Review of the Existing Methods." PLOS ONE **8**(1): e53346.

Gibb, S., C. Donaldson and R. Henshaw (1998). "Assessing strength of preference for abortion method using 'willingness to pay': a useful research technique for measuring values." Journal of Advanced Nursing **27**(1): 30-36.

Gipson, J. D. and M. J. Hindin (2008). ""Having another child would be a life or death situation for her": understanding pregnancy termination among couples in rural Bangladesh." American Journal of Public Health **98(10)**(10): 1827-1832.

Gipson, J. D., M. A. Koenig and M. J. Hindin (2008). "The effects of unintended pregnancy on infant, child, and parental health: a review of the literature." Studies in Family Planning **39(1)**(1): 18-38.

Girard, F. and W. Nowicka (2002). "Clear and Compelling Evidence: The Polish Tribunal on Abortion Rights." Reproductive Health Matters **10**(19): 22-30.

Glenton, C., A. M. Sorhaindo, B. Ganatra and S. Lewin (2017). "Implementation considerations when expanding health worker roles to include safe abortion care: a five-country case study synthesis." BMC Public Health **17**: 1-13.

Gober, P. (1997). "The role of access in explaining state abortion rates." Social Science & Medicine **44**(7): 1003-1016.

Goldie, S. J., S. Sweet, N. Carvalho, U. C. Natchu and D. Hu (2010). "Alternative strategies to reduce maternal mortality in India: a cost-effectiveness analysis." PLoS Med **7**(4): e1000264.

Graff, M. and D. A. Amoyaw (2009). "Barriers to Sustainable MVA Supply in Ghana: Challenges for the Low-Volume, Low-Income Providers." African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive **13**(4): 73-80.

Gresh, A. and P. Maharaj (2011). "A qualitative assessment of the acceptability and potential demand for medical abortion among university students in Durban, South Africa." Eur J Contracept Reprod Health Care **16**(2): 67-75.

Grindlay, K., K. Lane and D. Grossman (2013). "Women's and Providers' Experiences with Medical Abortion Provided Through Telemedicine: A Qualitative Study." Women's Health Issues **23**(2): e117-e122.

Grossman, D., S. Baum, L. Fuentes, K. White, K. Hopkins, A. Stevenson and J. E. Potter (2014). "Change in abortion services after implementation of a restrictive law in Texas." Contraception **90**(5): 496-501.

Grossman, D., C. Ellertson, D. A. Grimes and D. Walker (2004). "Routine follow-up visits after first-trimester induced abortion." Obstet Gynecol **103**(4): 738-745.

Grossman, D., K. Grindlay and B. Burns (2016). "Public funding for abortion where broadly legal." Contraception **94**(5): 453-460.

Gruber, J., P. Levine and D. Staiger (1997). Abortion Legalization and Child Living Circumstances: Who is the 'Marginal Child?', National Bureau of Economic Research, Inc, NBER Working Papers: 6034.

Guttmacher, S., F. Kapadia, N. Jim Te Water and H. de Pinho (1998). "Abortion Reform in South Africa: A Case Study of the 1996 Choice on Termination of Pregnancy Act." International Family Planning Perspectives **24**(4): 191-194.

Haas-Wilson, D. (1996). "The Impact of State Abortion Restrictions on Minors' Demand for Abortions." Journal of Human Resources **31**(1): 140-158.

Haas-Wilson, D. (1997). "Women's reproductive choices: the impact of Medicaid funding restrictions." Fam Plann Perspect **29**(5): 228-233.

Haddad, L., S. Yanow, L. Delli-Bovi, K. Cosby and T. A. Weitz (2009). "Changes in abortion provider practices in response to the Partial-Birth Abortion Ban Act of 2003." Contraception **79**(5): 379-384.

Hammel, E. A. and P. R. Galloway (2000). "Structural and Behavioural Changes in the Short Term Preventive Check in the Northwest Balkans in the 18th and 19th Centuries." European Journal of Population / Revue Européenne de Démographie **16**(1): 67-108.

Harries, J., N. Lince, D. Constant, A. Hargey and D. Grossman (2012). "The challenges of offering public second trimester abortion services in South Africa: health care providers' perspectives." Journal of Biosocial Science **44**(2): 197-208.

Harvey, N. and M. Gaudoin (2005). "Effectiveness of a nurse-led pregnancy termination clinic." Nursing Times **101**(17): 34-36.

Hendrickson, C., T. Fetters, S. Mupeta, B. Vwallika, P. Djemo and K. Raisanen (2016). "Client–pharmacy worker interactions regarding medical abortion in Zambia in 2009 and 2011." International Journal of Gynecology & Obstetrics **132**(2): 214-218.

Henshaw, R. C., S. A. Naji, I. T. Russell and A. A. Templeton (1994). "A prospective economic evaluation comparing medical abortion (using mifepristone and gemeprost) and surgical vacuum aspiration." British Journal of Family Planning **20**(3): 64-68.

Henshaw, S. K. (1995). "Factors hindering access to abortion services." Family Planning Perspectives **27**(2): 54-87.

Henshaw, S. K., I. Adewole, S. Singh, B. Oye-Adeniran, R. Hussain and A. Bankole (2008). "Severity and cost of unsafe abortion complications treated in Nigerian hospitals." International Family Planning Perspectives **34**(1): 40-50.

Henshaw, S. K. and L. B. Finer (2003). "The accessibility of abortion services in the United States, 2001." Perspectives on Sexual & Reproductive Health **35**(1): 16-24.

Hodorogea, S. and R. Comendant (2010). "Prevention of unsafe abortion in countries of Central Eastern Europe and Central Asia." International Journal of Gynecology & Obstetrics **110**: S34-S37.

Hollander, D. (1995). "Mifepristone and Vaginal Misoprostol are Effective, Acceptable and Inexpensive Medical Abortion Regimen." Family Planning Perspectives **27**(5): 223-224.

Howie, F. L., R. C. Henshaw, S. A. Naji, I. T. Russell and A. A. Templeton (1997). "Medical abortion or vacuum aspiration? Two year follow up of a patient preference trial." Br J Obstet Gynaecol **104**(7): 829-833.

Htay, T. T., J. Sauvarin and S. Khan (2003). "Integration of Post-Abortion Care: The Role of Township Medical Officers and Midwives in Myanmar." Reproductive Health Matters **11**(21): 27-36.

Hu, D., S. M. Bertozzi, E. Gakidou, S. Sweet and S. J. Goldie (2007). "The costs, benefits, and cost-effectiveness of interventions to reduce maternal morbidity and mortality in Mexico." PLoS One **2**(8): e750.

Hu, D., D. Grossman, C. Levin, K. Blanchard, R. Adanu and S. J. Goldie (2010). "Cost-effectiveness analysis of unsafe abortion and alternative first-trimester pregnancy termination strategies in nigeria and ghana." African Journal of Reproductive Health **14**(2): 85-103.

Hu, D., D. Grossman, C. Levin, K. Blanchard and S. Goldie (2009). "Cost-effectiveness analysis of alternative first-trimester pregnancy termination strategies in Mexico City." BJOG: An International Journal of Obstetrics & Gynaecology **116**(6): 768-779.

Hu, L. and A. Schlosser (2010). Does sex-selective abortion improve girls' well-being? evidence from India, Federal Reserve Bank of Chicago, Working Paper Series: WP-2010-11.

Hulme-Chambers, A., M. Temple-Smith, A. Davidson, L. Coelli, C. Orr and J. E. Tomnay (2018). "Australian women's experiences of a rural medical termination of pregnancy service: A qualitative study." Sexual & Reproductive Healthcare **15**: 23-27.

Hung, S. L. (2010). "Access to safe and legal abortion for teenage women from deprived backgrounds in Hong Kong." Reproductive Health Matters **18**(36): 102-110.

Hussey, L. S. (2011). "Is Welfare Pro-life? Assistance Programs, Abortion, and the Moderating Role of States." Social Service Review **85**(1): 75-107.

Hyman, A. G., T. L. Baird and I. Basnett (2008). "Establishing Second Trimester Abortion Services: Experiences in Nepal, Viet Nam and South Africa." Reproductive Health Matters **16**(31, Supplement): 135-144.

Ilboudo, P. G. C., G. Greco, J. Sundby and G. Torsvik (2015). "Costs and consequences of abortions to women and their households: a cross-sectional study in Ouagadougou, Burkina Faso." Health Policy & Planning **30**(4): 500-507.

Ilboudo, P. G. C., G. Greco, J. Sundby and G. Torsvik (2015). "Costs and consequences of abortions to women and their households: a cross-sectional study in Ouagadougou, Burkina Faso." Health Policy and Planning **30**(4): 500-507.

Ilboudo, P. G. C., G. Greco, J. Sundby and G. Torsvik (2016). "Estimating the costs for the treatment of abortion complications in two public referral hospitals: a cross-sectional study in Ouagadougou, Burkina Faso." BMC Health Services Research **16**: 1-10.

Izugbara, C. O., C. Egesa and R. Okelo (2015). "'High profile health facilities can add to your trouble': Women, stigma and un/safe abortion in Kenya." Social Science & Medicine **141**: 9-18.

Izugbara, C. O. and J. K. Ukwayi (2003). "The clientele of traditional birth homes in rural southeastern Nigeria." Health Care for Women International **24**(3): 177-192.

Janiak, E., I. Kawachi, A. Goldberg and B. Gottlieb (2014). "Abortion barriers and perceptions of gestational age among women seeking abortion care in the latter half of the second trimester." Contraception **89**(4): 322-327.

Jarlenski, M., J. A. Hutcheon, L. M. Bodnar and H. N. Simhan (2017). "State Medicaid Coverage of Medically Necessary Abortions and Severe Maternal Morbidity and Maternal Mortality." Obstetrics and Gynecology **129**(5): 786-794.

Jejeebhoy, S. J., S. Kalyanwala, A. J. F. Zavier, R. Kumar and N. Jha (2010). "Experience seeking abortion among unmarried young women in Bihar and Jharkhand, India: delays and disadvantages." Reproductive Health Matters **18**(35): 163-174.

Jerman, J., L. Frohwirth, M. L. Kavanaugh and N. Blades (2017). "Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States." Perspectives on Sexual & Reproductive Health **49**(2): 95-102.

Jerman, J. and R. K. Jones (2014). "Secondary Measures of Access to Abortion Services in the United States, 2011 and 2012: Gestational Age Limits, Cost, and Harassment." Women's Health Issues **24**(4): e419-e424.

Jewell, R. T. and R. W. Brown (2000). "An economic analysis of abortion: the effect of travel cost on teenagers." The Social Science Journal **37**(1): 113-124.

Johansson, A., T. Le Thi Nham, N. t. Lap and K. Sundstrom (1996). "Abortion in Context: Women's Experience in Two Villages in Thai Binh Province, Vietnam." International Family Planning Perspectives **22**(3): 103-107.

Johnson, B. R., M. Horga and L. Andronache (1996). "Women's perspectives on abortion in Romania." Social Science & Medicine **42**(4): 521-530.

Johnston, H. B., S. Akhter and E. Oliveras (2012). "Quality and efficiency of care for complications of unsafe abortion: a case study from Bangladesh." International Journal of Gynecology & Obstetrics **118**: S141-147.

Johnston, H. B., M. F. Gallo, J. Benson, H. B. Johnston, M. F. Gallo and J. Benson (2007). "Reducing the costs to health systems of unsafe abortion: a comparison of four strategies." Journal of Family Planning & Reproductive Health Care **33**(4): 250-257.

Johnston, H. B., E. Oliveras, S. Akhter and D. G. Walker (2010). "Health System Costs of Menstrual Regulation and Care For Abortion Complications in Bangladesh." International Perspectives on Sexual & Reproductive Health **36**(4): 197-201.

Johnston, H. B., R. Ved, N. Lyall and K. Agarwal (2003). "Where do rural women obtain postabortion care? The case of Uttar Pradesh, India." International Family Planning Perspectives **29**(4): 182-187.

Jones, B. S. and T. A. Weitz (2009). "Legal barriers to second-trimester abortion provision and public health consequences." American Journal of Public Health **99**(4): 623-630.

Jones, K. M. (2015). "Contraceptive Supply and Fertility Outcomes: Evidence from Ghana." Economic Development and Cultural Change **64**(1): 31-69.

Jones, R. K. (2017). "Are Uncertain Fertility Intentions a Temporary or Long-term Outlook? Findings from a Panel Study." Women's Health Issues **27**(1): 21-28.

Jones, R. K. and L. B. Finer (2012). "Who has second-trimester abortions in the United States?" Contraception **85**(6): 544-551.

Jones, R. K., M. Ingerick and J. Jerman (2018). "Differences in Abortion Service Delivery in Hostile, Middle-ground, and Supportive States in 2014." Women's Health Issues **28**(3): 212-218.

Jones, R. K. and J. Jerman (2017). "Characteristics and Circumstances of US Women Who Obtain Very Early and Second Trimester Abortions." Plos One **12**(1): 15.

Jones, R. K., U. D. Upadhyay and T. A. Weitz (2013). "At What Cost? Payment for Abortion Care by U.S. Women." Women's Health Issues **23**(3): e173-178.

Jowett, M. (2000). "Safe motherhood interventions in low-income countries: an economic justification and evidence of cost effectiveness." Health Policy **53**(3): 201-228.

Kacanek, D., A. Dennis, K. Miller and K. Blanchard (2010). "Medicaid funding for abortion: providers' experiences with cases involving rape, incest and life endangerment." Perspectives on Sexual & Reproductive Health **42**(2): 79-86.

Kahane, L. H. (2000). "Anti-abortion activities and the market for abortion services - Protest as a disincentive." American Journal of Economics and Sociology **59**(3): 463-485.

Kalist, D. E. (2004). "Abortion and Female Labor Force Participation: Evidence Prior to Roe v. Wade." Journal of Labor Research **25**(3): 503-514.

Kalsi, P. (2015). "Abortion Legalization, Sex Selection, and Female University Enrollment in Taiwan." Economic Development and Cultural Change **64**(1): 163-185.

Kalyanwala, S., A. J. F. Zavier, S. Jejeebhoy and R. Kumar (2010). "Abortion Experiences of Unmarried Young Women In India: Evidence from a Facility-Based Study In Bihar and Jharkhand." International Perspectives on Sexual and Reproductive Health **36**(2): 62-71.

Kamali, P., M. Hohmann, J. Herrero and W. Kunzel (1998). "[Gameprost, sulproston and dinoproston for induced abortion in the 15th-24th week of pregnancy]." Zentralbl Gynakol **120**(6): 293-300.

Kapp, N., K. Blanchard, E. Coast, B. Ganatra, J. Harries, K. Footman, A. Moore, O. Owolabi, C. Rossier, K. Shellenberg, B. Wahlin and C. Woodsong (2017). "Developing a forward-looking agenda and methodologies for research of self-use of medical abortion." Contraception.

Karasek, D., S. C. M. Roberts and T. A. Weitz (2016). "Abortion Patients' Experience and Perceptions of Waiting Periods: Survey Evidence before Arizona's Two-visit 24-hour Mandatory Waiting Period Law." Women's Health Issues **26**(1): 60-66.

Kassebaum, N. J., A. Bertozzi-Villa, M. S. Coggeshall, K. A. Shackelford, C. Steiner, K. R. Heuton, D. Gonzalez-Medina, R. Barber, C. Huynh, D. Dicker, T. Templin, T. M. Wolock, A. A. Ozgoren, F. Abd-Allah, S. F. Abera, I. Abubakar, T. Achoki, A. Adelekan, Z. Ademi, A. K. Adou, J. C. Adsuar, E. E. Agardh, D. Akena, D. Alasfoor, Z. A. Alemu, R. Alfonso-Cristancho, S. Alhabib, R. Ali, M. J. Al Kahbouri, F. Alla, P. J. Allen, M. A. AlMazroa, U. Alsharif, E. Alvarez, N. Alvis-Guzmán, A. A. Amankwaa, A. T. Amare, H. Amini, W. Ammar, C. A. T. Antonio, P. Anwari, J. Ärnlöv, V. S. A. Arsenijevic, A. Artaman, M. M. Asad, R. J. Asghar, R. Assadi, L. S. Atkins, A. Badawi, K. Balakrishnan, A. Basu, S. Basu, J. Beardsley, N. Bedi, T. Bekele, M. L. Bell, E. Bernabe, T. J. Beyene, Z. Bhutta, A. Bin Abdulhak, J. D. Blore, B. B. Basara, D. Bose, N. Breitborde, R. Cárdenas, C. A. Castañeda-Orjuela, R. E. Castro, F. Catalá-López, A. Cavlin, J.-C. Chang, X. Che, C. A. Christophi, S. S. Chugh, M. Cirillo, S. M. Colquhoun, L. T. Cooper, C. Cooper, I. da Costa Leite, L. Dandona, R. Dandona, A. Davis, A. Dayama, L. Degenhardt, D. De Leo, B. del Pozo-Cruz, K. Deribe, M. Dessalegn, G. A. deVeber, S. D. Dharmaratne, U. Dilmen, E. L. Ding, R. E. Dorrington, T. R. Driscoll, S. P. Ermakov, A. Esteghamati, E. J. A. Faraon, F. Farzadfar, M. M. Felicio, S.-M. Fereshtehnejad, G. M. F. de Lima, M. H. Forouzanfar, E. B. França, L. Gaffikin, K. Gambashidze, F. G. Gankpé, A. C. Garcia, J. M. Geleijnse, K. B. Gibney, M. Giroud, E. L. Glaser, K. Goginashvili, P. Gona, D. González-Castell, A. Goto, H. N. Gouda, H. C. Gugnani, R. Gupta, R. Gupta, N. Hafezi-Nejad, R. R. Hamadeh, M. Hammami, G. J. Hankey, H. L. Harb, R. Havmoeller, S. I. Hay, I. B. H. Pi, H. W. Hoek, H. D. Hosgood, D. G. Hoy, A. Husseini, B. T. Idrisov, K. Innos, M. Inoue, K. H. Jacobsen, E. Jahangir, S. H. Jee, P. N. Jensen, V. Jha, G. Jiang, J. B. Jonas, K. Juel, E. K. Kabagambe, H. Kan, N. E. Karam, A. Karch, C. K. Karema, A. Kaul, N. Kawakami, K. Kazanjan, D. S. Kazi, A. H. Kemp, A. P. Kengne, M. Kereselidze, Y. S. Khader, S. E. A. H. Khalifa, E. A. Khan, Y.-H. Khang, L. Knibbs, Y. Kokubo, S. Kosen, B. K. Defo, C. Kulkarni, V. S. Kulkarni, G. A. Kumar, K.

Kumar, R. B. Kumar, G. Kwan, T. Lai, R. Lalloo, H. Lam, V. C. Lansingh, A. Larsson, J.-T. Lee, J. Leigh, M. Leinsalu, R. Leung, X. Li, Y. Li, Y. Li, J. Liang, X. Liang, S. S. Lim, H.-H. Lin, S. E. Lipshultz, S. Liu, Y. Liu, B. K. Lloyd, S. J. London, P. A. Lotufo, J. Ma, S. Ma, V. M. P. Machado, N. K. Mainoo, M. Majdan, C. C. Mapoma, W. Marcenes, M. B. Marzan, A. J. Mason-Jones, M. M. Mehndiratta, F. Mejia-Rodriguez, Z. A. Memish, W. Mendoza, T. R. Miller, E. J. Mills, A. H. Mokdad, G. L. Mola, L. Monasta, J. de la Cruz Monis, J. C. M. Hernandez, A. R. Moore, M. Moradi-Lakeh, R. Mori, U. O. Mueller, M. Mukaigawara, A. Naheed, K. S. Naidoo, D. Nand, V. Nangia, D. Nash, C. Nejjari, R. G. Nelson, S. P. Neupane, C. R. Newton, M. Ng, M. J. Nieuwenhuijsen, M. I. Nisar, S. Nolte, O. F. Norheim, L. Nyakarahuka, I.-H. Oh, T. Ohkubo, B. O. Olusanya, S. B. Omer, J. N. Opio, O. E. Orisakwe, J. D. Pandian, C. Papachristou, J.-H. Park, A. J. P. Caicedo, S. B. Patten, V. K. Paul, B. I. Pavlin, N. Pearce, D. M. Pereira, K. Pesudovs, M. Petzold, D. Poenaru, G. V. Polanczyk, S. Polinder, D. Pope, F. Pourmalek, D. Qato, D. A. Quistberg, A. Rafay, K. Rahimi, V. Rahimi-Movaghar, S. ur Rahman, M. Raju, S. M. Rana, A. Refaat, L. Ronfani, N. Roy, T. G. S. Pimienta, M. A. Sahraian, J. A. Salomon, U. Sampson, I. S. Santos, M. Sawhney, F. Sayinzoga, I. J. C. Schneider, A. Schumacher, D. C. Schwebel, S. Seedat, S. G. Sepanlou, E. E. Servan-Mori, M. Shakh-Nazarova, S. Sheikhbahaei, K. Shibuya, H. H. Shin, I. Shiue, I. D. Sigfusdottir, D. H. Silberberg, A. P. Silva, J. A. Singh, V. Skirbekk, K. Sliwa, S. S. Soshnikov, L. A. Sposato, C. T. Sreeramareddy, K. Stroumpoulis, L. Sturua, B. L. Sykes, K. M. Tabb, R. T. Talongwa, F. Tan, C. M. Teixeira, E. Y. Tenkorang, A. S. Terkawi, A. L. Thorne-Lyman, D. L. Tirschwell, J. A. Towbin, B. X. Tran, M. Tsilimbaris, U. S. Uchendu, K. N. Ukwaja, E. A. Undurraga, S. B. Uzun, A. J. Vallely, C. H. van Gool, T. J. Vasankari, M. S. Vavilala, N. Venketasubramanian, S. Villalpando, F. S. Violante, V. V. Vlassov, T. Vos, S. Waller, H. Wang, L. Wang, X. Wang, Y. Wang, S. Weichenthal, E. Weiderpass, R. G. Weintraub, R. Westerman, J. D. Wilkinson, S. M. Woldeyohannes, J. Q. Wong, M. A. Wordofa, G. Xu, Y. C. Yang, Y. Yano, G. K. Yentur, P. Yip, N. Yonemoto, S.-J. Yoon, M. Z. Younis, C. Yu, K. Y. Jin, M. El Sayed Zaki, Y. Zhao, Y. Zheng, M. Zhou, J. Zhu, X. N. Zou, A. D. Lopez, M. Naghavi, C. J. L. Murray and R. Lozano (2014). "Global, regional, and national levels and causes of maternal mortality during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013." The Lancet **384**(9947): 980-1004.

Kay, B. J., J. Katzenellenbogen, S. Fawcus and S. A. Karim (1997). "An analysis of the cost of incomplete abortion to the public health sector in South Africa - 1994." South African Medical Journal **87**(4): 442-447.

Kelly, J., T. Sadeghieh and K. Adeli (2014). "Peer Review in Scientific Publications: Benefits, Critiques, & A Survival Guide." EJIFCC **25**(3): 227-243.

Kelly, K. and L. Grant (2007). "State Abortion and Nonmarital Birthrates in the Post-Welfare Reform Era: The Impact of Economic Incentives on Reproductive Behaviors of Teenage and Adult Women." Gender and Society **21**(6): 878-904.

Kiley, J. W., L. M. Yee, C. M. Niemi, J. M. Feinglass and M. A. Simon (2010). "Delays in request for pregnancy termination: comparison of patients in the first and second trimesters." Contraception **81**(5): 446-451.

Kinoti, S. N., L. Gaffikin and J. Benson (2004). "How research can affect policy and programme advocacy: example from a three-country study on abortion complications in sub-Saharan Africa." East Afr Med J **81**(2): 63-70.

Kishen, M. and Y. Stedman (2010). "The role of Advanced Nurse Practitioners in the availability of abortion services." Best Practice & Research Clinical Obstetrics & Gynaecology **24**(5): 569-578.

Koontz, S. L., O. Molina de Perez, K. Leon and A. Foster-Rosales (2003). "Treating incomplete abortion in El Salvador: cost savings with manual vacuum aspiration." Contraception **68**(5): 345-351.

Kumar, A., L. Hessini and E. M. H. Mitchell (2009). "Conceptualising abortion stigma." Culture, Health & Sexuality **11**(6): 625-639.

Lafaurie, M. M., D. Grossman, E. Troncoso, D. L. Billings and S. Chávez (2005). "Women's Perspectives on Medical Abortion in Mexico, Colombia, Ecuador and Peru: A Qualitative Study." Reproductive Health Matters **13**(26): 75-83.

Lalley, J. J., R. D. Jelsema, P. S. Huzel, S. B. Ransom and R. J. Sokol (2001). "The cost-effectiveness of misoprostol versus prostaglandin E2 for second trimester termination of pregnancy." Clinical Journal of Women's Health **1**(3): 149-156.

Lane, S. D., J. M. Jok and M. T. El-Mouelhy (1998). "Buying safety: the economics of reproductive risk and abortion in Egypt." Social Science & Medicine **47**(8): 1089-1099.

Lavelanet, A. F., B. R. Johnson and B. Ganatra (2020). "Global Abortion Policies Database: A descriptive analysis of the regulatory and policy environment related to abortion." Best Practice & Research Clinical Obstetrics & Gynaecology **62**: 25-35.

Le, H. H., M. P. Connolly, J. B. Yu, Y. Pinchevsky and P. S. Steyn (2015). "The public health and economic consequences of unintended pregnancies in South Africa." Healthcare in Low-Resource Settings **3**(1): 7.

Lee-Rife, S. M. (2010). "Women's empowerment and reproductive experiences over the lifecourse." Social Science & Medicine **71**(3): 634-642.

Leone, T., E. Coast, D. Parmar and B. Vwalika (2016). "The individual level cost of pregnancy termination in Zambia: a comparison of safe and unsafe abortion." Health Policy & Planning **31**(7): 825-833.

Leone, T., E. Coast, D. Parmar and B. Vwalika (2016). "The individual level cost of pregnancy termination in Zambia: a comparison of safe and unsafe abortion " Health, Policy & Planning **31(7)**(7): 825-833.

Levin, C., D. Grossman, K. Berdichevsky, C. Diaz, B. Aracena, S. G. Garcia and L. Goodyear (2009). "Exploring the costs and economic consequences of unsafe abortion in Mexico City before legalisation." Reproductive Health Matters **17**(33): 120-132.

Levine, P. B. and D. Staiger (2002). Abortion as Insurance, National Bureau of Economic Research, Inc, NBER Working Papers: 8813.

Li, C. L., L. P. Song, S. Y. Tang, L. Zhou, H. He, X. T. Mo and Y. M. Liao (2017). "Efficacy, Safety, and Acceptability of Low-Dose Mifepristone and Self-Administered Misoprostol for Ultra-Early Medical Abortion: A Randomized Controlled Trial." Reprod Sci **24**(5): 731-737.

Limacher, J. J., I. Daniel, S. Isaacksz, G. J. Payne, S. Dunn, P. C. Coyte and A. Laporte (2006). "Early Abortion in Ontario: Options and Costs." Journal of Obstetrics and Gynaecology Canada **28**(2): 142-148.

Lin, W. and J. Pantano (2015). "The Unintended: Negative Outcomes over the Life Cycle." Journal of Population Economics **28**(2): 479-508.

Lince-Deroche, N., D. Constant, J. Harries, K. Blanchard, E. Sinanovic and D. Grossman (2015). "The costs of accessing abortion in South Africa: women's costs associated with second-trimester abortion services in Western Cape Province." Contraception **92**(4): 339-344.

Lince-Deroche, N., D. Constant, J. Harries, J. Kluge, K. Blanchard, E. Sinanovic and D. Grossman (2018). "The costs and cost effectiveness of providing second-trimester medical and surgical safe abortion services in Western Cape Province, South Africa." PLoS One **13**(6): e0197485.

Lince-Deroche, N., T. Fetters, E. Sinanovic and K. Blanchard (2017a). "Accessing medical and surgical first-trimester abortion services: women's experiences and costs from an operations research study in KwaZulu-Natal Province, South Africa." Contraception **96**(2): 72-80.

Lince-Deroche, N., T. Fetters, E. Sinanovic, J. Devjee, J. Moodley and K. Blanchard (2017b). "The costs and cost effectiveness of providing first-trimester, medical and surgical safe abortion services in KwaZulu-Natal Province, South Africa." PLoS One **12**(4): e0174615.

Lince-Deroche, N., J. Harries, D. Constant, C. Morroni, M. Pleaner, T. Fetters, D. Grossman, K. Blanchard and E. Sinanovic (2018). "Doing more for less: identifying opportunities to expand public sector access to safe abortion in South Africa through budget impact analysis." Contraception **97**(2): 167-176.

Loeber, O. and C. Wijsen (2008). "Factors Influencing the Percentage of Second Trimester Abortions in the Netherlands." Reproductive Health Matters **16**(31, Supplement): 30-36.

Lott, J. R., Jr. and J. Whitley (2007). "Abortion and Crime: Unwanted Children and Out-of-Wedlock Births." Economic Inquiry **45**(2): 304-324.

Machungo, F., G. Zanconato and S. Bergstrom (1997). "Socio-economic background, individual cost and hospital care expenditure in cases of illegal and legal abortion in Maputo." Health & Social Care in the Community **5**(2): 71-76.

Machungo, F., G. Zanconato and S. Bergström (1997). "Socio-economic background, individual cost and hospital care expenditure in cases of illegal and legal abortion in Maputo." Health & Social Care in the Community **5**(2): 71-76.

Magotti, R. F., P. G. Munjinja, R. S. Lema and E. K. Ngwalle (1995). "Cost-effectiveness of managing abortions: manual vacuum aspiration (MVA) compared to evacuation by curettage in Tanzania." East Afr Med J **72**(4): 248-251.

Malamud, O., C. Pop-Eleches and M. Urquiola (2016). Interactions Between Family and School Environments: Evidence on Dynamic Complementarities?, National Bureau of Economic Research, Inc, NBER Working Papers: 22112.

Manouana, M., P. Kadhel, A. Koffi and E. Janky (2013). "Avortements illégaux par le misoprostol en Guadeloupe." Journal de Gynécologie Obstétrique et Biologie de la Reproduction **42**(2): 137-142.

Margo, J., L. McCloskey, G. Gupte, M. Zurek, S. Bhakta and E. Feinberg (2016). "Women's Pathways to Abortion Care in South Carolina: A Qualitative Study of Obstacles and Supports." Perspectives on Sexual & Reproductive Health **48**(4): 199-207.

Marlow, H. M., S. Wamugi, E. Yegon, T. Fetters, L. Wanaswa and S. Msipa-Ndebele (2014). "Women's perceptions about abortion in their communities: perspectives from western Kenya." Reproductive Health Matters **22**(43): 149-158.

Matthews, S., D. Ribar and M. Wilhelm (1997). "The effects of economic conditions and access to reproductive health services on state abortion rates and birthrates." Family Planning Perspectives **29**(2): 52-60.

Medoff, M. (2015). "THE IMPACT OF STATE ABORTION POLICY ON THE PRICE OF AN ABORTION." Behavior and Social Issues **24**: 56-67.

Medoff, M. H. (1999). "An Estimate of Teenage Abortion Demand." Journal of Socio-Economics **28**(2): 175-184.

Medoff, M. H. (2000). "Black Abortion Demand." Review of Black Political Economy **28**(1): 29-36.

Medoff, M. H. (2007). "Price, Restrictions and Abortion Demand." Journal of Family and Economic Issues **28**(4): 583-599.

Medoff, M. H. (2008). "Abortion costs, sexual behavior, and pregnancy rates." Social Science Journal **45**(1): 156-172.

Medoff, M. H. (2008a). "The response of abortion demand to changes in abortion costs." Social Indicators Research **87**(2): 329-346.

Medoff, M. H. (2008b). "The Spillover Effects of Restrictive Abortion Laws." Gender Issues **25**(1): 1-10.

Meier, K. J. and D. R. McFarlane (1994). "State family planning and abortion expenditures: Their effect on public health." American Journal of Public Health **84**(9): 1468-1472.

Mercier, R. J., M. Buchbinder and A. Bryant (2016). "TRAP laws and the invisible labor of US abortion providers." Critical Public Health **26**(1): 77-87.

Messinger, C. J., I. Mahmud, S. Kanan, Y. T. Jahangir, M. Sarker and S. F. Rashid (2017). "Utilization of mobile phones for accessing menstrual regulation services among low-income women in Bangladesh: a qualitative analysis." Reproductive Health **14**: 1-11.

Mitchell, E. M., A. Kwizera, M. Usta and H. Gebreselassie (2010). "Choosing early pregnancy termination methods in Urban Mozambique." Social Science & Medicine **71**(1): 62-70.

Moher, D., L. Shamseer, M. Clarke, D. Ghersi, A. Liberati, M. Petticrew, P. Shekelle, L. A. Stewart and P.-P. Group (2015). "Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement." Systematic Reviews **4**(1): 1.

Molland, E. (2016). "Benefits from Delay? The Effect of Abortion Availability on Young Women and Their Children." Labour Economics **43**: 6-28.

Monea, E. and A. Thomas (2011). "Unintended Pregnancy and Taxpayer Spending." Perspectives on Sexual & Reproductive Health **43**(2): 88-93.

Montouchet, C., J. Trussell, C. Montouchet and J. Trussell (2013). "Unintended pregnancies in England in 2010: costs to the National Health Service (NHS)." Contraception **87**(2): 149-153.

Moore, A. M., M. Dennis, R. Anderson, A. Bankole, A. Abelson, G. Greco and B. Vwalika (2018). "Comparing women's financial costs of induced abortion at a facility vs. seeking treatment for complications from unsafe abortion in Zambia." Reproductive Health Matters **26**(52): 138-150.

Murtagh, C., E. Wells, E. G. Raymond, F. Coeytaux and B. Winikoff (2018). "Exploring the feasibility of obtaining mifepristone and misoprostol from the internet." Contraception **97**(4): 287-291.

Murthy, A. and M. D. Creinin (2003). "Pharmacoeconomics of medical abortion: a review of cost in the United States, Europe and Asia." Expert Opin Pharmacother **4**(4): 503-513.

Mutua, M. M., L. Manderson, E. Musenge and T. N. O. Achia (2018). "Policy, law and post-abortion care services in Kenya." Plos One **13**(9): 18.

Mutungi, A. K., E. O. Wango, K. O. Rogo, V. N. Kimani and J. G. Karanja (1999). "Abortion: Behaviour of adolescents in two districts in Kenya." East African Medical Journal **76**(10): 541-546.

Myers, C. K. (2017). "The Power of Abortion Policy: Reexamining the Effects of Young Women's Access to Reproductive Control." Journal of Political Economy **125**(6): 2178-2224.

Naghma e, R. (2011). "Cost of the treatment of complications of unsafe abortion in public hospitals." J Pak Med Assoc **61**(2): 169-172.

Narkavonnakit, T. and T. Bennett (1981). "Health consequences of induced abortion in rural northeast Thailand." Studies in Family Planning: 58-65.

Ngwena, C. (2010). "Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa." Hum. Rts. Q. **32**(4): 783-864.

Nickson, C., A. M. A. Smith and J. M. Shelley (2006). "Travel undertaken by women accessing private Victorian pregnancy termination services." Australian & New Zealand Journal of Public Health **30**(4): 329-333.

Ogu, R., F. Okonofua, A. Hammed, E. Okpokunu, A. Mairiga, A. Bako, T. Abass, D. Garba, A. Alani and K. Agholor (2012). "Outcome of an intervention to improve the quality of private sector provision of postabortion care in northern Nigeria." International Journal of Gynecology & Obstetrics **118**: S121-126.

Ordinioha, B. and S. Brisibe (2008). "Clandestine abortion in Port Harcourt: providers' motivations and experiences." Niger J Med **17**(3): 291-295.

Oreffice, S. (2007). "Did the Legalization of Abortion Increase Women's Household Bargaining Power? Evidence from Labor Supply." Review of Economics of the Household **5**(2): 181-207.

Ostrach, B. and M. Cheyney (2014). "Navigating social and institutional obstacles: low-income women seeking abortion." Qualitative health research **24(7)**(7): 1006-1017.

Osur, J., T. L. Baird, B. A. Levandowski, E. Jackson and D. Murokora (2013). "Implementation of misoprostol for postabortion care in Kenya and Uganda: a qualitative evaluation." Glob Health Action **6**: 1-11.

Ouedraogo, R. and J. Sundby (2014). "Social determinants and access to induced abortion in Burkina Faso: from two case studies." Obstet Gynecol Int **2014**: 402456.

Palma Manríquez, I., C. Moreno Standen, A. Álvarez Carimoney and A. Richards (2018). "Experience of clandestine use of medical abortion among university students in Chile: a qualitative study." Contraception **97**(2): 100-107.

Parmar, D., T. Leone, E. Coast, S. F. Murray, E. Hukin and B. Vwalika (2017). "Cost of abortions in Zambia: A comparison of safe abortion and post abortion care." Global Public Health **12**(2): 236-249.

Payne, C. M., M. P. Debbink, E. A. Steele, C. T. Buck, L. A. Martin, J. A. Hassinger and L. H. Harris (2013). "Why Women are dying from unsafe Abortion: Narratives of Ghanaian abortion providers." African Journal of Reproductive Health **17**(2): 118-128.

Penfold, S., S. Wendot, I. Nafula and K. Footman (2018). "A qualitative study of safe abortion and post-abortion family planning service experiences of women attending private facilities in Kenya." Reproductive Health **15**(1): N.PAG-N.PAG.

Penney, G. C., L. McKessock, R. Rispin, H. Elrefaey and A. Templeton (1995). "AN EFFECTIVE, LOW-COST REGIMEN FOR EARLY MEDICAL ABORTION." British Journal of Family Planning **21**(1): 5-6.

Perrin, E., M. Berthoud, M. Pott, A. G. Toledo Vera, D. Perrenoud and F. Bianchi-Demicheli (2011). "Clinical course in women undergoing termination of pregnancy within the legal time limit in French-speaking Switzerland." Swiss Med Wkly **141**: w13282.

Pheterson, G. and Y. Azize (2005). "Abortion Practice in the Northeast Caribbean: “Just write down stomach pain”." Reproductive Health Matters **13**(26): 44-53.

Pillai, M., V. Welsh, K. Sedgeman, A. C. Gazet, J. Staddon and H. Carter (2015). "Introduction of a manual vacuum aspiration service: a model of service within a NHS Sexual Health Service." Journal of Family Planning & Reproductive Health Care **41**(1): 27-32.

Pongsatha, S., N. Morakot and T. Tongsong (2002). "Demographic characteristics of women with self use of misoprostol for pregnancy interruption attending Maharaj Nakorn Chiang Mai Hospital." J Med Assoc Thai **85**(10): 1074-1080.

Pop-Eleches, C. (2006). "The Impact of an Abortion Ban on Socioeconomic Outcomes of Children: Evidence from Romania." Journal of Political Economy **114**(4): 744-773.

Pop‐Eleches, C. (2006). "The Impact of an Abortion Ban on Socioeconomic Outcomes of Children: Evidence from Romania." Journal of Political Economy **114**(4): 744-773.

Potdar, R., T. Fetters and L. Phirun (2008). "Initial loss of productive days and income among women seeking induced abortion in Cambodia." Journal of Midwifery & Women’s Health **53**(2): 123-129.

Potdar, R., T. Fetters and L. Phirun (2008). "Initial loss of productive days and income among women seeking induced abortion in Cambodia." Journal of Midwifery & Women's Health **53**(2): 123-129.

Prada, E., A. Bankole, O. T. Oladapo, O. A. Awolude, I. F. Adewole and T. Onda (2015). "Maternal Near-Miss Due to Unsafe Abortion and Associate Short-Term Health and Socio-Economic Consequences in Nigeria." African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive **19**(2): 52-62.

Prada, E., I. Maddow-Zimet and F. Juarez (2013). "The Cost of Postabortion Care and Legal Abortion In Colombia." International Perspectives on Sexual & Reproductive Health **39**(3): 114-123.

Prata, N., A. Sreenivas, F. Greig, J. Walsh and M. Potts (2010). "Setting priorities for safe motherhood interventions in resource-scarce settings." Health Policy **94**(1): 1-13.

Raifman, S., P. Anderson, S. Kaller, D. Tober and D. Grossman (2018). "Evaluating the capacity of California's publicly funded universities to provide medication abortion." Contraception **98**(4): 306-311.

Ramachandar, L. and P. J. Pelto (2004). "Abortion Providers and Safety of Abortion: A Community-Based Study in a Rural District of Tamil Nadu, India." Reproductive Health Matters **12**(24, Supplement): 138-146.

Ramos, M. G. and E. G. Rios (2015). "CONTROVERSIES IN THE TREATMENT OF INCOMPLETE ABORTION, MVA VERSUS MEDICAL TREATMENT WITH MISOPROSTOL." Revista Peruana De Ginecologia Y Obstetricia **61**(1): 57-64.

Roberts, S. C. M., H. Gould, K. Kimport, T. A. Weitz and D. G. Foster (2014). "Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States." Women's Health Issues **24**(2): e211-218.

Robson, S., T. Kelly, D. Howel, M. Deverill, J. Hewison, M. Lie, E. Stamp, N. Armstrong and C. May (2009). "Randomised preference trial of medical versus surgical termination of pregnancy less than 14 weeks' gestation (TOPS)." Health Technology Assessment **13**(37): 1-148.

Rodgers, Y. v. d. M. (2019). The Global Gag Rule and Women's Reproductive Health: Rhetoric Versus Reality. Oxford, Oxford University Press.

Rodriguez, M. I., W. S. Mendoza, C. Guerra-Palacio, N. A. Guzman and J. E. Tolosa (2015). "Medical abortion and manual vacuum aspiration for legal abortion protect women's health and reduce costs to the health system: findings from Colombia." Reproductive Health Matters **22**: 125-133.

Rossier, C. (2007). "Abortion: An Open Secret? Abortion and Social Network Involvement in Burkina Faso." Reproductive Health Matters **15**(30): 230-238.

Sagala, J. K. (2005). "Bush's global gag rule and Africa: impact on reproductive health." International Journal of Global Health & Health Disparities **4**(1): 13-29.

Sanders, J. N., H. Conway, J. Jacobson, L. Torres and D. K. Turok (2016). "The Longest Wait: Examining the Impact of Utah's 72-Hour Waiting Period for Abortion." Women's Health Issues **26**(5): 483-487.

Say, L., D. Chou, A. Gemmill, Ö. Tunçalp, A.-B. Moller, J. Daniels, A. M. Gülmezoglu, M. Temmerman and L. Alkema (2014). "Global causes of maternal death: a WHO systematic analysis." The Lancet Global Health **2**(6): e323-e333.

Schaff, E. A. and E. A. Schaff (2010). "Mifepristone: ten years later." Contraception **81**(1): 1-7.

Schiavon, R., M. E. Collado, E. Troncoso, J. E. Soto Sánchez, G. O. Zorrilla and T. Palermo (2010). "Characteristics of private abortion services in Mexico City after legalization." Reproductive Health Matters **18**(36): 127-135.

Schuster, S. (2010). "Women's experiences of the abortion law in Cameroon: “What really matters”." Reproductive Health Matters **18**(35): 137-144.

Sedgh, G., J. Bearak, S. Singh, A. Bankole, A. Popinchalk, B. Ganatra, C. Rossier, C. Gerdts, Ö. Tunçalp, B. R. Johnson, Jr., H. B. Johnston and L. Alkema (2016). "Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends." The Lancet **39(10041)**: 16-22.

Sethe, S. and A. Murdoch (2013). "Comparing the Burden: What Can We Learn by Comparing Regulatory Frameworks in Abortion and Fertility Services?" Health Care Analysis **21**(4): 338-354.

Sethna, C. and M. Doull (2007). "Far From Home? A Pilot Study Tracking Women’s Journeys to a Canadian Abortion Clinic." Journal of Obstetrics and Gynaecology Canada **29**(8): 640-647.

Sethna, C. and M. Doull (2013). "Spatial disparities and travel to freestanding abortion clinics in Canada." Women's Studies International Forum **38**: 52-62.

Shah, I. H., E. Åhman and N. Ortayli (2014). "Access to safe abortion: progress and challenges since the 1994 International Conference on Population and Development (ICPD)." Contraception **90**(6, Supplement): S39-S48.

Shankar, M., K. I. Black, P. Goldstone, S. Hussainy, D. Mazza, K. Petersen, J. Lucke and A. Taft (2017). "Access, equity and costs of induced abortion services in Australia: a cross-sectional study." Australian & New Zealand Journal of Public Health **41**(3): 309-314.

Sharma, S. and K. Guthrie (2006). "Nurse-led telephone consultation and outpatient local anaesthetic abortion: a pilot proiect." Journal of Family Planning and Reproductive Health Care **32**(1): 19-22.

Shearer, J. C., D. G. Walker and M. Vlassoff (2010). "Costs of post-abortion care in low- and middle-income countries." International Journal of Gynecology & Obstetrics **108**(2): 165-169.

Sheldon, S. and J. Fletcher (2017). "Vacuum aspiration for induced abortion could be safely and legally performed by nurses and midwives." Journal of Family Planning & Reproductive Health Care **43**(4): 260-264.

Singh, S. (2010). "Global consequences of unsafe abortion." Womens Health (Lond) **6**(6): 849-860.

Singh, S. and I. Maddow-Zimet (2015). "Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world, 2012: a review of evidence from 26 countries." BJOG: An International Journal of Obstetrics & Gynaecology **123(9)**: 1489-1498.

Sjostrand, M., V. Quist, A. Jacobson, S. Bergstrom and K. O. Rogo (1995). "Socio-economic client characteristics and consequences of abortion in Nairobi." East Afr Med J **72**(5): 325-332.

Sjostrom, S., H. Kopp Kallner, E. Simeonova, A. Madestam and K. Gemzell-Danielsson (2016). "Medical Abortion Provided by Nurse-Midwives or Physicians in a High Resource Setting: A Cost-Effectiveness Analysis." PLoS One **11**(6): e0158645.

Sneeringer, R. K., D. L. Billings, B. Ganatra and T. L. Baird (2012). "Roles of pharmacists in expanding access to safe and effective medical abortion in developing countries: A review of the literature." Journal of Public Health Policy **33**(2): 218-229.

Sommer, M. H. (2010). "Abortion in late Imperial China: routine birth control or crisis intervention?" Late Imp China **31**(2): 97-165.

Souza, Z. C. S. d. N., N. M. F. Diniz, T. M. Couto and S. M. d. A. Gesteira (2010). "Trajectory of women that performed a provoked abortion contained in the discourse of a clandestine procedure." Acta Paulista de Enfermagem **23**(6): 732-736.

Sowmini, C. V. (2013). "Delay in termination of pregnancy among unmarried adolescents and young women attending a tertiary hospital abortion clinic in Trivandrum, Kerala, India." Reproductive Health Matters **21**(41): 243-250.

Suffla, S. (1997). "Experiences of induced abortion among a group of South African women." S Afr J Psychol **27**(4): 214-222.

Suh, S. (2018). "Accounting for abortion: Accomplishing transnational reproductive governance through post-abortion care in Senegal." Global Public Health **13**(6): 662-679.

Sundaram, A., M. Vlassoff, A. Bankole, L. Amanya, T. Onda, C. Kiggundu and F. Mirembe (2013). The economic cost of unsafe abortion: A study of post-abortion care patients in Uganda. XXVII IUSSP Conference. Busan, Republic of Korea.

Sundaram, A., M. Vlassoff, F. Mugisha, A. Bankole, S. Singh, L. Amanya and T. Onda (2013). "Documenting the Individual- and Household-Level Cost of Unsafe Abortion in Uganda." International Perspectives on Sexual & Reproductive Health **39**(4): 174-184.

Sundari Ravindran, T. and S. Fonn (2011). "Are social franchises contributing to universal access to reproductive health services in low-income countries?" Reproductive Health Matters **19**(38): 85-101.

Sutton, B. (2017). "Zonas de clandestinidad y “nuda vida:” Mujeres, cuerpo y aborto." Estudos Feministas **25**(2): 889-902.

Svanemyr, J. and J. Sundby (2007). "The Social Context of Induced Abortions among Young Couples in Côte d'Ivoire." African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive **11**(2): 13-23.

Tewari, S. K., I. R. Pirwany, T. A. Mahmood and R. J. Kelleher (1995). "MIFEPRISTONE IN MID-TRIMESTER TERMINATION OF PREGNANCY - VALUE FOR MONEY." British Journal of Family Planning **21**(1): 7-9.

Thapa, S., S. Neupana, I. Basnett, K. Ramnarayan and E. Read (2012). "Women having abortion in urban Nepal: 2005 and 2010 compared." Kathmandu Univ Med J (KUMJ) **10**(39): 8-13.

Thapa, S., J. Poudel and S. Padhye (2004). "Triaging patients with post-abortion complications: a prospective study in Nepal." J Health Popul Nutr **22**(4): 383-398.

Thomas, C. M., R. Schmid, S. Cameron, C. M. Thomas, R. Schmid and S. Cameron (2010). "Is it worth paying more for emergency hormonal contraception? The cost-effectiveness of ulipristal acetate versus levonorgestrel 1.5 mg." Journal of Family Planning & Reproductive Health Care **36**(4): 197-201.

Thomas, D. (2007). "Abortion Law and the Unregulated Business of Female Sex-Selective Abortions in India." Web Journal of Current Legal Issues(5).

Thomas, J., S. Paranjothy and A. Templeton (2003). "An audit of the management of induced abortion in England and Wales." International Journal of Gynecology & Obstetrics **83**(3): 327-334.

Tousaw, E., R. K. La, G. Arnott, O. Chinthakanan and A. M. Foster (2017). "“Without this program, women can lose their lives”: migrant women’s experiences with the Safe Abortion Referral Programme in Chiang Mai, Thailand." Reproductive Health Matters **25**(51): 58-68.

Tricco, A. C., E. Lillie, W. Zarin and et al. (2018). "Prisma extension for scoping reviews (prisma-scr): Checklist and explanation." Annals of Internal Medicine **169**(7): 467-473.

Tunc, T. E. (2008). "Designs of devices: the vacuum aspirator and American abortion technology." Dynamis **28**: 353-376.

Tupper, C., S. Speed Andrews, C. Tupper and S. Speed Andrews (2007). "Setting up an outpatient service for early medical termination." Journal of Family Planning & Reproductive Health Care **33**(3): 199-202.

Upadhyay, U. D., M. A. Biggs and D. G. Foster (2015). "The effect of abortion on having and achieving aspirational one-year plans." BMC Women's Health **15**(1): 102.

Upadhyay, U. D., A. F. Cartwright and N. E. Johns (2018). "Access to Medication Abortion Among California's Public University Students." Journal of Adolescent Health **63**(2): 249-252.

Upadhyay, U. D., N. E. Johns, R. Barron, A. F. Cartwright, C. Tapé, A. Mierjeski and A. J. McGregor (2018). "Abortion-related emergency department visits in the United States: An analysis of a national emergency department sample." BMC Medicine **16**(1): N.PAG-N.PAG.

Upadhyay, U. D., N. E. Johns, S. L. Combellick, J. E. Kohn, L. M. Keder and S. C. M. Roberts (2016). "Comparison of Outcomes before and after Ohio's Law Mandating Use of the FDA-Approved Protocol for Medication Abortion: A Retrospective Cohort Study." PLoS Medicine **13**(8): 1-23.

Upadhyay, U. D., N. E. Johns, K. R. Meckstroth and J. L. Kerns (2017). "Distance Traveled for an Abortion and Source of Care After Abortion." Obstetrics & Gynecology **130**(3): 616-624.

Upadhyay, U. D., T. A. Weitz, R. K. Jones, R. E. Barar and D. G. Foster (2014). "Denial of Abortion Because of Provider Gestational Age Limits in the United States." American Journal of Public Health **104**(9): 1687-1694.

Vach, T. H., A. Bishop, V. T. Hoa, L. X. Hien, T. D. Chien and T. I. Nguyen (1998). "Potential impact of introducing pregnancy testing into menstrual regulation services in Vietnam." International Family Planning Perspectives **24**(4): 165-169.

Valente, C. (2014). "Access to Abortion, Investments in Neonatal Health, and Sex-Selection: Evidence from Nepal." Journal of Development Economics **107**: 225-243.

Van Bebber, S. L., K. A. Phillips, T. A. Weitz, H. Gould and F. Stewart (2006). "Patient costs for medication abortion: results from a study of five clinical practices." Women's Health Issues **16**(1): 4-13.

Visaria, L., A. Barua and R. Mistry (2008). "Medical Abortion in India: Role of Chemists and Providers." Economic and Political Weekly **43**(36): 35-40.

Vlassoff, M., T. Fetters, S. Kumbi and S. Singh (2012). "The health system cost of postabortion care in Ethiopia." International Journal of Gynecology & Obstetrics **118**: S127-133.

Vlassoff, M., F. Mugisha, A. Sundaram, A. Bankole, S. Singh, L. Amanya, C. Kiggundu and F. Mirembe (2014). "The health system cost of post-abortion care in Uganda." Health Policy & Planning **29**(1): 56-66.

Vlassoff, M., S. F. Musange, I. R. Kalisa, F. Ngabo, F. Sayinzoga, S. Singh and A. Bankole (2015). "The health system cost of post-abortion care in Rwanda." Health Policy & Planning **30**(2): 223-233.

Vlassoff, M., S. Singh, O. Tsuyoshi and T. Onda (2016). "The cost of post-abortion care in developing countries: a comparative analysis of four studies." Health Policy & Planning **31**(8): 1020-1030.

Vlassoff, M., D. Walker, J. Shearer, D. Newlands and S. Singh (2009). "Estimates of health care system costs of unsafe abortion in Africa and Latin America." International perspectives on sexual and reproductive health **35**(3): 114-121.

Vlassoff, M., D. Walker, J. Shearer, D. Newlands and S. Singh (2009). "Estimates of health care system costs of unsafe abortion in Africa and Latin America." International Perspectives on Sexual & Reproductive Health **35**(3): 114-121.

Wainer, J. (2008). "Abortion and the struggle to be good in the 1970s." Australian & New Zealand Journal of Psychiatry **42**(1): 30-37.

Weitz, T. A. and K. Cockrill (2010). "Abortion clinic patients' opinions about obtaining abortions from general women's health care providers." Patient Education & Counseling **81**(3): 409-414.

Whitaker, S. (2011). "The Impact of Legalized Abortion on High School Graduation through Selection and Composition." Economics of Education Review **30**(2): 228-246.

White, K., K. Adams and K. Hopkins (2019). "Counseling and referrals for women with unplanned pregnancies at publicly funded family planning organizations in Texas." Contraception **99**(1): 48-51.

Whittaker, A. (2002). "Reproducing inequalities: abortion policy and practice in Thailand." Women & Health **35**(4): 101-119.

Wiebe, E. R. and P. Janssen (2000). "Time lost from work among women choosing medical or surgical abortions." Women's Health Issues **10**(6): 327-332.

Wilder, E. I. (2000). "Socioeconomic and Cultural Determinants of Abortion among Jewish Women in Israel." European Journal of Population / Revue Européenne de Démographie **16**(2): 133-162.

Winikoff, B., D. Hassoun and H. Bracken (2011). "Introduction and provision of medical abortion: a tale of two countries in which technology is necessary but not sufficient." Contraception **83**(4): 322-329.

Winocur, M. (2006). "Paulina, un caso paradigmático." Debate Feminista **34**: 185-205.

Woog, V., S. Singh and A. Bankole (2007). A review of the evidence on the cost of post-abortion care in Africa. Fertility regulation behaviors and their costs: contraception and unintended pregnancies in Africa and eastern Europe & central Asia. E. Lule, S. Singh and S. A. Chowdhury. Washington, World Bank**:** 40-92.

Wu, W.-J., S. Maru, K. Regmi and I. Basnett (2017). "Abortion Care in Nepal, 15 Years after Legalization
Gaps in Access, Equity, and Quality." Health and Human Rights **19**(1): 221-230.

Wu, W.-J., S. Maru, K. Regmi and I. Basnett (2017). "Abortion Care in Nepal, 15 Years after Legalization: Gaps in Access, Equity, and Quality." Health and Human Rights **19**(1): 221-230.

Xia, W., S. She and T. H. Lam (2011). "Medical versus surgical abortion methods for pregnancy in China: a cost-minimization analysis." Gynecol Obstet Invest **72**(4): 257-263.

Yavangi, M., M. R. Sohrabi and S. Riazi (2013). "Out of pocket payment for obstetrical complications: a cost analysis study in iran." Int J Prev Med **4**(11): 1296-1303.

Zamberlin, N., M. Romero and S. Ramos (2012). "Latin American women's experiences with medical abortion in settings where abortion is legally restricted." Reprod Health **9**(1): 34.

Zamberlin, N., M. Romero and S. Ramos (2012). "Latin American women's experiences with medical abortion in settings where abortion is legally restricted." BMC Reproductive Health **22(9)**(9(34)): 11.