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Abortion and well-being: A narrative literature review

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A B S T R A C T

"Well-being" is utilised in multiple ways – an everyday word, a component of health, a policy objective, reflecting a diverse set of shifting meanings, conceptualisations, definitions, measurements, and theorising. Influenced by structural and social conditions, well-being can be enhanced or diminished and is experienced at a range of scales (individual, community, society). Globally, abortion is a common practice with implications for well-being. However, the intersections and linkages between abortion and well-being have not yet been explicitly synthesised. To extend understandings, theorising, and measurements, we conducted a systematically searched narrative literature review of evidence pertaining to abortion and well-being.

We used a grounded theory-driven approach to theoretically sample items until concept (abortion and well-being) saturation was reached, meaning our study was guided by the literature, rather than imposing an external set of theories. Our database searches (January 01, 2005–June 19, 2023) identified 7665 unique records yielding 753 records for the review, from which n = 167 items were selected for extraction.

Our analysis of extracted items yielded four main themes. First, only a minority (13/167) of studies explicitly engaged with well-being. Second, the majority of studies incorporated well-being-allied concepts, without explicitly framing their research as about well-being. We developed insights from these studies using four sub-themes: social connectedness, individual agency, mental health, and physical health. Third, there is limited use of theory and/or frameworks in the empirical evidence. Last, we interrogated the empirical research on abortion and well-being over the life course.

Well-being and allied concepts can be useful and productive analytic framings with relevance for research on abortion. We invite readers to consider how these concepts might be used to develop and iterate innovation – methodologically, empirically, and theoretically – to clarify, extend and deepen links between abortion and well-being.

1. Introduction

Well-being is evoked and utilised in multiple forms – an everyday word, a component of health, a policy objective, and as a diverse set of shifting meanings, conceptualisations, definitions, measurements, and theorising. Well-being can be enhanced or diminished and is experienced at a range of scales (individual, community, society), influenced by structural and social conditions. Abortion as a common practice globally has implications for well-being, however, these linkages have not been explicitly synthesised. To extend understandings, theorising, and measurements, we develop a systematically searched narrative literature review of evidence about abortion and well-being.

Well-being research has a long history, and the meanings and understandings of well-being continue to evolve (Stoll, 2014). There is broad agreement that well-being is relational, including with self (intrapersonal) and others (interpersonal), and theorising individual well-being distinguishes between subjective and objective well-being (Dodge, Daly et al., 2012). Subjective well-being focuses attention on personal fulfilment and experiences and is characterised by an individual's internal subjective assessment - based on cognitive judgements and affective reactions - of their own life (Das, Jones-Harrell et al., 2020). Subjective well-being includes multiple, overlapping, aspects including social, psychological, and spiritual. Objective well-being tends to be defined in relation to factors associated with quality of life

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(environment, housing, nutrition, wealth, education, health, social networks, political voice), as well as material living conditions, and the extent to which those needs are met (Voukelatou, Gabrielli et al., 2021). Diverse disciplinary approaches to well-being are reflected in a range of approaches to assessing or measuring well-being (Al-Janabi et al., 2012; Lorimer et al., 2022; Nussbaum, 2000; Robeyns, 2003) and a proliferation of well-being scales and sub-scales (Cooke et al., 2016; Lindert et al., 2015; Linton et al., 2016).

By its relational nature, individual well-being is situated in and interacts with meso- (e.g., community) and macro-level (e.g., nation state) contexts and dimensions of well-being. The Geneva Charter for Well-being (2021) emphasises the multi-scalar nature of well-being, underscoring an urgent need for "well-being societies". It emphasises that all individual and collective dimensions of life are essential over the life course (p.3 WHO, 2023). Building on the WHO's vision of health and stemming from an appreciation of indigenous knowledge systems, well-being societies require a holistic approach to not just the health of current and future generations, but also that of the planet.

At the 76th World Health Assembly (2023), member states adopted a global framework ('Achieving well-being: a global framework for integrating well-being into public health utilizing a health promotion approach') to provide key strategic directions for achieving "well-being societies" (p.3 WHO, 2023). Any shift from disease-based measures (e.g. disability adjusted life years (DALYs), healthy life years (HALEs)) to well-being-based measures (e.g. health and social conditions, material living standards, environmental-economic accounting) (p.22 WHO, 2023) has implications for how well-being is conceptualised, defined, measured and understood, including for sexual and reproductive health.

Quality abortion care is essential healthcare with implications for safety, agency, and good health, intersecting with fundamental capabilities such as life, bodily health, and integrity (WHO, 2022). Out of an estimated 250.4 million pregnancies annually globally (2015–2019), 48% were unintended and 29%, or 73.3 million, ended in induced abortion (Bearak et al., 2020). An estimated 45% of these were unsafe, with the majority of least- and less-safe abortions occurring in legally restrictive contexts (Ganatra et al., 2017). Abortion care includes of the provision of information, abortion management (including induced abortion and care related to pregnancy loss), and post-abortion care (WHO, 2022), and can be classified across multiple dimensions, including type (medical or surgical), safety (least, less, and safe), legality, and provider (e.g., self, formal, telemedicine). Each abortion has its own trajectory - the processes and transitions occurring over time for a pregnancy that ends in abortion – including care that might be delayed, thwarted, denied or accessed (Coast, Norris, Moore, & Freeman, 2018). Abortion stigma is widespread (Kumar, Hessini, & Mitchell, 2009) with implications for the availability and quality of abortion care provided and experienced.

As a common reproductive health event that many pregnant persons around the world experience, abortion is a key health care concern that is intimately tied to subjective and objective well-being. Several studies have explored the impact of abortion access beyond immediate health outcomes and have highlighted the broader implications of abortion care for well-being. Studies have found that the legalisation of abortion has positively influenced female educational attainment and labour force participation (Ananat, Gruber, Levine, & Staiger, 2009; Kalist, 2004; Myers, 2017). Additionally, research has shown that abortion bans impose significant costs on individuals, households, and societies, with the financial fallout potentially extending over several years (Miller, Wherry, & Foster, 2023). Reviews have considered abortion and concepts allied to well-being, including: emotional responses of women terminating a pregnancy for medical reasons (González-Ramos et al., 2021), psychosocial experiences of adolescents and young women in sub-Saharan Africa (Zia et al., 2021), the economic consequences of abortion (Coast et al., 2021), the psychological effects of abortion (Zareba et al., 2020), and the experiences of LGBTIQA + people (Bowler et al., 2023). Yet, the broader well-being implications of abortion care – including denial or inaccessibility of care – have not been synthesised. There is also a surprising lack of explicit conceptualisation of well-being and abortion, and their linkages (if any).

Our objective is exploratory; seeking to understand how well-being is conceptualised in abortion care literature and the potential of the concept of "well-being" for the field of abortion research. Through a narrative literature review (NLR), we aim to 1) examine empirical evidence on the implications of abortion access for well-being 2) understand how empirical studies on abortion have approached the concept of well-being and 3) offer suggestions for future theorising and research on abortion and well-being.

2. Materials and methods

Our approach is "systematic and narrative" (Greenhalgh et al., 2018), selected to reflect our purpose of identifying diverse aspects and components of well-being and abortion. The searches were systematic to ensure thoroughness in gathering and screening results given the broad scope of our review and the large amount of potentially relevant literature. Our review did not follow the rigid appraisal and aggregation of data that is typical of a systematic review. Our literature review is narrative because it serves to offer a scholarly summary with interpretation and critique for the broad concept of well-being. We selected not to do a scoping review (Peters et al., 2020) because of the large amount of evidence yielded by our systematic searches. Our systematically searched narrative literature review (NLR) drew on the JBI Manual for Evidence Synthesis (MDJ, C et al., 2020). We draw on PRISMA-ScR (Tricco et al., 2018) to report findings. A NLR does not systematically describe the entire universe of evidence; it aims to identify and full-text extract items with maximum diversity of insights that are relevant to the topic of abortion and well-being (Greenhalgh, 2018).

The search (Table 1) begins with 2005 when medical abortion pills-mifepristone and misoprostol - were added to the WHO Model List of Essential Medicines (WHO, 2005). This reflects that evidence pre-2005 will likely be less relevant than more recent studies. Inclusion criteria were: full text published in English, Spanish, Portuguese, French or Turkish, published between January 01, 2005 and June 19, 2023, contain empirical evidence [quantitative, qualitative, multi-, or mixed evidence] on the relationship between induced abortion and/or post-abortion care for induced abortion and well-being, and peer-reviewed journal articles or grey literature (published or unpublished). When screening, we operationalised "relationship between induced abortion and/or post-abortion care for induced abortion and well-being" by only including items that engaged with abortion **and** wellbeing (e.g., empirical studies exploring poor quality of care in abortion trajectories would meet the criteria). Similarly, if the item did not link to both elements, it would be excluded (e.g., focusing on well-being more broadly, but did not engage with abortion empirically).

Exclusion criteria were: books or book chapters, did not contain empirical evidence on the relationship between induced abortion and/or post-abortion care for induced abortion and well-being, only reported

Table 1
Search framework.

PICOTS	Micro-	Meso-	Macro-
Populations	Abortion care-seeker	Sub-national communities and systems (e.g.: health, political, legal, commercial, economic, etc.)	Societies, nation states and supra-national systems (e.g.: regional, transnational)
Interventions	Induced abortion and/or post-abortion care for induced abortion		
Control	None		
Outcomes	Quantitative and/or qualitative empirical evidence on the relationship between abortion and well-being		
Timeframe	January 01, 2005–June 19, 2023		
Settings	Any		

empirical evidence on spontaneous abortion, in languages other than English, Portuguese, French, Turkish and Spanish, literature reviews (systematic, scoping, narrative, meta-), and single case reports. Items were excluded from full text extraction but noted for future reference if: literature reviews [e.g., scoping, evidence (gap) maps, systematic, meta-ethnography etc.], or, English title and abstract screening suggested potential relevance, but full text is published in a language other than English, Spanish, Portuguese, French or Turkish.

On June 19, 2023, we conducted searches in three bibliographic databases: MEDLINE via Ovid, Scopus, and LILACS via Global Index Medicus. These databases collectively cover a range of literature, geographic regions, and subject areas, including medicine, psychology, nursing, and social sciences. A comprehensive search strategy was developed by MdA, EC, AF, RN. To start the process, the full authorial team recommended a set of relevant studies which were used to develop a transparent and reproducible search strategy. We included a diverse range of domains under the concept of well-being to retrieve as many relevant articles as possible. Keyword searches were conducted in title and abstract fields, employing truncation, proximity, and frequency operators. To minimise bias, we did not apply language limits. Where available, animal studies were excluded using a search filter. Complete search strategies for all databases are available (https://osf.io/k5bnu). These searches were supplemented with expert-recommended grey literature. We deployed two strategies to elicit recommendations: emails to authors' professional networks, and posts shared on social media. No comprehensive backward and forward citation checks of included studies were conducted.

Search results from all databases were imported into EndNote 20 (Clarivate, London, UK). Following Bramer et al. (2016) and Falconer (2018), duplicates were removed. Eligibility criteria were tested against a purposefully selected sample [n = 30] of items by three reviewers (MdA, EC, RN), who discussed conflicts and iterated criteria. A second purposefully selected sample [n = 30] was tested, and overall agreement was achieved. After deduplication, studies were imported into Rayyan (a cloud-based app for reviews) (Ouzzani, Hammady, Fedorowicz, & Elmagarmid, 2016) for title and abstract screening against the eligibility criteria and each record screened by a single person. All languages, as well as any identified systematic or literature reviews, were included at this stage and proceeded to full text screening. Each record was screened only once, the "blind mode" was activated to minimise bias, and reviewers regularly communicated to address any uncertainties. Full texts of potentially relevant studies were retrieved and uploaded to a new Rayyan project and assessed in detail by MdA, EC and RN against the eligibility criteria. Reasons for exclusion were recorded for all excluded studies.

We used a structured approach in our NLR that draws on the methodological literature for qualitative reviews (Barnett-Page & Thomas, 2009). A data extraction form (https://osf.io/pm4sc) was developed, tested and iterated. The extraction of all extracted items is available in an inventory (https://osf.io/v3t2n/). Data extraction was structured to reflect the distribution of items that were eligible for extraction: micro, meso and macro (Table 1). Any eligible for extraction item identified as meso only or macro only was extracted as: i) these levels are less well theorised and understood, ii) there are relatively fewer of these items, and iii) to ensure coverage of relevant literature in our NLR across all three scales.

For eligible items that were labelled micro (whether micro-only or in combination with meso or macro) we used an inductive approach to full-text selection and extraction. We used a grounded theory-driven approach to theoretically sample items for extraction until concept (abortion and well-being) saturation was reached so that we were guided by the literature, rather than imposing an external set of theories (Bowers & Creamer, 2020; Simsek et al., 2023; Wolfswinkel et al., 2013). We selected this approach rather than a randomly drawn sample from the eligible studies because we are interested in maximising evidence insights on links between abortion and well-being. A random sample risks – randomly – selecting a set of things that are from the same contexts or draw the same conclusions. Practically – resources and time - full-text extraction of every included study was infeasible. Conceptually, for an NLR seeking to understand the landscape of evidence on abortion and well-being what is most important is the diversity of conceptualisations and understandings of well-being in the abortion literature. Full-text extraction of every included item would produce substantial repetition and redundancy.

During full-text extraction, MdA, EC and RN maintained a live record of concepts and themes already full-text extracted, and purposefully selected eligible items to full-text extract concepts and themes that had not yet been captured. We deployed relevance – likely contribution to ideas development – rather than a characteristic (e.g.: methodology, geography) to purposefully select items to full-text extract. The full list of concepts and ideas identified during full-text extraction is provided (https://osf.io/mzfv3) and should be interpreted as akin to initial inductive coding prior to higher-level theorising. This list of over 300 concepts and ideas represents a source for future searches, conceptualisation and theorising about abortion and well-being. Items that were not full-text extracted but were eligible for full text review and data extraction are included in an inventory (https://osf.io/d3xrq). Literature reviews (systematic, scoping, narrative, meta-) identified by our search are included in an inventory (https://osf.io/q4hdb).

In keeping with narrative literature review approaches, items were not quality assessed. Full text eligible to be included items were checked against Retraction Watch using EndNote 20[1 and 2]; no eligible to be included items were subsequently retracted. Four excluded items were identified as having been retracted. DeepL Translator (DeepL SE, Cologne, Germany) was used to support full-text translation for data extraction, if needed.

3. Results

3.1. Descriptive overview

Our database searches identified 7665 unique records (Fig. 1) yielding 753 records (9.82% inclusion rate) for the review. An inventory of all studies eligible for full text review and data extraction [n = 753] is available (https://osf.io/d3xrq). The distribution of the year of publication of eligible studies shows that the volume of work relevant to the relationship between abortion and well-being appears to be increasing over time (https://osf.io/zcy74). The distribution of authorship of eligible items is dominated by authors from the Global North, particularly the United States (US) and reflects political attention, data availability, the institutional affiliation of authors, the location of funding and other resources for conducting studies, and our included languages. A summary table of all included data extracted items [n = 167] is available (https://osf.io/64tnf). Data were extracted from studies including evidence from all world regions: Africa 36/167; Asia 13/167; Europe 25/167; Latin America and Caribbean 24/167; Northern America 62/167; Oceania 4/167; and multiple regions 3/167). Data were extracted from studies including evidence from n = 51 countries; 60/167 (36%) extracted studies were based on evidence from the US. Studies used a range of evidence including quantitative (68/167), qualitative (79/167) and mixed methods (20/167). Studies included a range of empirical methods. Reported findings, particularly qualitative studies exploring abortion experiences or recollections of care-seeking, are partial and subjective experiences of care-seekers located in a specific moment in time, context, geography, and pathway.

Our analysis of included items yielded four main themes that we explore in detail below. First, we consider the minority of studies that explicitly included well-being. Second, we focus on the majority of

[1] https://support.clarivate.com/Endnote/s/article/EndNote-20-Retraction-Alerts?language=en_US.

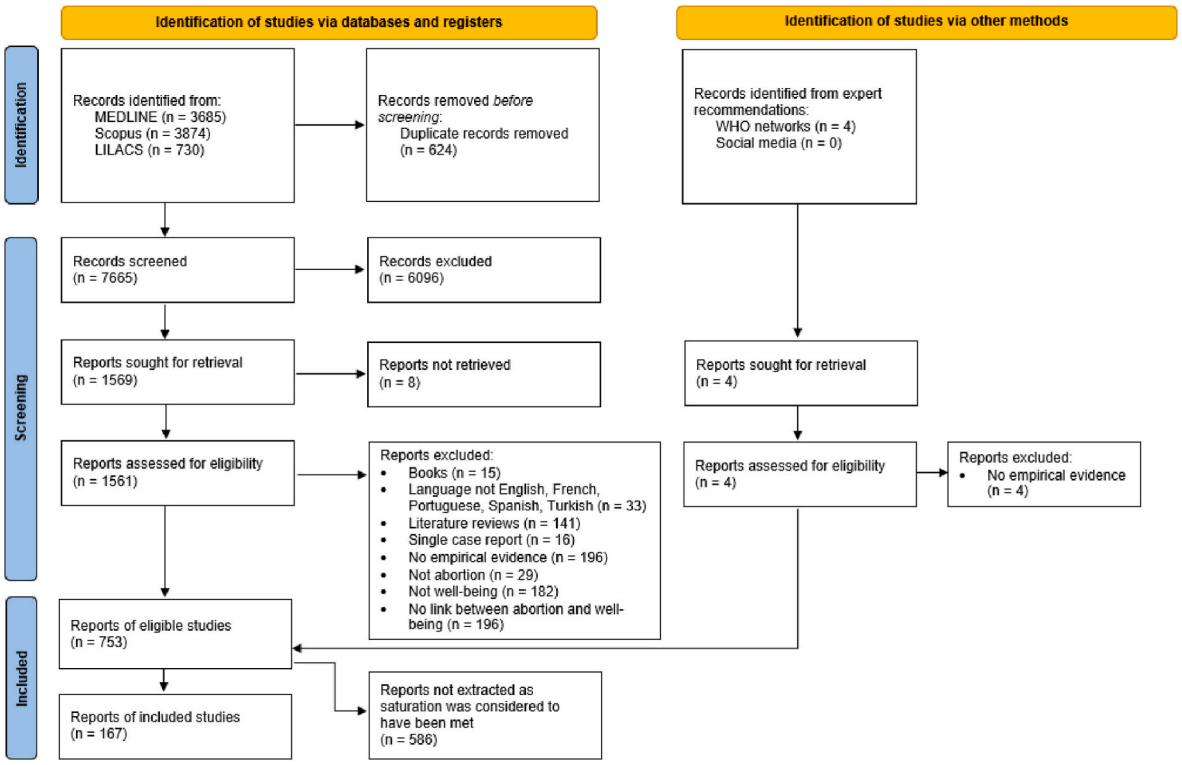

Fig. 1. PRISMA flow diagram.

studies that incorporated well-being-allied concepts (e.g., social connectedness), without explicitly framing their research as about well-being. To help organise this large and diverse body of evidence, we group insights from these studies using four sub-themes: social connectedness, individual agency, mental health, and physical health. Third, we draw attention to the limited use of theory and/or frameworks in the empirical evidence, and the overemphasis on the "micro" levels. Last, we interrogate the empirical research on abortion and well-being over the life course.

3.2. Well-being in abortion research

A minority (13/167) of included studies explicitly engaged with or referred to well-being as a concept. Studies using validated scales focused on mental health (e.g. depression, anxiety) (Biggs, Upadhyay, McCulloch, & Foster, 2017), psychological well-being (e.g. self-esteem, life satisfaction) (Biggs et al., 2017; Holmlund et al., 2021), sexual well-being (Pohjoranta, Mentula, Hurskainen, Suhonen, & Heikinheimo, 2018), psycho-sexological well-being (Limoncin et al., 2017), and subjective well-being (Huss, 2021).

Of the qualitative or mixed-methods studies (n = 7) that explicitly engaged with well-being, 6/7 were focused on evidence from abortion care providers. A study from Peru used the concept of 'infrastructures of abortion care', described as a set of relations between actors, technologies, and strategies that are brought into being by an interest in the embodied and emotional well-being of the people seeking to have an abortion (Duffy, Freeman, & Rodriguez, 2023). Another study examining healthcare providers in Norway used the concept of lifeworld-care, which includes elements that are "essential for understanding the patient and implies a desire to contribute to well-being", such as making room for freedom, agency and vulnerability (Kjelsvik, Tveit Sekse et al., 2018). In this study, "well-being is regarded as vitality and includes both the possibility of movement and the possibility of rest." (p.4200) One study focused on support from a feminist accompaniment group in Argentina, constructed well-being in relation to quality of care (Bercu, Filippa et al. 2022). In this study, participants described high-quality abortion care as feeling *acompañamiento* and *contención* from their providers – i.e., receiving kind, caring, compassionate and emotionally supportive care.

Three studies specifically focused on elements of risk in conceptualising well-being. Safeguarding was identified as part of wider issues of protection and well-being, recognising that personal risks may be different for adults and minors (Romanis & Parsons, 2023). Two studies from South Africa (Teffo and Rispel, 2017, 2020) focused on the experiences of abortion care providers. The 2020 study framed psychosocial well-being of providers as critical to the provision of responsive and respectful abortion services; the analyses presented provider coping strategies, including negative or maladaptive strategies such as treating women in disparaging or judgmental ways.

3.3. Well-being-allied concepts in abortion research

Few studies explicitly focused on well-being linked with abortion care provision or experiences, however more than 300 concepts allied to aspects of subjective and objective well-being were identified from the included literature (https://osf.io/mzfv3). Well-being related influences were identified at a range of scales and experiences including when abortion care was sought and obtained or sought but thwarted or delayed or denied or inaccessible. To help organise our insights from the mass of allied concepts and evidence, we present insights for four inductively developed sub-themes: social connectedness, individual agency, mental health, and physical health.

3.3.1. Social connectedness

Well-being is relational. Processes driven by unequal power relationships create social connectedness or cohesion, broad concepts associated with enhanced well-being; and create social exclusion, associated with diminished well-being (Kawachi & Berkman, 2000; Popay, 2010, Orazani, Cárdenas, Reynolds, & Mendoza-Denton, 2023). From the included literature we identified three broad dimensions relating to

social connectedness: social, political, and economic.

3.3.2. Social

At the micro-level, some models of abortion care provision were documented as leading to feelings of connectedness, others leading to feelings of isolation, loneliness, and abandonment. Holistic accompaniment and care approaches utilise a horizontal model that, "[…] involves trusting women, not asking for the reasons for their abortion, preventing criminalisation, economic support, respecting autonomy, emotional accompaniment, and being flexible" (Veldhuis, Sanchez-Ramirez, & Darney, 2022). Those supported by accompaniment models to access abortion, for example, described feeling safe and empowered, including in contexts where abortion is criminalised or stigmatised (Veldhuis et al., 2022; Duffy et al., 2023).

Studies documented stigma and shame in relation to abortion care (Keys, 2010, Teffo & Rispel, 2017, Coles, Makino, Stanwood, Dozier, & Klein, 2010, Cotter, Sudhinaraset et al., 2021, Veldhuis et al., 2022, Duffy et al., 2023, Monchalin, Perez Pinan et al., 2023, Somefun, Constant, & Endler, 2023). Stigma acted as a barrier to care because it contributes to an absence of accurate information (Purcell et al., 2014; Keogh et al., 2021), to fear of social and community repercussions (Aiken, Padron, Broussard, & Johnson, 2018; Solheim, Moland, Kahabuka, Pembe, & Blystad, 2020), and to trepidation of formal sector care-seeking. In Ghana, young women's perceptions of negative provider attitudes, combined with cost barriers and inadequate knowledge of the law pushed them "to resort to potentially unsafe or ineffective methods of abortion … and to source their information from friends who may also lack accurate knowledge." (Keogh et al., 2021). In contexts like Malta, where abortion is socially and legally restricted, teenagers were particularly likely to feel a need to keep abortion a secret, and cited costs, and their school and work commitments for why they opted for online abortion services (Dibben, Stabile, Gomperts, & Kohout, 2023).

Fear of mistreatment by healthcare providers was reported in multiple studies. In legally restrictive settings this intersected with age, race and ethnicity – for example, for Black women in Brazil, fear of mistreatment was the main barrier to care-seeking (Goes et al., 2020). In other cases, healthcare providers – formal and informal-could be supportive and validating interlocutors in their abortion trajectory. In South Africa, Womxn's experiences of pre-abortion counselling were described as "non-directive, balanced, supportive and empathic", where counselling was an educational and learning experience (Mavuso & Macleod, 2020). Adolescents in Argentina, Bangladesh, Ethiopia, and Nigeria felt their providers sometimes validated their decisions and were, in some instances, "like a friend" allowing them to have "the most satisfying service" (Jacobson et al., 2022). In Brazil, adolescents mentioned that during their abortion procedure they received attention, affection, and information from healthcare professionals (de Faria, Domingos, Merighi, & Ferreira, 2012).

Where abortion telemedicine was available through formal services, users reported high levels of satisfaction, higher quality of care in relation to comfort, care, flexibility, and ongoing support, shorter wait times, privacy and affordability (Boydell, Reynolds-Wright, Cameron, & Harden, 2021; Chareka, Crankshaw, & Zambezi, 2021; Higgins, Lands, Valley, Carpenter, & Jacques, 2021; Wollum, Huerta et al., 2022). In other contexts, women who could afford to seek care in private facilities reported feeling more respected and affirmed; particularly when they felt listened to and engaged with during their abortion and post-abortion discussions with healthcare providers (Cotter, Sudhinaraset et al., 2021). Accompaniment or feminist models of abortion support and provision also highlighted the social element of abortion care-seeking and care-receipt. Accompaniment networks, centring individuals as "protagonists of their own abortions" (Bercu et al., 2021), enabled and supported autonomy and agency as a key facet of the "self-care" of abortions (Baum et al., 2020; Bercu et al., 2021; Wollum, Huerta et al., 2022; Duffy et al., 2023); holding the potential to make abortion a positive experience (Veldhuis et al., 2022).

Social stigma against abortion emboldened acts of disrespect or abuse for those accessing abortion-related care (Sundaram et al., 2013; Baum et al., 2020), including insufficient or withheld pain relief (Silveira, McCallum, & Menezes, 2016; Fathallah, 2019). This included providers "conscientiously" refusing care to women (Awoonor-Williams et al., 2020), sometimes with fatal consequences. Evidence from the US showed how protesters outside care facilities can intimidate and distress abortion-seekers, interfering with access to formal sector care (Brown, Plummer et al., 2022; Arey, 2023). The absence of a supportive environment could mean that some people avoided formal providers due to fear of incarceration, judgement, stigmatising behaviours, and disrespectful care (Chareka et al., 2021; Madeiro & Diniz, 2015; Monchalin, Perez Pinan et al., 2023). Fears about a breach of professional secrecy or demands to speak with parents or partners before provision of care, deterred care-seeking for some (Santos & Fonseca, 2022). For some, familiar, accessible care was prioritised over legality and safety. For example, Mexican immigrant women sought care that is accessible and familiar, regardless of its legality or safety, in lieu of formal sector services (Deeb-Sossa & Billings, 2014). The authors drew attention to "the ways in which the barriers experienced by these women are the product of intersecting forms of oppression based on race, gender, sexuality, class, ability, age, immigration status and linguistic abilities, among others." In the US, adolescent abortion seekers' expectations for care were low, and "an absence of negative treatment became a positive experience" (Coles et al., 2010). A study in Switzerland found that people who identified as prospective parents dealing with a diagnosis of foetal anomaly felt that the lack of standardised bereavement care and fragmented healthcare support during prenatal diagnosis negatively influenced the appropriateness of the care they received for stigmatised "late" abortions (Hendriks & Abraham, 2022).

At the macro-level, social structures contributed to the denial, coercion, structural violence, silencing or invisibilisation of abortion care, with implications for social connectedness. Analyses of the experiences of Catholic women in Latin America drew attention to the feelings of loneliness and abandonment engendered by the silencing of stigmatised abortion care-seeking among this population and how they negotiated their experience of abortion with their religious identity (Johnson, 2018). Analyses of women's experiences of abortion and post-abortion care in private facilities in Kenya showed how micro-level domains of provider privacy, trust or confidentiality were situated within community meso-level contexts of mistrust and lack of privacy (Cotter, Sudhinaraset et al., 2021).

Women's fears of their abortion care being "outed" within their communities were a critical dimension of the acceptability of different sorts of abortion providers (Cotter, Sudhinaraset et al., 2021). Requests for abortion care may be denied if contrary to a common social norm. A study that retrospectively analysed legal and medical files of rape survivors denied an abortion in India offers detailed insights into the interconnected ways in which the Indian legal and medical systems denied abortions (Bhate-Deosthali & Rege, 2019).

3.3.3. Political

Laws restricting access to abortion care have been associated with a higher risk of death during pregnancy and up to one year postpartum in the US (Vilda et al., 2021), as well as increased infant mortality (Pabayo et al., 2020; Karletsos, Stoecker, Vilda, Theall, & Wallace, 2021). Meso- and macro-level policy barriers to care – waiting periods, third party authorisations, multiple professionals involved, requisites for a particular health facility to provide abortion, gestational limits, ultrasound requirements, multiple visit requirements, lack of insurance coverage or financial assistance to pay for abortion, and lack of local services – limited abortion access, delayed care and/or contributed to deterring abortion-seeking (Berglas, Kimport, Williams, Mark, & Roberts, 2019). Legal restrictions impact the abortion seeker and the provider and can make it difficult to identify providers and curtail information pathways. They could also require travelling within a state or country, sometimes

abroad, to access abortion care. Restrictive abortion laws and policies led to fear of criminal prosecution and deter women from accessing formal sector care (Diniz & Madeiro, 2012, Awoonor-Williams et al., 2020). Clinic closures (due to legal changes, finances, or other reasons) increased travel distances for abortion access, affecting people's ability to seek and use abortion services (Garnsey et al., 2021; Venator & Fletcher, 2021). Abortion providers in Ohio US discussed how abortion regulations affected their ability to provide comprehensive care (Field et al., 2022). Specifically, the need to interpret abortion regulations undermined providers' expertise and professional autonomy, in turn causing them to feel that they could not exercise clinical judgment, which limited abortion access and increased risks to patient's lives and health. Sufrin et al. (2009) conducted surveys with abortion providers who provided clinical care in correctional facilities for incarcerated women in the US. Although their survey did not include incarcerated women, they found that full access to abortion services was not available in all settings, particularly depending on the dominant political party in the state.

Abortion laws and policies could be variably interpreted at the micro-level to advantage or disadvantage bodily autonomy. In Sri Lanka the availability of abortion services depended not only on the law and awareness of the law, but on how it was interpreted and enforced and attitudes of the medical community towards induced abortion (Abeyasinghe, Weerasundera, Jayawardene, & Somarathna, 2009). Where criminal law regulated abortion, this was associated with a perception that abortion is criminal. In Kenya, the perceived illegality of abortions combined with religious faiths that forbade abortion, and fear that colleagues and supervisors disapproved resulted in providers not offering pregnancy termination services. Legal restrictions and legal ambiguity were cited to hinder provision of care for abortion-related complications, though this type of care was legal (Izugbara, Egesa, Kabiru, & Sidze, 2017). Similarly in Zambia, though the abortion law was relatively liberal, there was a widespread perception it was not and access to safe abortion services was limited (Fetters, Samandari, Djemo, Vwallika, & Mupeta, 2017).

Fear of criminal prosecution could deter people from seeking care in contexts where abortion access was legally restricted. Restrictive legal contexts, poor awareness of abortion information, high cost of services, gender inequalities, parental notification laws, and negative experiences with healthcare providers all shaped and constrained autonomy (Diniz & Madeiro, 2012; McLean, 2023). In Brazil, sex workers used illegally acquired misoprostol or (less frequently) invasive methods like needles and probes to induce an abortion. Fear of police complaints meant that most women delayed seeking care for complications despite symptoms such as fever and persistent bleeding, and when in public hospitals for treatment of complications, did not inform their health workers about their abortion attempts. For most of them, abortion was a solitary experience (Madeiro & Diniz, 2015). Increased legal and policy barriers to quality abortion care were associated with increases in unwanted pregnancies and resulting births (Coles, Makino et al. 2010; Pearson, Aqtar et al., 2023). Barriers to safe abortion care, such as mandatory waiting periods, have been found to more than double the risk of having a mistimed or unwanted birth (Coles et al., 2010).

3.3.4. Economic

Multiple studies documented costs – direct, indirect and opportunity - as barriers to care at the micro-level (Ely & Otis, 2011; Monchalin, Perez Pinan et al., 2023; Silva & McNeill, 2008; Tavrow, Withers, & McMullen, 2012). Economic hardship also resulted in or exacerbated other barriers; the time spent to gather resources needed to afford an abortion often resulted in delays in accessing an abortion. Monchalin et al. (2023) explored barriers to abortion services among Indigenous Peoples in Canada. One participant noted how their financial hardship made it difficult to reach abortion services: "… I didn't have a car, so I didn't know how I was getting there. I didn't have money to get there. It's about a seven- or 8-h drive from where I was living, and that's the only place that anyone in Newfoundland can go." In Uganda, women often had to receive more expensive, complex and time-consuming second-trimester abortions due to delays in care-seeking because of financial barriers (Cleeve, Faxelid, Nalwadda, & Klingberg-Allvin, 2017). Costs and the impact on delayed care-seeking, meant that some people used telemedicine or self-management to access abortion (Higgins et al., 2021; Wollum, Huerta et al., 2022). Where clandestine services or off-label misoprostol access was available, it was accompanied by out-of-pocket costs, and for abortion-seekers these costs may influence choice of service and type of provider; making decision-making not just about abortion itself but about safety versus cost (Chareka et al., 2021). Where women are forced to resort to less safe abortion methods and subsequently seek care for abortion-related complications, the costs for service may be difficult to meet, in addition to related costs such as transportation, admission, and treatment (Baynes, Diadhiou, Lusiola, O'Connell, & Dieng, 2022). Immigrants may also have to bear additional costs for interpreters, once again adding to indirect abortion costs and requiring disclosure to access care (Deeb-Sossa & Billings, 2014).

Economic burdens related to accessing abortion care and care for complications can have adverse effects on those who received the abortion, their children, and others in their household (Henshaw et al., 2008; Sundaram et al., 2013; Baynes et al., 2022). Reporting findings from a US based study "For households with one adult and one child earning the median monthly income in a majority of states, the out-of-pocket cost for a first and second trimester abortion is financially catastrophic. A lack of insurance coverage and the fact that 40% of Americans have insufficient funds saved to cover the cost of an abortion […] may force many abortion seekers with limited finances to sacrifice basic necessities and/or take on considerable financial risks to pay for an abortion" (Zuniga, Thompson et al., 2020). At the macro-level of the health system, a study in Pakistan showed how the costs of treating abortion-related complications impacted hospital budgets (Naghma e, 2011).

3.3.5. Agency

Agency – an individual's control over their material and social environment – was identified as a dimension of well-being in relation to abortion in a wide range of contexts. A study in Uganda showed how participants "positioned abortion as an agentive action aimed at regaining control over one's body and future." (p.1295 Cleeve et al., 2017). For some people, operationalising reproductive agency can result in abuse. A study in Canada documented that study participants experienced "reproductive violence around abortion decision making, as well as mistreatment, including coerced contraception." (p.3 Monchalin, Perez Pinan et al., 2023). In India, for women who had disclosed rape by their husbands and were denied abortion services in a public hospital, abortion was refused on the grounds of it being their first pregnancy or offered only if the woman agreed to contraception or sterilisation (Bhate-Deosthali & Rege, 2019).

When abortion decision-making and access are supported by non-judgemental advice, knowledge, and support mechanisms (e.g., finances, accompaniment) it can affirm individual choices and agency (Cotter, Sudhinaraset et al., 2021; Low, Chen, & Cameron, 2021; Wollum, Huerta et al., 2022). Telemedicine, in particular, enabled flexibility and comfort (Boydell et al., 2021), allowed taking medication according to the user's schedule and convenience, and not missing work or needing additional childcare (Kerestes et al., 2022). Crucially, telemedicine also allowed maintenance of privacy (Oduro & Otsin, 2014, Kerestes et al., 2022; Somefun et al., 2023).

3.3.6. Mental health

At the individual level, studies have documented correlations between accessible abortion care and positive mental health outcomes, as well as between abortion restrictions and negative mental health outcomes. In the US, a study of abortion stories identified "specific, often

positive, feelings" about abortion experiences, as well as to "not having abortion regret and feelings of gratitude." (Swan, Rouland et al., 2021). Psychological outcomes (anxiety, self-esteem, life satisfaction) among women in the US who were denied an abortion were more negative initially compared with those who received an abortion just under the facility's gestational limit; both groups achieved similar psychological outcomes after 6–12 months (Biggs et al., 2017). Carrying an unintended pregnancy to term was associated with an increased prevalence of anxiety and depression among women in Brazil (Ludermir, de Araujo, Valongueiro, & Lewis, 2010). In the US, states that prohibit Medicaid funding of abortions were found to have significantly higher rates of postpartum depression than in states that funded Medicaid abortions (Medoff, 2008).

3.3.7. Physical health

Studies from a range of settings identified barriers to abortion care, and showed that these can lead to delayed care seeking, turning to higher risk methods or providers, in turn resulting in associated complications which could be fatal (Awoonor-Williams et al., 2020; Keogh et al., 2021; Govule et al., 2022). Barriers to quality abortion care were multidimensional (legal, informational, geographic, economic) and could have ripple effects. Time required to arrange travel, including raising funds to cover travel and abortion care costs could lead to further delays (Purcell et al., 2014; Cleeve et al., 2017). Delays resulted in increased gestational age and could push women toward legally approved gestational limits with challenges for accessing safe services, including denial of safe services (Hill, Tawiah-Agyemang, & Kirkwood, 2009; DePineres et al., 2017; Somefun et al., 2023).

In the US, insecurely housed populations tended to present later in gestation and more frequently experience abortion-related complications than individuals who were stably housed (Orlando et al., 2020). Barriers to accessing abortion care disproportionately affected the physical health of populations made marginal. For example, in fragile and conflict-affected settings in Nigeria and Central African Republic, women who accessed formal sector care for complications of unsafe abortion experienced a higher frequency of severe abortion complications and required more complex care to manage and survive their complications than women in stable African settings (Pasquier et al., 2023).

A multi-country study (Govule et al., 2022) of the experiences of women seeking care for abortion complications in health facilities in 11 African countries found that the influence of complication severity on experience of care appeared significant. Women with moderate and severe complications had 12% and 40% higher odds of reporting negative experiences, respectively, and there were widespread reports of negative experiences of care among women receiving treatment for abortion complications in health facilities. Women receiving care under more prohibitive abortion laws had half the odds of reporting poor experiences of care, compared to less restrictive laws, which was contrary to the expected association.

3.4. Limited use of theory or frameworks in abortion and well-being research

Most included studies (83%) did not situate their work using any theories or frameworks. For the minority that did, they were almost all qualitative. Studies used care-related theories and frameworks (e.g., person-centered care (Sudhinaraset et al., 2017), Ipas's definition of abortion care continuum (Turner & Huber, 2016)), stigma/abortion stigma, and reproductive justice and/or coercion. These frameworks were applied against a broad range of well-being dimensions.

Care-related articles focused on two aspects of the abortion experience: experiences during the abortion, and feelings about the abortion experience. The former included experiences and perceptions of judgement, companionship and accompaniment, confidentiality, support, pain management, safety, receipt of knowledge and information, attentiveness, listening, respect, and timely delivery of care. Feelings about the abortion experience included confidentiality, humiliation, autonomy, empowerment, guilt, and fears for the future. Bercu et al. (2022) used the person-centered care framework to analyse how participants described high-quality abortion care. Within this definition, high-quality care was segmented into four types of interpersonal interactions "attentive communication from providers and accompaniers, clear and understandable information provision, non-judgmental support, and individualized options for pain management." In Kenya, Cotter et al. (2021) used the domains of the Person-Centered Care Framework for Reproductive Health Equity to identify gaps in women's experiences of care in private facilities. Findings showed that "abortion care overlapped most with the person-centered domains of autonomy, communication and supportive care, and trust, privacy, and confidentiality" and that women who reported receiving clear communication and comprehensive information reported more positive experiences. A study focused on understanding the abortion experiences of young people in four countries used the Person-Centered Care Framework for Reproductive Health Equity to structure their findings and offer recommendations for youth-focused abortion care (Jacobson et al., 2022). Using Ipas's comprehensive definition of abortion care in their sample of Australian abortion providers who provided abortion care to survivors of gender-based violence, Mainey et al. (2023) found that when participants "encountered barriers to person-centered abortion care, they bent or broke the law, local policy and cultural norms to facilitate timely holistic care." (p.1329).

Eight articles from three countries (US n = 4, Kenya n = 2, Uganda n = 2) used a stigma framework. These studies included different populations including adolescents (Coles et al., 2010), teachers and student peer counsellors (Hakansson, Super, Oguttu, & Makenzius, 2020), and abortion care-seekers (Frohwirth, Coleman et al., 2018). Frohwirth et al. (2018) analysed the relationship between stigma and religion in the US, finding that most respondents mentioned the influence that religion, religious communities, or God had in their experiences obtaining and reflecting on their abortions, although their experiences of abortion stigma and ways of coping with this stigma varied. Several studies looked at counsellor or provider perspectives of stigma in different contexts using a stigma framework. A study by Seewald et al. (2019) aimed to understand how the abortion stigma providers receive influenced clinical complications in North America, South America, and Africa. They found that abortion stigma directly and indirectly contributed to abortion complications. In terms of patients, the stigma they faced influenced decisions of how and where to seek care, whether to access follow-up care following complications, and if they should disclose their pregnancy and abortion to medical staff. For the provider, stigma influenced their decisions around patient referrals or whether to attempt treatment in-office, disclosures when making a referral, and their treatment in case reviews. The authors proposed a framework within which to situate the "vicious cycle of stigma and abortion complication."

Reproductive justice (RJ) frameworks were used and some of the studies using RJ focused on specific made marginal study populations such as Black women (Brown, Plummer et al., 2022) and Mexican immigrants (Deeb-Sossa & Billings, 2014) in the US. Studies using RJ tended to focus on domains of well-being such as experiences of coercion, racism, deportation, lack of access to infrastructure, lack of access to privacy, physical violence, and psychological violence. Brown et al. (2022) used the Reproductive Justice and Public Health Critical Race Praxis frameworks to understand abortion in the context of structural racism and reproductive injustice. Participants identified how 'choice' around abortion is not always available to Black women due to the constraints of racism and reproductive injustice and discussed the domains related to their experiences. These domains included "community experience and intergenerational wisdom, personal experience and beliefs, the process of accessing abortion, and reflecting on abortion experience and recovery". Brown and colleagues developed a generative

and alternative frame of Black women's experiences that offers critical and interconnected suggestions for ways in which abortion care should meet Black women's needs. Pearson et al. (2023) used reproductive coercion – "a form of gender-based violence, typically perpetrated by an intimate partner or family member by coercing or forcing a woman to become pregnant against her wishes or interfering with her use of contraception or abortion" – in their study in Bangladesh. They found that reproductive coercion was often perpetrated by male partners and in-laws and included both pregnancy-promoting (threats, violence, obstruction of access to menstrual regulation,[2] and contraceptive sabotage) and pregnancy-preventing (threats, violence, pressure, and force to abort or use contraception, and accusations of infidelity) tactics motivated by son preference, desire to maintain power over the woman, and marriage formation or dissolution.

One included study used the theoretical decision-making model of fertility control as their framework to explore the relationship between restrictive state abortion laws in the US and postpartum depression (Medoff, 2014). The study found that while there were no significant differences in the incidence of postpartum depression between states with certain restrictive laws, states that prohibited Medicaid funding for abortions had significantly higher rates of postpartum depression. Monchalin et al. (2023) used an indigenous-led, community-partnered approach informed by Indigenous feminism within which to situate their research. Their research on abortion access among Indigenous Peoples in Canada identified "logistical barriers, poor treatment, stigma, impacts of colonialism on attitudes towards abortion, traditional knowledge, and follow-up care and support." (p.2). Other frameworks identified in our included studies include grounded theory (Dykes, Slade, & Haywood, 2011; Brandi, Woodhams, White, & Mehta, 2018; Fathallah, 2019), ecological approach (Pereira, Pires, & Canavarro, 2017), Collective Health (Santos & Fonseca, 2022), proximate determinants (Tamang et al., 2017), the Levesque access framework (Kerestes et al., 2021), and feminist and decolonial theory (Duffy et al., 2023).

3.5. Empirical abortion well-being research and life course

Overall, there were relatively few studies offering insights into the potential influence of an abortion experience on well-being over the life course. This likely reflects some of the ethical and practical concerns shaping empirical abortion research designs. While these studies provided detailed insights into the immediate implications of abortion for well-being (e.g., delays, financial implications, post abortion complications), there is less evidence or theorisation of how well-being and abortion intersect and interact over the life course, and how abortion experiences (do not) shape well-being related outcomes (e.g., health, financial well-being, emotional well-being).

Most studies on abortion concentrated around the time of, or shortly after, an abortion or post-abortion care-seeking (Chakravarty et al., 2023; Cui, Gemzell-Danielsson, & Gomperts, 2023; Kimport & Rasidjan, 2023, Ouedraogo et al., 2023; Zhang et al., 2023). Longitudinal studies of abortion were rare, particularly in exploring if and how abortion links with well-being over the life course. Except for the Turnaway studies (e.g., Biggs, Brown et al., 2020; Rocca, Samari et al., 2020) and a handful of other studies (Moore, Dennis et al., 2018; Ostrach, 2020; Wollum, Huerta et al., 2022), most articles used cross-sectional data or retrospective data (e.g., Huss & Kaiser, 2022; Rajkumar, 2022; Steinberg, Laursen et al., 2019; Zandberg, Waller et al., 2023). In some studies (e.g., Mbona, Kistan, & Sebitloane, 2023), abortion seekers completed a survey shortly before their abortion procedure (medical or surgical), detailing their knowledge of abortion and their reasons for care-seeking. They were surveyed again after their abortion, asked to reflect on their experiences and feelings about the procedure. Other studies (e.g., Aguilar, Lundsberg, Stanwood, & Gariepy, 2023), recruited participants a short period after their abortion (e.g., within 30 days), partly to reduce recall bias. Others (e.g., McLean, 2023) explored reactions (including contemplating abortion) to unplanned pregnancies over peoples' life course, rather than restricting study responses to a specific time period. These explorations of well-being in abortion experiences suggest that well-being is both impacted in the short term (e.g., recovery after care for complications) *and* longer term (i.e., assumed to have physically recovered after care for complications, or assumed to have a lasting emotional implication).

There was little research focusing on the post-abortion period that extended beyond medical care. Rather than an episodic experience, abortion can resonate over the course of a person's trajectory and life, and they may – at different moments at different points in their lives, need a non-judgmental resource to help process their abortion experiences (Kimport, Perrucci et al., 2012). In the US, a study of abortion stories identified that for people who had an abortion due to medical issues or foetal anomalies, some used mementos "to heal and remember their pregnancy and abortion experiences" (Swan, Rouland et al., 2021, p. 210).

4. Discussion

4.1. Conceptualising abortion and well-being

Well-being is evoked, framed, shaped, and discussed in much abortion-related literature in passing rather than being articulated in terms of a definition, theory, framework, or measurement. There have been nascent efforts in related sexual and reproductive health domains to engage more explicitly with well-being – for example in maternal health (Jomeen & Martin, 2018, pp. 214–221, Wadephul, Glover, & Jomeen, 2020; Kelly, Kurinczuk, Fitzpatrick, & Alderdice, 2022), sexual health (Lorimer et al., 2019; Mitchell, Lewis, O'Sullivan, & Fortenberry, 2021), and adolescent health (Ross, Hinton et al., 2020; Avedissian & Alayan, 2021).

A minority of our included studies explicitly engaged with well-being as a concept. In the abortion literature we extracted, the term "well-being" is more likely to be used in an ad hoc way (for example "health and well-being") and did not form a central focus of abortion research. Most articles that focused on or measured a well-being-allied topic did not explicitly use the term 'well-being.' For those that did, most did not specify what well-being means in the study context, either in terms of its definition or measurement. However, work on abortion and well-being that was theoretically grounded offered powerful suggestions for ways in which abortion care should meet people's needs (Brown, Plummer et al., 2022; Jacobson et al., 2022).

While there is research and evidence focused on the impact of obstructed, delayed, or restricted access to abortion on mortality, morbidity and well-being-allied concepts at the individual level, there are several dimensions that remain understudied. Much of the evidence base focuses on the individual level; more attention to how abortion and well-being intersect at the meso-level (e.g., education systems or health systems) and the macro-level (e.g., knowledge environments or laws) would help develop a more holistic understanding of well-being and abortion. This echoes recent research exploring the impact of abortion stigma at the meso- and macro-levels, potentially offering important methodological and theoretical insights into the intersections of abortion and well-being (Millar, 2020; Coleman-Minahan, 2021, Strong, Coast, & Nandagiri, 2023).

While health impacts of abortion have focused on unsafe abortion methods, related complications and their care, recent work has engaged with how self-managed abortion and telemedical abortion (formal and informal) can be safe(r) methods (Raifman, Ralph, Biggs, & Grossman, 2021; Sorhaindo & Sedgh, 2021, Aiken, Romanova, Morber, & Gomperts, 2022). Engaging with how well-being is shaped by abortion modalities – e.g., self-managed, facility-based, or telemedical (or other

[2] Menstrual regulation refers to uterine evacuation to ensure a state of non-pregnancy, or early abortion.

configurations) is less understood. There is some work reflecting on the impact of accompaniment networks on outcomes (e.g., (Bercu et al., 2021; Veldhuis et al., 2022), but engaging with their practices and methods of care-provision could help highlight the positive and joyful dimensions important to conceptualisations of well-being. There is also a need to understand how these models of care operate in later gestations (Bercu et al., 2021; Keefe-Oates, Tejada, Zurbriggen, Grosso, & Gerdts, 2022). This could help elucidate implications of abortion for well-being over the life course. Understanding the well-being implications for the constellation of actors involved in the provision of abortion care is a further extension of the intersections of abortion and well-being.

More research and evidence that engages with the complex emotions surrounding abortion are needed. Much of existing research focuses on the abortion and often collects data shortly after the experience. Engaging with emotions and their shifts over the life course (i.e., longitudinally), may help disentangle emotions about the abortion experience (e.g., pain, procedures), their decision-making, and meanings of abortion for them (Pistani & Ceccato, 2014).

4.2. Methodological implications for studying abortion and well-being

There is a rich and diverse body of qualitative and mixed-methods evidence that frame and shape concepts or domains of well-being in relation to abortion – without labelling or defining it as well-being – in the context and 'voice' of their respondents. The richness of well-being-allied domains and concepts offers avenues for theorising abortion well-being in novel ways. Given the under-developed role of well-being in abortion research, evidence from qualitative research offers exploratory insights. These insights could be used to inform quantitative research instruments that measure well-being in relation to abortion.

Participatory approaches to understanding well-being (Robeyns, 2003) or the use or adaptation of existing scales (Council, 2012, Salsman et al., 2014; Lindert, Bain et al., 2015; Cooke, Melchert et al., 2016; Linton, Dieppe et al., 2016) offer potentially generative avenues for abortion research, although many well-being scales and sub-scales remain unvalidated outside of Global North and/or English language contexts. By considering how abortion research resonates with non-abortion research on well-being, connections and opportunities for theorising and deepening understanding might emerge, including for example, of different types and trajectories of abortion care-seeking, or of legal or health system context, or for specific populations. To illustrate, a study assessing young people's well-being in the context of HIV in sub-Saharan Africa (Govindasamy et al., 2020), identified key themes that shaped experiences suggestive of well-being – all of which are similarly present in abortion literature as shaping abortion experiences.

There were gaps in the diversity of populations in the included studies, the majority of which recruited abortion care-seekers from the site of care sought (i.e., abortion clinic, telemedicine, medical abortion by mail). The lack of diversity in the populations included in well-being and abortion studies is not only a significant barrier to understanding and measuring well-being but also to improving abortion services, experiences, and outcomes for all individuals regardless of background or identity. Some included studies focused on specific populations, and concluded that ethnicity, racial background or immigrant status uniquely influence the process of abortion care, including access and quality of care (Brown, Plummer et al., 2022; Deeb-Sossa & Billings, 2014; Mavuso & Macleod, 2020; Monchalin, Perez Pinan et al., 2023). Migrant experiences may differ based on their legal status, the reasons for migration (e.g., forced displacement), duration of migration, or the type of migration (e.g., internal, international). Macro-level studies that segmented their populations by some of these characteristics found that migrant status, immigrant enforcement, and language played a role in abortion access (Autorino, Mattioli, & Mencarini, 2020; Redd et al., 2023). Little is known on how age intersects with well-being and abortion, beyond research focused on judicial bypasses for young people or on young peoples' experiences of care-seeking (Clyde et al., 2013; Coles et al., 2010), and the life course impact could highlight the longer-term implications of abortion and well-being. Similarly, contrasting this with older peoples' experiences could help deepen some of the understandings of well-being, risk, and harm that surround notions of abortion. Abortion research on trans, non-binary, and gender-expansive individuals is limited, and more work thinking about how well-being is implicated in their abortion trajectories is needed (Fix et al., 2020; Bowling et al., 2021; Moseson et al., 2022). The well-being implications of abortion for displaced persons or individuals living in a humanitarian setting, differently abled individuals (intellectually or physically), or incarcerated persons remain inadequately researched and understood.

We suggest that established approaches to conceptualising well-being can offer creative opportunities for abortion research and offer illustrative examples. For example, capability-based approaches (Nussbaum, 2011; Sen, 1999) to well-being emphasise the multi-dimensionality of well-being and how an individual can deploy the resources available to them to achieve well-being. For example, an individual can go to a clinic (ability) but if they are refused abortion care (conditions), then that person's abortion care-seeking opportunities or abilities are limited in ways that are intersectional. Frameworks such as Ross et al.'s (2020) approach to conceptualising adolescent well-being or Lorimer et al.'s (2022) conceptualisation of sexual well-being could be adapted and iterated to theorise domains of abortion and well-being that could focus on whether an individual has the conditions necessary to enable them to do something rather than the abilities to do so. Some areas of interest may include reflecting on how abortion is linked to broader social and material environments including safe water, housing, sanitation, education, information, privacy, and fulfilment. Here, drawing on frameworks like Reproductive Justice (Ross & Solinger, 2017) or the abortion trajectories framework (Coast et al., 2018) may help point to specific elements that require further evidence and interrogation from a well-being perspective.

Engaging explicitly with the temporality of abortion and well-being at a range of scales, from a single abortion trajectory to the life course is a potentially generative focus for future research (Coast et al., 2018). A trajectories framework would allow for understanding beyond the abortion to situate it from pregnancy recognition to abortion-seeking to [any] post-abortion care. A life course framing would allow for abortion well-being not to be limited by the episodic framing; for example, by extending understanding of "post" in relation to post-abortion care would help to move beyond a narrow focus on treatment of postabortion complications to include broader domains of emotional and mental well-being. The safety of abortion and its implications for understanding well-being could similarly be extended; whilst biomedical safety is understood as a continuum rather than a binary, abortion safety tended to be framed narrowly in the included evidence in our narrative literature review despite recent conceptualisations (Ganatra et al., 2017, Gemzell-Danielsson & Cleeve, 2017, Nandagiri, 2018, Gerdts, Bell, Shankar, Jayaweera, & Owolabi, 2022, Nandagiri, 2022). Dimensions of "social safety", for example, and their implications for well-being offer expanded ways of understanding the implications of abortion (non-) care, including self-management (Nandagiri, 2018, 2022). A constellations approach, although currently developed specifically in relation to self-managed abortion (Berro Pizzarossa & Nandagiri, 2021; Nandagiri & Berro Pizzarossa, 2023), could be used to identify and understand all the actors (whether enabling or not) involved in a single abortion trajectory and the implications for well-being of both the abortion-seeker and any other actors and their interactions.

4.3. Study limitations and strengths

This systematically searched narrative literature review has limitations. The included languages (i.e., English, Spanish, Portuguese, French, Turkish) and time frame of the search (2005–19/06/2023)

limited the scope of what was included in this study. Relevant articles outside of our inclusion languages and years may have been missed. However, 33/7665 articles yielded were in an excluded language at the full-text screening stage [Fig. 1] and we conclude that what our search did not linguistically capture is minimal. The exclusion of articles pre-2005 reflects the constantly evolving context of abortion, for example shifting legal contexts. This means that evidence – including some very recent evidence – becomes contextually outdated. Other types of literature, such as books and chapters, were also excluded which may have included relevant information. Our request from experts to share additional items may have resulted in relevant evidence being missed because our networks might not have been sufficiently diverse or deep. To further develop the universe of potentially useful evidence for understanding abortion and well-being, use could be made of citation tracking and/or AI-informed approaches to generate out from our inventories. As a narrative literature review, we did not quality assess extracted items.

Our conceptualisation of well-being is both a limitation and strength in this literature review. On the one hand, the broad scope and definition impacted how we searched and what the search yielded. Our search included a plethora of terms, concepts, and themes that may be considered or included in well-being. This is simultaneously a strength, as the search yielded great breadth and depth in the abortion and well-being literature. Our sizable search yield and eligible for inclusion rate (20.47% for title-abstract and 48% for full-text) demonstrate the expansive scope of our review. This allowed us to capture well-being in its multiple dimensions and framings. Our engagement with well-being was led by the analysis and conclusions of reported studies. In some cases, the implications for well-being may be more complex (e.g., positive impact on subjective well-being due to accessing care, even when care is poor or discriminatory) and may be missed.

The scale of articles that were eligible for inclusion means that we were unable to extract all of them. Our saturation approach was designed to confront the limitation of not extracting all the eligible studies. Narrative reviews are not required to include all relevant literature on a topic and do not aim to be inclusive of all literature, similar to considerations of saturation or thematic sufficiency in primary qualitative research. We included all the macro and meso-only articles before taking a grounded theory inductive approach to the micro-only studies, ensuring that what was extracted reflected the breadth and depth of the eligible literature. The shortcoming of this approach is that not everything that was eligible was extracted. Our consistent and constant revisiting of what was extracted in comparison to the eligible literature has resulted in an included sample for a narrative literature review that we are confident is reflective of the literature, rooted in the grounded theory approach that underpins saturation.

5. Conclusion

Well-being can be a useful and productive analytic framing that offers generative insights for abortion research. Well-being and allied concepts are clearly relevant in the field of abortion and reproductive health more broadly. We invite readers to consider how these concepts might be used to develop and iterate innovation – methodologically, empirically, and theoretically – to clarify, extend and deepen links between abortion and well-being.

Our replicable search strategy and inventories – eligible studies, other languages studies and literature reviews – offer a rich set of material that can be exploited for further focused analyses and understandings of the intersections between well-being and abortion care-seeking and provision. For example, further analyses could be of different types and trajectories of abortion care-seeking, or of legal or health system context, or for specific populations. Future studies may account for recent theorisations – e.g., on the "constellation of actors" (Berro Pizzarossa & Nandagiri, 2021) and engage with the role of family members, partners, and other actors in shaping individual well-being. The inventories allow for considering how well-being intersects with other generative theories and frameworks, such as reproductive self-determination, structural violence, reproductive justice, and intersectionality.

Further exploring these areas within abortion research can elucidate the ways in which differential access to quality abortion and other reproductive health care impacts well-being on micro-, meso- and macro-levels, and may have implications for how well-being is conceptualised, defined, measured, and understood.

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CRediT authorship contribution statement

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The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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