The decision-making experiences of women who legally aborted: A meta-ethnography

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Abstract

Background. Abortion is one of the most common gynaecological procedures. It is related to personal, social, and economic reasons under a legal term that is recognised as a common sexual and reproductive right in most of countries. However, making the decision to abort is complex, because it is politicised and is often framed in public discourse related to moral or ethical issues beyond women's experiences. Therefore, it is subject to medical criteria, religious evaluations, and sociological analysis.

Purpouse. The aim of this synthesis of qualitative studies was to synthesise the decision-making experiences of women who legally aborted.

Research design and method. The Noblit and Hare's interpretive meta-ethnography was conducted, and it was written in accordance with the eMERGe meta-ethnography reporting guidance. Ten studies met the research objective and inclusion criteria, after a comprehensive systematic search strategy in five databases.

Findings. The metaphor "The wrestling between why and what will happen next" and three themes emerged from the data analysis: (1) Forces that incite the arm wrestling; (2) Facing social stigma; and (3) Defeated by a greater rival. The metaphor provided interpretive experiences of the moral conflict experienced by women who decided to have an abortion and emerged from the confrontation of the reasons why they decided to abort and the social repercussions that making the decision entails. The result of the struggle was loneliness and vulnerability.

Conclusión. The lines of action impact policy makers, the media, and health professionals. Actions should focus on the de-stigmatisation and normalisation of abortion, the use of appropriate language, and the training and sensitisation of health professionals.

Keywords

Decision Making, Gender Role, Induced Abortion, qualitative research, women

Introduction

Worldwide, abortion is among the commonest gynaecological procedures with nearly one-third of women having at least one abortion during their reproductive years.[1,2] About 25% of pregnancies ended in abortion in 2010–2014, or 56 million induced abortions each year during this period.[3] Although the global rate of unwanted pregnancies has decreased, the proportion of unwanted pregnancies that end in abortion has increased.[4]

The issue of abortion is both timely and highly relevant. Women's possibilities for considering termination of pregnancy safely and legally vary. In some countries women have free access to abortion whereas in others it is penalised. Women's access to abortion has been challenged in various parts of the world. For example, after a Zika outbreak many pregnant women in Latin American countries sought abortions out of concern of how the virus could affect the developing foetus. In Poland, mass demonstrations by women succeeded in reversing proposed legislation banning abortions.[5] Legality is an important issue since it dictates whether women have access to either safe or unsafe abortions.

Many women who unintentionally get pregnant and want to terminate their pregnancy take a risk in doing so when safe options are unavailable. Factors which drive unsafe abortions include existence of restrictive legislation, the conscientious objection of health professionals, infrastructure and equipment requirements, high costs, and the stigmatisation of the process.[6] Unsurprisingly, there is disparity in access to sexual and reproductive health care between high- and low-income countries.[4] In many high-income countries, free and accessible abortions for women are available which resulted from political victories initiated by the women's movement. General themes of this movement

are that every woman has the right to make decisions about her body and a woman's decision should not be questioned.[7]

The voluntary interruption of pregnancy is related to personal, social, and economic reasons and recognised in legal terms as common sexual and reproductive rights in many countries. Dealing with voluntary abortion is somewhat complex because, in many cultural contexts, it tends to be socially stigmatised and subject to medical criteria, religious evaluations, and sociological analysis.[8] Abortion is politicised and is often framed in public discourse in more abstract terms and debated as a moral or ethical issue that moves away from women's experiences. Furthermore, it tends to be underrepresented, misrepresented, or over-associated with negative outcomes in the media and popular culture.[9] Despite increased research on this topic in recent years, a comprehensive analysis that focuses on the experiences of women in making the decision to abort has not been conducted.

Aim

The aim of this paper was to synthesise the available body of qualitative work regarding the decision-making experiences of women who legally aborted.

Methods

An interpretive form of knowledge synthesis based on the seven steps outlined by Noblit & Hare (1988)[10] was performed. The objective of this meta-ethnography was to enrich human discourse by translating individual qualitative studies into one another through re-interpretation and transformation of their analytic and theoretical concepts. The eMERGe reporting guidance[11] was followed to improve the quality, transparency, and comprehensiveness of the study (See Supplementary File 1).

Search methods

A comprehensive systematic search strategy was undertaken in December 2020 by SFB and GRG. The search strategy was developed according to the phenomenon of interest (legal abortion), the purpose of the study or evaluation (experiences), the sample

(women), and the type of research (qualitative research). Search terms and medical subject headings were combined using OR and AND, and truncations were utilised to create a broader search. Inclusion criteria included: original qualitative articles or mixed articles; the focus must be on the experience of women who legally aborted; articles written in English, Spanish, or Portuguese; and the publication years 2015–2020. Gray literature, discussion articles, or review papers were excluded.

Search outcomes

The Preferred Reporting Items for Systematic-Reviews and Meta-Analyses flow diagram[12] (Figure 1) describes the filtering process. One thousand and fifty-eighth records were identified in PubMed, Scopus, CINAHL, PsycINFO, and Web of Sciences databases. Following the removal of 501 duplicate results, 75 articles were selected after evaluation of the title and abstract. The final sample of 10 articles resulted after full readings. The selection process was conducted by the SFB and GRG although meetings of all authors were held to reach consensus.

Quality appraisal

Each paper was critically appraised using the Critical Appraisal Skills Program (CASP) tool.[13] General assessment indicated the articles were of high quality regarding their goals, designs, analyses, and results (Table 1). SFB and GRG performed the evaluation independently and the results of the evaluations were discussed with MJMF and CC.

Data extraction and synthesis

A critical reading of the 10 included studies was performed where initial data abstraction involved describing each study's relevant information to provide context (Table 2).

Step 4 was carried out by GRG and supervised by SFB, MJMF, and CC. The analysis began with the article containing the most data.[15] First- (participants' quotations) and second-order (authors' interpretations) constructs[24] were extracted from each article and recorded in a table. The table contained the constructs, a brief description of each construct, and the line-by-line code. The meaning units and codes were discussed in the research group and intra- and inter-study comparisons were made in search of similarities

and contrasts. This led to the formation of new concepts and the adoption of existing concepts. Table 2 was used as context for the comparisons.

The translation tables allowed incorporation of the findings from the studies into one another by analogous (concepts in one study can incorporate those of another) and refutational (concepts in different studies contradict one another) translations to form new third-order concepts[24] (step 5). The synthesis process was inductive and involved reflective discussion during writing of the findings (step 6). A lines-of-argument synthesis based on the metaphorical themes was created through an in-depth, back-and-forth, iterative analysis process between the translations and the articles. Discussion and consensus sessions were held periodically by the entire team of authors. The findings of this synthesis were evaluated using the Confidence in the Evidence from Reviews of Qualitative research (CERQual) tool[25] (See Supplementary File 2).

Results

An analysis of 10 primary articles was conducted which focused on the experiences of adult women who decided to abort through legal channels. Data was obtained from a total of 224 women from United States, Canada, China, Brazil, Argentina, Sweden, Kenya and India. Qualitative research designs were exploratory and descriptive, and interviews were mainly in-depth or semi-structured, face-to-face or virtual, and individual or in focus groups (Table 2).

The metaphor "The wrestling between why and what will happen next" emerged from reciprocal and refutational translations and reflects interpretive experiences of women who decided to terminate their pregnancy voluntarily and through legal channels. This metaphor is based on 3 themes: (1) Forces that incite arm wrestling; (2) Facing social stigma; and (3) Defeated by a greater rival. This representation describes the struggle (moral conflict) between the conditions that trigger decision-making (*why a decision was made*) and the stigmatisation context of deciding to abort (*what will happen next*). Vulnerability and loneliness result from this conflict.

Confidence in the Evidence from Reviews of Qualitative research assessment[25] showed high confidence on one theme and moderate confidence on the remaining two. This implies that the results are a reasonable representation of the phenomenon of interest (See Supplementary File 2).

Forces that incite arm wrestling

This theme summarises the reasons why women made the decision to abort. Among them, personal conditions stood out. The lack of time due to other responsibilities or a low economic level, which made it difficult to care for a new-born, were the most outstanding aspects. For this reason, they referred to the pregnancy as wrong or untimely due to external factors which affected them in that moment of their lives.[14,15,17,20]

> "You know, I had failed in the civil service exam, so I didn't have a job at that time. I hadn't got married yet, so I didn't have any financial ability to raise the baby. I needed to depend on my parents at that time. My father was angry that I could not pass the exam, and if he knew that I was pregnant, he would consider that a shame for our family."[17]

Some women based their decision on their emotional situation in reference to their partner, their young age, their religious beliefs, or having gone through a traumatic situation such as a sexual assault.[15,17,18,21,23] Being single was also one of the elements expressed by the participants.[23]

Women victims of an assault highlighted that pregnancy was the most painful outcome they could cope with. So, making that decision meant letting go of the reminder of that event,[18,22] as one woman reported:

> *"I will not say that I do not feel sorry for the child, I have. But at that moment I had to think about myself, I cannot carry on a pregnancy like this, feeling a child move inside me, watching my body change, feeling the pain of childbirth, knowing that it's like an invader inside of me. I do not know how I could deal with it [...], I could not look at the child and not remember. I also do not know if I could send it to adoption."*[18]

Their family situation was also a factor that influenced their decision. The existence of previous children and the lack of time to take care for them was an example,[14,15,17,20] as reflected in this quotation:

> *"My husband wanted me to give birth, but my parents are taking care of my child [the one she already had]. I think that it would be tough for them to babysit another one. And my husband's family didn't agree to raise this one if I give birth to it. I had many arguments with my husband over this issue."*[17]

Some women indicated that current family conditions were incompatible with the arrival of a baby. Many were responsible for the care of their sick parents or husbands since in most communities the role of domestic caregiver fell on women.[17]

Facing social stigma

The struggle between personal needs and the contextual implications under which they lived led to an experience marked by social stigma. The pregnancy termination process was defined as a unique, unrepeatable, and devastating event. A large number of the participants based their testimonies on the fear, guilt, and shame they felt which caused a state of anxiety. In many cases, although their personal situation was not ideal, the decision was based on being repudiated due to their family or social environment and being judged in the future as a consequence of the decision they had made.[14,15,17–20,22]

> *"It's embarrassing. Because … I knew a lot of people in there …. And I feel irresponsible. Because that's something you want to be discreet, not [involve] everybody in the neighbourhood."*[15]

Some women stated that their suffering was compounded by mistreatment or contempt on the part of health professionals and the bureaucracy of the care process that resulted in a high number of appointments. The lack of information on the process also caused a point of uncertainty in them where they did not find the necessary security to carry out the process of pregnancy termination in the least traumatic way.[14–16,18,20,22]

Under the personal cost and moral dilemma that the decision entailed, they expected more humane support with which to feel less judged. However, many women experienced an attitude based on disrespect, unprofessionalism, and lack of empathy. Those who received comprehensive, empathetic, and sensitive care experienced feelings of security and

comfort.[15,18] The loneliness they felt and the coldness with which they were treated on some occasions led the women to suffer beyond the decision they were making.[14–16,22,23]

> *"I felt like the doctor was judging the person, my character … he didn't treat me like a person, an individual. He treated me like, 'Get on up on the table. Let's get this over with because you ain't nothing.' You know, 'Look at you…you're paying $500 to get rid of something you made.' That's the way I felt …. At least [he could have] assured me that he know[sic] that what I'm going through is not easy. I think that's what I was looking for."*[15]

For these reasons many women indicated that if they had to go through the pregnancy termination process again, they would carry it out in a different way. They reported that, if they had the option, they would prefer sedation so that the dehumanising acts would not increase the emotional pain. They also indicated a preference for a procedure based on medication where they could find the autonomy and security that they were seeking.[14,15]

Defeated by a greater rival

The decision to abort was a moral conflict for the women. The women had personal reasons for their decision but they faced the social context and resultant feelings such as fear, guilt, and shame. Many women felt lonely and vulnerable during the process due to a limited support network and a fear regarding the repercussions of expressing their decision to abort.[15–19,21–23]

> *"And the hardest thing was because I didn't want to tell anyone, we feel very ashamed. The feeling is strange. We are very ashamed; we do not want to tell. We want to solve it, and if the pregnancy hadn't happened, no one would have known."*[22]

The decision-making process was difficult and they had to carefully weigh many factors. The most important component in analysing their decision was based on the fact that for many of them the pregnancy occurred at the wrong time, causing them anguish and despair. This is reflected by one of the women in the study[15]:

> *"I had to make a real life-changing decision. I mean, it's not easy … I don't think we just get up to just say, okay, today, you know what, I'm going to … kill a baby. You don't think like that. You look at all the things…. and I just didn't want to bring the kids in like that."*

Women reported being socially criticised which generated greater emotional distress. This additional suffering derived from feeling judged by the rest of the community and the contempt experienced from health professionals. The critical reactions they experienced made them feel unsupported, lonely, and misunderstood. The lack of intimacy and privacy triggered an emotionally complex experience during the process.[14,15,17]

The fear of being judged was the greatest counterweight to the reasons for abortion. The vast majority of women expressed being scared by the social consequences to which they could be subjected to. Many of them verbalised the anguish this caused them to think that their decision could affect future marriages or the way in which the rest of society could see them after ending their pregnancy in this way.[14,15,17]

Conversely, for those women who had suffered a sexual violation, the abortion was experienced as a relief since the pregnancy was a reminder of a permanent and open wound. Some of the interviewees defined the feelings experienced during the experience as strengthening. They verbalised being convinced of the decision they had made since they defined it as the correct one despite the social attitudes that surrounded them. After these experiences, many found peace and relief in their decision, metaphorically representing it as a victory in the fight against social stigma.[18,22]

Discussion

After analysis of 10 primary articles included in this meta-ethnography, the metaphor "The wrestling between why and what will happen next" emerged. This metaphor refers to the experiences of women who decide to abort under legal channels. This "struggle" represents the moral conflict that arises during decision-making and is influenced by personal reasons and the social stigma that surrounds abortion. Thus, we find an emotional disparity that leads to an experience based on vulnerability and loneliness during the abortion process.

Legal access to abortion varies globally, from more restrictive (where abortion is totally prohibited or allowed only to save a woman's life) to less restrictive (where there are no restrictions on the reason for termination of pregnancy). The Centre for Reproductive Rights[26] reported that 60% of women live in countries where abortion is allowed without restrictions or for a wide variety of reasons and 27% live in countries where abortion was generally prohibited. However, legal prohibitions on abortion do not prevent women from obtaining it. In fact, abortion rates appear to be slightly higher (37 abortions per 1000 women between 2010 and 2014) in countries where abortion is prohibited or severely restricted than in countries where it is available on demand (34 per 1000 women).[6] This finding underscores the fundamental importance of abortion in the reproductive lives of women around the world. However, women's access to safe and affordable abortion differs substantially from region to region and access to abortion has often proven to be precarious.[5]

Legal regulations are not the only factors affecting women's access to abortion, their agency and autonomy to make decisions about abortion, and their abortion experiences: cultural norms and values regarding abortion also have a big role.[5] Some societies, such as Cuba, Japan, and some post-Soviet countries, have sometimes been characterised as having a "culture of abortion".[27,28] Some religions raise moral objections to the termination of a pregnancy through induced abortion, and beyond personal moral dilemmas, opposition to abortion by institutionalised religions is sometimes a major barrier to access.[5] Furthermore, the media has a role in shaping and being influenced by public discourse, understandings, and attitudes about abortion.[9] Previous literature has delved into the reasons women give for seeking an abortion. However, this process is much more complex and ambivalent, where reasons tend to be combined, can often be contingent, and are sometimes informed as part of a woman's assessment of her best course of action.[29,30]

This context is a breeding ground for the stigmatisation of abortion. Stigma is a complex concept[31] that is palpable in our results. The fact that access to abortion is so limited, that few providers are trained and prepared to provide safe abortion services, and that abortion laws are part of the criminal code in many countries, could be more than a binary concept of cause and consequence and where the intensity of abortion stigmatisation can fluctuate depending on how access to legal abortion is restricted.[32]

Along with stigma, other social processes emerge such as prejudice and discrimination.[33,34] Research on health stigma has shown that discrimination is a consequence of stigma.[35] At the root of discrimination is a difference in power. In abortion, women who are denied care, who go to untrained providers, or who are incarcerated for having an abortion are discriminated against. However, there are groups of women who experience stigma but not discrimination, although they may experience internalised stigma.[32] This leads to negative self-evaluations, reputational concerns, and negative social interactions that can lead to cheating on a partner, and social isolation, thus alienating women from the socio-emotional support they need.[36] In many cases the abortion is hiding to avoid negative judgments from friends, family, community or society, leading to social isolation, loneliness or repression of emotions.[3]

Our findings show vulnerability as a result of stigma. This concept recognises the complex interactions between individual and environmental forces, where the presence or absence of social support is associated with a better or worse adaptive response.[37] The principle of vulnerability is understood as a sum of everything that is experienced throughout existence. However, in our results, not all people are characterised by the same threshold of intensity of feeling. Each individual has a different degree of suffering which will lead to unique behaviours or experiences. This will depend on the social contexts in which the experience takes place, access to information, the availability of resources, and the institutional dimension under which they are found.[38]

Among the reasons that may explain the stigma of abortion are the attribution of personality to the foetus, legal restrictions in certain countries that reinforce the notion that abortion is morally wrong, the belief that abortion is a dirty or unhealthy procedure, and the stigmatisation of the procedure by anti-abortion forces as a deliberate tactic.[39] In addition, a transversal gender component can be added. For example, Kumar et al. (2009)[40] show that abortion violates two fundamental ideals of femininity: promoting motherhood and sexual purity. The desire to be a mother is essential to be labelled as a "good woman".[41] Furthermore, the idea that women should have sex just to procreate reinforces the idea that sex for pleasure is frowned upon for women. Abortion, therefore, supposes that a woman has had "non-procreative" sex and seeks to exercise control over her own reproduction and sexuality, which threatens existing gender norms.[40] The stigmatisation that women experience may not stem from the act of aborting a foetus;

rather, it may be associated with having conceived an unwanted pregnancy, of which abortion is a marker. Stigma may be associated with feelings of shame about sexual practices, lack of effective contraception, or misplaced faith in a disappointing partner.[42] Similarly to other research,[36] our results show that abortion stigma is the consequence of a breach of the expectations of others and of one's own moral code. In response, women offered justifications and excuses for their actions and tried to avoid negative judgments through secrecy and selective disclosure. Specifically, our results reflect that their justifications were based on the socially imposed image of normative femininity. Caring for other children, or being the caregivers of sick relatives, were reported. The literature establishes the relationship between a woman's sense of morality and the decisions she makes as a caregiver, since consideration of the well-being of others is a central imperative.[43]

Implications for practice and research

Based on these findings, the following lines of action are proposed. The de-stigmatisation of abortion and its normalisation are required. This requires the cooperation of policy makers and the media. However, in accordance with other studies, this normalisation cannot be directed at the rationalisation of abortion since in the long term it would not be possible to interrupt the narrow constructions of gender that stigma fosters. The message must be careful, avoiding the endorsement of "justified" causes versus "unfounded" ones. The discourse, therefore, should seek to problematise the expectations placed on women, deconstruct stigmatising labels, and establish parallels between abortion and other experiences that transgress gender ideals. Training and sensitisation of health professionals are required. This entails sharing the experiences of women, training in the provision of comprehensive care, and strengthening virtues such as compassion, empathy, and understanding. Traditionally, Western scientific medicine, in the face of the alleged rationality, objectivity, and scientific neutrality, has produced and reproduced hegemonic social values that have served to justify and legitimise a situation of inferiority and discrimination against women.

Strengths and limitations

The strengths of this study are based on the use of a qualitative methodology. This meta-ethnography helps to identify research gaps, informs the development of primary studies, and provides evidence for developing, implementing, and evaluating health interventions. Furthermore, it allows for conceptual development and provides a novel contribution to the literature beyond narrative and systematic literature reviews. The exhaustive search of studies carried out using English, Spanish, and Portuguese as language filters has allowed the incorporation of articles from different geographical contexts. The inclusion of articles published in the last 5 years could be seen as a limitation but taking into account scientific advances on this topic and recent legal reforms, we consider this selection justified. This meta-ethnography study followed the original approach developed by Noblit and Hare (1988)[10] and the eMERGe reporting guidelines,[11] and our findings were evaluated using CERQual.[25] These elements contribute to forming robust evidence as a basis for political and practical decision-making, and to improve the trustworthiness and applicability of the results in the clinical setting and future research. Moreover, the included studies were evaluated using the CASP tool.[44]

As a limitation, we highlight that most of the studies come from similar contexts, although with particularities. In addition, only women who have chosen abortion within a legal framework were included. It would be interesting to know the experiences of women who clandestinely abort, where the concern for the health security of women is added the social stigma.

Conclusion

The metaphor "The wrestling between why and what will happen next" represents the experiences of women who decide to legally abort. The emergent moral conflict is a consequence of the explanations and justifications that women use to support their decision and the social stigma that surrounds the termination of pregnancy. This results in loneliness and vulnerability for women. The lines of action should be directed towards the de-stigmatisation and normalisation of abortion by addressing the issue in the media using appropriate language as well as better training and sensitisation of health professionals.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Xunta de Galicia (Competitive Reference Group ED431C-2018/38), Spain.

Author contributions

All authors have fulfilled the conditions required for authorship. Conceptualization, SFB, MJMF, GRG and CC; methodology, SFB, GRG, and MJMF; formal analysis, SFB, GRG, MJMF, and CC; investigation, SFB and GRG; resources, SFB, MJMF, and CC; data curation, SFB; writing—original draft preparation, SFB; writing, review and editing, SFB, MJMF, CC, and GRG; visualization, SFB, MJMF, CC, and GRG; supervision, SFB, MJMF and CC.

References

1. Sedgh G, Singh S, Shah IH, et al. Induced abortion: incidence and trends worldwide from 1995 to 2008. *The Lancet* 2012; 379: 625–632.
2. Jones RK, Kooistra K. Abortion incidence and access to services in the United States, 2008. *Perspect Sexual Reproductive Health* 2011; 43: 41–50.
3. Kjelsvik M, Sekse RJT, Moi AL, et al. Women's experiences when unsure about whether or not to have an abortion in the first trimester. *Health Care Women Int* 2018; 39: 784–807.
4. Bearak J, Popinchalk A, Ganatra B, et al. Unintended pregnancy and abortion by income, region, and the legal status of abortion: estimates from a comprehensive model for 1990–2019. *Lancet Glob Health* 2020; 8: e1152–e1161.
5. Marecek J, Macleod C, Hoggart L. *Abortion in Legal, Social, and Healthcare Contexts*. London, England: SAGE Publications Sage UK, 2017.
6. Sedgh G, Ashford LS, Hussain R. *Unmet Need for Contraception in Developing Countries: Examining Women's Reasons for Not Using a Method*, 2016.
7. Huntington AD. Working with women experiencing mid-trimester termination of pregnancy: The integration of nursing and feminist knowledge in the gynaecological setting. *J Clin Nur* 2002; 11: 273–279.

8. Miranda Lucas MJ, d'Argemir DC. Discourses of health professionals and voluntary women about abortion. *Rev Bioetica Derecho* 2016; 38: 37.
9. Purcell C, Hilton S, McDaid L. The stigmatisation of abortion: a qualitative analysis of print media in Great Britain in 2010. *Cult Health Sex* 2014; 16: 1141–1155.
10. Noblit GW, Hare RD. *Meta-ethnography: Synthesizing Qualitative Studies*. Newbury Park: sage, 1988.
11. France EF, Cunningham M, Ring N, et al. Improving reporting of meta-ethnography: the eMERGe reporting guidance. *BMC Med Res Methodol* 2019; 19: 25.
12. Page MJ, McKenzie JE, Bossuyt PM, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *Int J Surg* 2021; 88: 105906.
13. Long HA, French DP, Brooks JM. Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Res Meth Med Health Sci* 2020; 1: 31–42.
14. Aiken AR, Johnson DM, Broussard K, et al. 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* 2018; 44: 181–186.
15. Altshuler AL, Ojanen-Goldsmith A, Blumenthal PD, et al. A good abortion experience: a qualitative exploration of women's needs and preferences in clinical care. *Soc Sci Med* 2017; 191: 109–116.
16. Cano JK, Foster AM. They made me go through like weeks of appointments and everything": documenting women's experiences seeking abortion care in Yukon territory, Canada. *Contraception* 2016; 94: 489–495.
17. Ciren B, Fjeld H. Pragmatics of everyday life: a qualitative study of induced abortion among Tibetan women in Lhasa. *Health Care Women Int* 2020; 41: 777–801.
18. de Medeiros Guimarães AC, da Silva Ramos K. Feelings of women in the experience of legal abortion due to sexual violence. *J Nurs UFPE/Revista de Enfermagem UFPE* 2017; 11(6): 2349–2356.
19. Johnson MC. *Ni la pareja, ni la familia, ni la Iglesia deciden por mí": la experiencia del aborto en mujeres Católicas*. Sexualidad, Salud y SociedadRio de Janeiro), 2018, pp. 51–70.
20. Kilander H, Berterö C, Thor J, et al. Women's experiences of contraceptive counselling in the context of an abortion–an interview study. *Sex Rep Healthc* 2018; 17: 103–107.
21. LaRoche KJ, Foster AM. Exploring Canadian women's multiple abortion experiences: implications for reducing stigma and improving patient-centered care. *Women's Health Issues* 2018; 28: 327–332.

22. Machado CL, Fernandes AMdS, Osis MJD, et al. Gravidez após violência sexual: vivências de mulheres em busca da interrupção legal. *Cadernos de Saúde Pública* 2015; 31: 345–353.
23. Makleff S, Wilkins R, Wachsmann H, et al. Exploring stigma and social norms in women's abortion experiences and their expectations of care. *Sex Rep Health Matt* 2019; 27: 50–64.
24. Schütz A. Collected papers, Vol. 1. The Hague: Martinus Nijhoff, 1962.
25. Lewin S, Glenton C, Munthe-Kaas H, et al. Using qualitative evidence in decision making for health and social interventions: an approach to assess confidence in findings from qualitative evidence syntheses (GRADE-CERQual). *PLoS Medicine* 2015; 12: e1001895.
26. Rights CfR. *The World's Abortion Laws*, 2021, https://maps.reproductiverights.org/worldabortionlaws.
27. Bélanger D, Flynn A. The persistence of induced abortion in Cuba: exploring the notion of an "abortion culture". *Stud Fam Plann* 2009; 40: 13–26.
28. Karpov V, Kääriäinen K. Abortion culture" in Russia: its origins, scope, and challenge to social development. *J Appl Sociol* 2005; os-22: 13–33.
29. Lie ML, Robson SC, May CR. Experiences of abortion: a narrative review of qualitative studies. *BMC Health Serv Res* 2008; 8: 150.
30. Kirkman M, Rowe H, Hardiman A, et al. Reasons women give for abortion: a review of the literature. *Arch Womens Ment Health* 2009; 12: 365–378.
31. Kumar A. Everything is not abortion stigma. *Women's Health Issues* 2013; 23: e329–e331.
32. Shellenberg KM, Moore AM, Bankole A, et al. Social stigma and disclosure about induced abortion: results from an exploratory study. *Glob Public Health* 2011; 6: S111–S125.
33. Stuber J, Meyer I, Link B. Stigma, prejudice, discrimination and health. *Soc Sci Med* 2008; 67: 351–357.
34. Phelan JC, Link BG, Dovidio JF. Stigma and prejudice: one animal or two? *Soc Sci Med* 2008; 67: 358–367.
35. Bell K, Salmon A, Bowers M, et al. Smoking, stigma and tobacco 'denormalization': Further reflections on the use of stigma as a public health tool. A commentary on Social Science & Medicine's Stigma, Prejudice, Discrimination and Health Special Issue (67: 3). *Soc Sci Med* 2010; 70: 795–799.

36. Cockrill K, Nack A. I'm not that type of person": managing the stigma of having an abortion. *Deviant Behav* 2013; 34: 973–990.
37. Monteiro SRdRP. O marco conceitual da vulnerabilidade social. *Sociedade Em Debate* 2011; 17: 29–40.
38. Angel S, Vatne S. Vulnerability in patients and nurses and the mutual vulnerability in the patient–nurse relationship. *J Clin Nurs* 2017; 26: 1428–1437.
39. Norris A, Bessett D, Steinberg JR, et al. Abortion stigma: a reconceptualization of constituents, causes, and consequences. *Women's Health Issues* 2011; 21: S49–S54.
40. Kumar A, Hessini L, Mitchell EM. Conceptualising abortion stigma. *Cult Health Sex* 2009; 11: 625–639.
41. Russo NF. The motherhood mandate. *J Soc Issues* 1976; 32: 143–153.
42. Furedi A. Issues for service providers: a response to points raised. *J Med Ethics* 2001; 27: ii28–ii32.
43. Lewis L. Epistemic authority and the gender lens. *Sociol Rev* 2007; 55: 273–292.
44. Skills CA, Programme. *CASP Checklist: 10 Questions to Help You Make Sense of a Qualitative Research*, 2018, https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf.

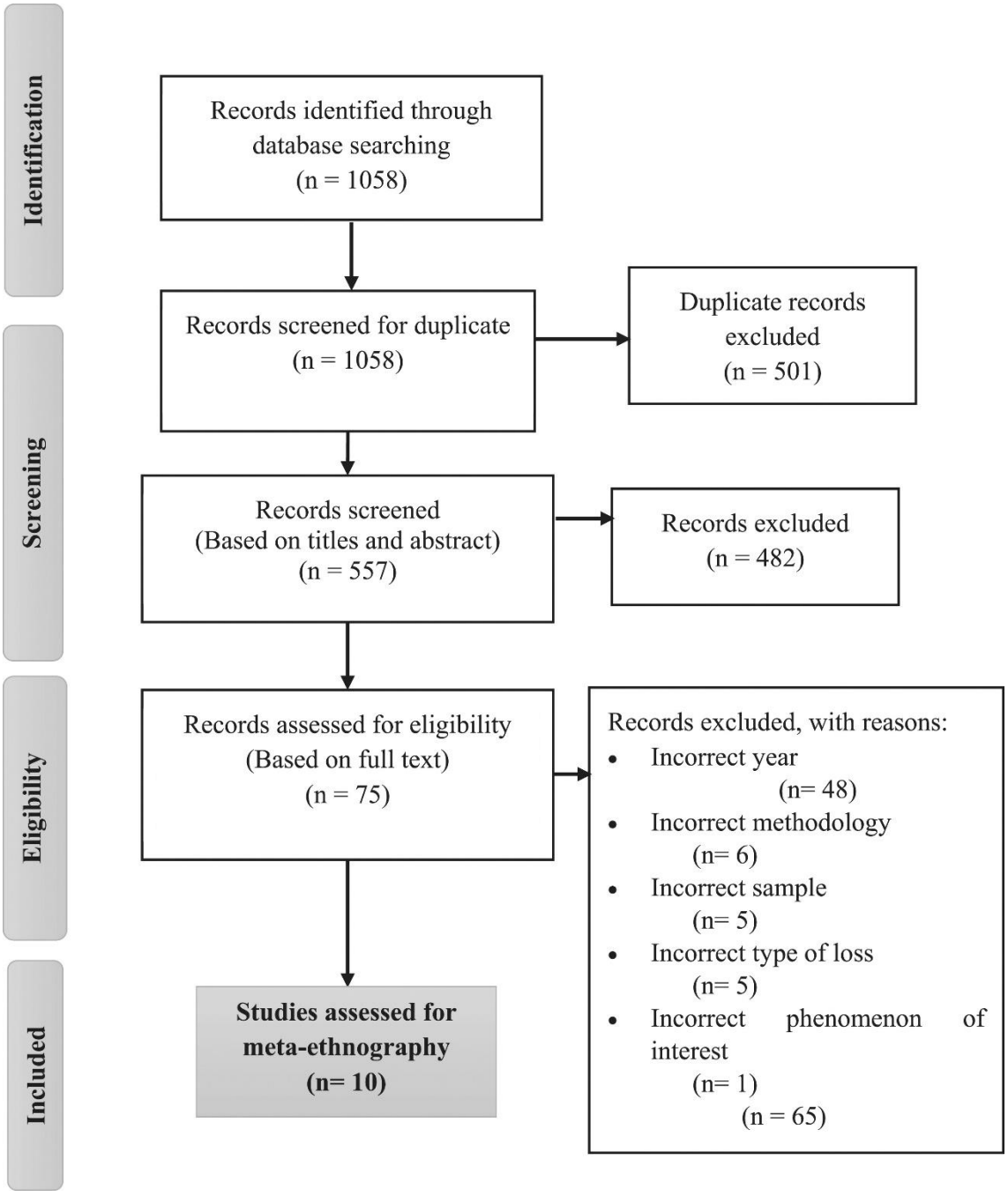

Figure 1. Preferred reporting items for systematic-reviews and meta-analyses flowchart.

Table 1. Quality assessment of included studies.

Articles	Questions									
	1	2	3	4	5	6	7	8	9	10
Aiken et al. (2018)[14]	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
Altshuler et al. (2017)[15]	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
Cano & Foster (2016)[16]	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
Ciren & Heidi Fjeld (2019)[17]	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
De Medeiros Guimarães & Da Silva (2017)[18]	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
Johnson (2018)[19]	✓	✓	-	✓	✓	✗	✓	✓	✓	✓
Kilander et al. (2018)[20]	✓	✓	✓	✓	✓	-	✓	✓	✓	✓
LaRoche et al. (2018)[21]	✓	✓	✓	✓	✓	-	✓	✓	✓	✓
Machado et al. (2015)[22]	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓
Makleff et al. (2019)[23]	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓

✓ Yes – Unclear ✗ No; Critical appraisal questions: (1) Was there a clear statement of the aims of the research? (2) Is the qualitative methodology appropriate? (3) Was the research design appropriate to address the aims of the research? (4) Was the recruitment strategy appropriate? (5) Were the data collected in a way that addressed the research issue? (6) Has the relationship between researcher and participants been adequately considered? (7) Have ethical issues been taken into consideration? (8) Was the data analysis sufficiently rigorous? (9) Is there a clear statement of findings? (10) How valuable is the research?

Table 2. Characteristics of included studies.

Authors, (year), Location	Methods	Aim	Sample	Trimester when abortion is performed	Data collection method	Key findings
Aiken et al. (2018)[14] USA	Qualitative study	(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	38 women	-	Semi-structured in-depth interviews	(1) self-managing a medical abortion at home using online telemedicine can be a preference over travelling abroad to access abortion services; (2) regardless of the pathway chosen, women experience a lack of pre- and post-abortion support in the Irish healthcare system; (3) feelings of desperation while searching for safe abortion care can lead to considering or attempting dangerous methods; and (4) Irish abortion law and attitudes have impacts beyond physical health considerations, engendering shame and stigma
Altshuler et al. (2017)[15] USA	Qualitative study	To examine ways in which women's needs and preferences in abortion care differ from intrapartum care	24 women	First trimester	Semi-structured intensive interviews	Three themes emerged: to be affirmed as moral decision-makers, to be able to determine their degree of awareness during the abortion, and to have care provided in a discreet manner to avoid being judged by others for having an abortion. These findings suggest that some women have distinctive emotional needs and preferences during abortion care, likely due to different circumstances and socio-political context of abortion

Table 2. Characteristics of included studies.

Authors, (year), Location	Methods	Aim	Sample	Trimester when abortion is performed	Data collection method	Key findings
Cano & Foster (2016)[16] Canada	Qualitative study	To document women's experiences seeking and obtaining abortion services while residing in Yukon Territory, identify financial and personal costs and explore avenues through which services could be improved	16 women	-	In-depth semi-structured phone interviews	Women in the Yukon face a number of barriers to accessing timely abortion care. Creating a more streamlined and transparent process, offering abortion a "medical home" and allowing women to self-refer could alleviate existing barriers. The introduction of mifepristone promises to offer women a choice with respect to abortion procedure and also has the potential to reduce geographic disparities and wait times and enhance privacy. Developing and evaluating creative service delivery models, including telemedicine provision, appears warranted
Ciren & Heidi Fjeld (2019)[17] China-Norway	Qualitative study	To explore the experiences and perceptions of 16 Tibetan women who had undergone induced abortions, and five healthcare workers from hospitals in Lhasa in which abortions are carried out	16 women	-	Semi-structured interview	The abortion decision-making process involves complex emotions in the moral space between pragmatics and sociocultural values, also in the cases of medically and legally safe abortions

Table 2. Characteristics of included studies.

Authors, (year), Location	Methods	Aim	Sample	Trimester when abortion is performed	Data collection method	Key findings
De Medeiros Guimarães & Da Silva (2017)[18] Brazil	Descriptive and exploratory qualitative study	To know the feelings presented by women victims of sexual violence who experienced the abortion provided by law	10 women	-	Semi-structured interview	Feelings about violence, pregnancy diagnosis, decision making about abortion and after this procedure were identified. Legal abortion was the best alternative, according to the study participants
Johnson (2018)[19] Argentina	Qualitative methodology and biographical approach	This work analyses, through narratives of Catholic women who aborted, the ways in which they negotiate this experience with their religious identity	10 women	-	Interview	The diverse ways in which abortion and religiosity are articulated in each biography were explored, as well as the different negotiations between religiosity and abortion: of those who politicize the experience, as well as of those who rework and re-signify their religiosity
Kilander et al. (2018)[20] Sweden	Interpretative phenomenological approach	To identify and understand women's lived experiences of contraceptive counselling given at the same time as abortion counselling	13 women	-	Interview	We identified two themes: need for respectful counselling and needs for guidance and access to contraceptives. The essence "Being in a state of limbo and feeling sceptical" was coalesced from the themes. The women described a state of limbo, as being caught in an unwanted and emotionally charged situation. They reported that respectful counselling and meeting a skilled health professional helped to dispel their scepticism and

Table 2. Characteristics of included studies.						
Authors, (year), Location	Methods	Aim	Sample	Trimester when abortion is performed	Data collection method	Key findings
						influenced their plans for contraceptive use post abortion. Furthermore, women who wanted an intrauterine device described difficulties in access post abortion
LaRoche et al. (2018)[21] Canada	Qualitative study	To understand better the ways that women who have had multiple abortions talk about and view those experiences	41 women	First trimester	Semi-structured in-depth telephone/Skype interviews	Women described their abortion experiences as unique life events, even in cases when the overarching circumstances surrounding the pregnancies were similar. Participants recalled multiple factors that influenced their decisions to terminate, including their relationship status; level of support from family and friends; financial situation; health status; previous reproductive health, pregnancy, and abortion experiences; and desire to parent. In general, a previous abortion demystified the abortion process but did not play a significant role in decision making. Women described intensified feelings of shame and both internalized and externalized stigma surrounding their decision to have more than one abortion.

Table 2. Characteristics of included studies.

Authors, (year), Location	Methods	Aim	Sample	Trimester when abortion is performed	Data collection method	Key findings
						However, the overwhelming majority were confident in their decisions
Machado et al. (2015)[22] Brazil	Qualitative study	To know the experience of women that have been sexually assaulted: diagnosis of the pregnancy, seeking legal abortion, and hospitalization in a university hospital	10 women	-	Semi-structured interview	The women had been previously unaware of their right to a legal abortion, were ashamed about the sexual assault, kept it secret, and had not sought immediate care. The diagnosis of pregnancy provoked anxiety and the wish to undergo an abortion. Women treated through private health plans received either insufficient orientation or none at all. Respectful treatment by the healthcare staff proved relevant for the women to cope with the abortion
Makleff et al. (2019)[23] Kenya and India	Qualitative study	To examine the experiences of women who obtained an abortion in Kenya and India with regard to stigma, expectations, and perceptions of abortion quality of care	45 women	-	Semi-structured interview and focus group	These findings help elucidate how social norms and abortion stigma interplay with women's perceptions about abortion in Kenya and India, including their low expectations of care and concerns about safety or mistreatment. Women's perceptions of community disapproval of abortion may have derived from local social norms related to religion, motherhood, responsibility for

Table 2. Characteristics of included studies.						
Authors, (year), Location	Methods	Aim	Sample	Trimester when abortion is performed	Data collection method	Key findings
						contraception, and sexual mores for young and unmarried women. Negative stories women heard in their communities, the prevailing secrecy around abortion, perceived stigma, and the related fear of sanctions for having an abortion were all factors that contributed to their low expectations and fears

United States of America (USA); No information (-).