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Technology in Abortion Care: a Scoping Review on Contexts of Use, Research Methods, Ethical Considerations and Impact

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Abstract

Globally, about 40% of women and people assigned female at birth live under laws that restrict or prohibit access to safe abortion care. Even where abortion is legal, socio-cultural stigma and health inequities hinder timely, equitable access. Technologies have been developed to support abortion seekers and providers in overcoming barriers to information, safe abortion care, and support. However, research on abortion care technologies is fragmented, spanning medical and computing publications, and lacking a consolidated understanding. To address this gap, we conducted a scoping review of 92 studies, examining technological applications, contexts of use, research methods, ethical considerations, and pathways to impact. This analysis informs the HCI research agenda for abortion care, highlighting future directions, and fostering reflection on design, ethics, and meaningful impact. We call on HCI researchers to move beyond telemedicine and U.S.-centric perspectives, re-politicize abortion care technologies, and consider temporality in delivering timely abortion care amid broader sociopolitical constraints.

CCS Concepts

• **Human-centered computing** → **Human computer interaction (HCI)**; • **Applied computing** → **Health informatics**.

Keywords

abortion, reproductive health, telemedicine, digital health, ethics

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1 Introduction

The Human-Computer Interaction (HCI) community has been increasingly investigating abortion through engagements with activists [105, 122], informal and professional care providers [111, 118, 148], and efforts to validate participants [97, 98]. As this body of work grows, now is an opportune moment to reflect on what has been explored, and the implications of this research. Such reflection is essential to ensure that future HCI research is grounded in interdisciplinary understanding and ethically responsive to the sociotechnical complexities of abortion care.

For over two decades, technology has increasingly played a critical role in abortion care, helping abortion seekers and providers navigate barriers to safe, timely, and equitable access to care [55]. Digital tools and platforms have been designed and deployed at local, national, and international levels to deliver information, connect people to services, and provide support. Early examples include the telemedicine abortion service provided by Women on Web since 2004, established to "*transcend national borders and reach the most restricted settings with safe abortion services*" [138]. More recently, the COVID-19 pandemic accelerated the adoption of telemedicine and hybrid models of care, enabling continued access to abortion services during lockdowns and restrictions across many regions worldwide [24, 39, 90, 156, 165]. In regions where abortion is restricted or prohibited, technology serves as a lifeline enabling individuals to self-manage their abortion at home [1, 138]. Even in regions where abortion is legal, stigma, health inequities, and healthcare professionals' conscientious objection continue to create barriers within formal healthcare systems [34, 50, 127]. In such contexts, technology-supported abortion services may be a preferred, or required, pathway to care.

To advance and inform the HCI research agenda, it is essential to understand how technology has been used in abortion care to date. Yet, research on abortion care technologies is fragmented, spanning across medical and computing publications, and would benefit from an interdisciplinary examination within HCI. In this paper, we present a scoping review of 92 peer-reviewed studies, mapping existing research on technologies designed to support abortion care. This includes systems for information-seeking, access

to services, abortion procedure, and continuity of care. Our review addresses the following research questions:

- RQ1** In which contexts has research explored abortion care technologies?
- RQ2** Which applications of technology have been investigated, and what research methods were used?
- RQ3** How do researchers navigate ethical challenges when conducting research in this context?
- RQ4** How do they seek to create impact through such research?

Our work makes four key contributions: (1) an overview of existing research on abortion care technologies, (2) a mapping of investigated applications and research methods, (3) an analysis of ethical challenges and strategies for addressing them, and (4) a reflection on how research in this space can foster meaningful impact in abortion care and beyond. Our work enables a multidirectional translation pathway, whereby the HCI, digital health, medical and public health communities can learn from one another's approaches to research, design, ethics, and impact when developing abortion care technologies.

2 Background

Abortion, or termination of pregnancy, is a common reality worldwide, experienced across societies, cultures, and generations. Indeed, each year, nearly half of all pregnancies worldwide (around 121 million) are unintended, and approximately six in ten of these, along with three in ten intended pregnancies, end in induced abortion [141]. An abortion is an intervention to end a pregnancy, and is undertaken for a variety of medical, socio-economic, and personal reasons. There is no single profile of abortion seekers; instead, individuals seeking abortion reflect a wide spectrum of identities, circumstances, and needs [44]. As the World Health Organization highlights, restricting access to abortion does not reduce the number of abortions, but greatly increases the likelihood of unsafe procedures, underscoring termination of pregnancy as a critical component of reproductive healthcare [140]. In this section, we present key definitions and context for abortion care internationally, to situate our scoping review.

2.1 Abortion Care

When legally permitted, abortion care is commonly provided through two main methods: medication abortion and surgical abortion. *Medication abortion* (also known as medical abortion) usually involves the intake of mifepristone followed by misoprostol. More rarely, a misoprostol-only regimen is used. While there is no absolute gestational limit for the use of medications to induce abortion, safety, efficacy, and clinical protocols vary by gestational age. Self-managed medication abortion is typically recommended only up to a certain stage of pregnancy, with thresholds differing across jurisdictions. *Surgical abortion*, such as vacuum aspiration, is performed in clinical settings and may require anesthesia and additional medical oversight. Moreover, models of provision for abortion care can vary, ranging from community-based services (such as medication abortions provided in general practices), to in-clinic or hospital-based care, and self-managed abortions at home. Hybrid models have emerged as well, especially during the COVID-19 pandemic, combining remote and in-person elements

(such as an initial teleconsultation followed by in-clinic or at-home medication provision). Timely access to abortion care is crucial, as delays can increase the risk of complications [78] and the likelihood that a person will need a later-stage surgical procedure instead of an earlier, less invasive medication abortion [54]. They can also significantly affect individuals' mental health in both the short and long term [184] particularly in contexts mandating a waiting periods, where the experience of *waiting* often becomes one of *coping* [12]. Finally, delays and access barriers can push abortion seekers beyond the legal window for care [142].

2.2 Abortion Laws

Access to safe abortion care is closely tied to the autonomy, dignity, and human rights of women and people assigned female at birth, as affirmed by the World Health Organization [139]. Yet, in many parts of the world, abortion remains restricted or prohibited. Approximately 40% of women and people assigned female at birth live under restrictive laws [65]. For instance, gestational limits, mandatory waiting periods, and requirements for in-person consultations can create barriers to timely and lawful access to abortion care [54, 64]. In recent years, legal landscapes around abortion have shifted in both restrictive and permissive directions. The *Dobbs v. Jackson Women's Health Organization* decision in the United States overturned federal protection for abortion rights, enabling individual states to impose severe restrictions or outright bans [175]. Similarly, Poland has introduced some of Europe's most restrictive abortion laws, leading to reports of increased unsafe abortions and cross-border travel for care [83]. Conversely, other countries have moved toward legalization or expanded access. Ireland legalized abortion in 2018 following a national referendum [26], while in 2024, France became the first country to enshrine abortion in its constitution – a symbolic move that, however, does not guarantee effective or equal access to abortion and leaves room for a potentially restrictive legislative framework [176]. Indeed, legality does not guarantee accessibility. Stigma surrounding abortion continues to shape access and care experiences, affecting both abortion seekers and providers. It also impacts healthcare professionals' willingness and ability to provide abortion services. Conscientious objection further limits service availability and exacerbates inequities in access [142]. Furthermore, protests by anti-abortion groups outside practices providing abortion services led governments to implement safe access zones to protect both patients and providers [143].

2.3 The Role of Technology

Following recent abortion restrictions and bans in the U.S., HCI research has increasingly examined how legislative changes shape individuals' interactions with reproductive health technologies [29, 52, 148] and associated privacy policies [74]. This body of work in HCI examines the role of technology in platforming abortion activism, and information provision. Other HCI research focuses on fertility tracking and digital contraception tools [62, 81, 101, 119], an area in which abortion bans and restrictive laws are often discussed as related concerns. In contrast, our review examines technologies specifically designed to support abortion care, including information-seeking, access to services, abortion

procedure, and continuity of care. Since the early 2000s, a range of technologies has been developed and implemented to support abortion seekers and providers in navigating barriers to information, safe abortion care, and support across local, national, and international contexts. Telemedicine has been a particularly transformative intervention. Organizations like Women on Web have been providing online access to medication abortion for individuals in restrictive legal settings internationally [138], demonstrating how digital platforms can circumvent geographic and regulatory constraints. During the COVID-19 pandemic, countries including Ireland [59], Canada [57], the U.K. [137] and France [51] rapidly expand telemedicine services to maintain access to abortion under lockdown conditions. Alongside this shift, a large number of clinical trials find that patients' outcomes with telemedicine services are comparable to those of in-clinic care, demonstrating the effectiveness and safety of telemedicine abortion services [55, 100]. Beyond telemedicine, online communities and platforms emerged as critical resources for abortion seekers. These spaces allow individuals to share information about providers, exchange personal experiences, and offer peer-to-peer support [131], serving as crucial resources in regions where abortion is highly restricted or prohibited, or where formal services are limited or difficult to access.

As outlined above, there has been rapid adoption of technology for abortion services in recent years. Abortion care technologies are used in what is often a highly stressful, time-constrained period of a person's life, operating within politically sensitive and ethically complex environments. This reality highlights the need for a comprehensive mapping of the field. Existing literature reviews have focused on assessing the effectiveness, safety, and patient satisfaction of telemedicine services from a medical perspective [55, 100]. Grounded in an HCI perspective, our work complements and advances this prior research by examining how abortion care technologies are developed and studied, what methodological approaches researchers use, and how they navigate ethical challenges to create meaningful impact.

3 Method

We conducted a scoping review to address our research questions. A scoping review is a systematic and transparent method that supports the mapping of "a body of knowledge that is heterogeneous in methods or discipline" [178]. This method is therefore well-suited for mapping existing research on abortion care technologies, which spans the fields of medicine and computer science. Our approach follows the scoping review framework proposed by Arksey and O'Malley [14], and adheres to the PRISMA–ScR reporting guidelines [178].

3.1 Protocol Development and Registration

We conducted preliminary searches to refine the eligibility criteria, identify relevant databases, and finalize search queries. First and second authors piloted data charting by independently extracting data from ten papers. Insights from this pilot and discussions with all co-authors informed the development of our protocol, which we registered with the Open Science Foundation [130].

3.2 Literature Search

Database searches were conducted on December 9, 2024, across medical and computing venues, with no time restrictions, to capture the full scope of relevant research to date.

3.2.1 Eligibility. An article was included in our corpus if it met the following eligibility criteria:

- EC1** Reports research directly examining technologies designed to support abortion care.
 - includes studies that have for primary focus health and mental health care around abortion.
 - excludes studies focusing on technologies and online platforms not specifically designed to support abortion care.
 - excludes studies examining abortion care technologies through an analysis of social media data.
 - excludes studies concerned with analyzing public discourse around abortion and abortion care.
 - excludes studies that investigate the effectiveness of drugs or surgical procedures.
- EC2** Is a full-length research article written in English.
 - excludes documents that are not full-length research papers (e.g., abstracts, works in progress, position papers, opinions, comments, protocols, posters, books, ...).
 - excludes articles not written in English.
- EC3** Reports research involving human participants.
 - excludes literature reviews.

3.2.2 Database Selection. We selected a set of databases that comprehensively index literature on digital health: the ACM Digital Library, PubMed, ScienceDirect, Web of Science, and Scopus. This selection aligns with common practice for digital health reviews [21, 37, 96, 147] and is informed by prior searches using our query in additional databases, including Ovid and IEEE Xplore, which returned no full-length research articles.

3.2.3 Search Terms. Search terms were selected to capture publications at the intersection of technology-supported healthcare and abortion care, with the goal of identifying technologies specifically designed to support abortion care. The authors iteratively brainstormed and refined terms related to abortion and digital health. The combination "*abortion*" and "*digital health*", along with related variants ("*mobile health*", "*telemedicine*", "*telehealth*", "*ehealth*", "*mhealth*") led to relevant results. Other terms were excluded as they frequently returned papers outside our eligibility criteria. For example, "*abort*" often appeared in systems papers in the ACM Digital Library, while "*termination of pregnancy*" and related variants returned a mix of eligible papers that already used the term "*abortion*" and additional results that were not relevant [2, 32, 79]. Other examples include broader technology terms such as "*computer*", frequently used to describe data-analysis methods [40, 43, 124]. Terms related to "*online communities*" were also excluded, as they often returned studies focused on general social media platforms or forums not specifically designed to support abortion care. Instead, we selected the phrase "*online support*", which, when paired with "*abortion*", more effectively captured technologies purposefully designed for this context.

3.2.4 Search Strategy. The databases ScienceDirect, Web of Science, PubMed, and Scopus were searched for articles containing the term “*abortion*” and at least one of the following terms in the title, abstract, or keywords¹: “*digital health*,” “*mobile health*,” “*telemedicine*,” “*telehealth*,” “*ehealth*,” “*mhealth*,” and “*online support*”. The ACM Digital Library, given its focus on computing publications, was searched for articles containing “*abortion*” in the title or abstract.

3.2.5 Screening. The first author used the databases’ filtering systems to automatically exclude publication types that did not meet EC2. The search results were then screened for eligibility by the first and second authors, assessing each paper’s title and abstract against eligibility criteria EC1 and EC3. When the abstract did not provide sufficient information to determine eligibility, the full text was reviewed. Both authors then examined the full text of all papers deemed eligible based on abstract screening to confirm their inclusion or exclusion. Any discrepancies were resolved through discussion until consensus was reached.

3.3 Data Extraction

We charted data across five dimensions: research context, technology context of use, research methods, ethical considerations, and impact. The full set of charting factors is detailed in our scoping review protocol, which is registered with the Open Science Framework [130]. The corpus was divided between the first and second authors, who independently extracted data from the included papers. The authors met regularly to resolve uncertainties and ensure consistency in the data extraction process.

3.4 Data Analysis

For data items charted into predefined categories, we report the number of studies within each category and provide descriptive summaries, illustrated with examples from the corpus. When an “Other” category was used to capture concepts not covered by the predefined categories, we describe these approaches in the text. For items recorded as free text, we synthesize and summarize the range of approaches identified across the corpus. Ethical considerations and research impacts, recorded through both predefined categories and extracted text, are presented as descriptive summaries organized around the predefined categories and expanded with new themes where additional issues were identified in the data.

3.5 Positionality Statement

Disclosing positionality in this sensitive context, such as acknowledging one’s stance on, or personal experience with, abortion care, is a delicate and potentially risky matter. In a landscape where abortion laws are continually shifting, and with no visibility on future legislative changes, such disclosure could expose researchers to legal, institutional, and social pressures. In this statement, we present our positionality at the group level, reflecting only what we collectively feel comfortable sharing in published work.

¹PubMed does not support keyword searches and was therefore searched using titles and abstracts only.

All authors are women and regard abortion as essential healthcare. One resides in a U.S. state with an abortion ban, the others are based in Ireland where abortion is legal. As an interdisciplinary team, we bring diverse expertise to this work. One author contributes clinical insights shaped by national-level leadership in abortion care, while the others bring HCI perspectives with a focus on women’s and reproductive health. Two authors have previously published HCI research on abortion activism, which informs our commitment to understanding and supporting reproductive healthcare within socio-technical contexts. To varying degrees, we have participated in abortion rights activism, and our perspectives are shaped by these professional and personal commitments. We acknowledge that we are all white, highly educated, and based in the Global North, with experiences of reproductive healthcare situated in Irish, French, and American contexts. This positionality informed how we approached, interpreted, and framed the literature. We recognize the limits of our perspectives and the importance of critically engaging with voices and experiences beyond our own.

4 Findings

4.1 Search Results

Our search yielded an initial corpus of 903 papers. Following the screening process and application of eligibility criteria, we identified a final set of 92 papers for inclusion in our analysis. The screening process and study selection are summarized in the PRISMA flow diagram (Figure 1).

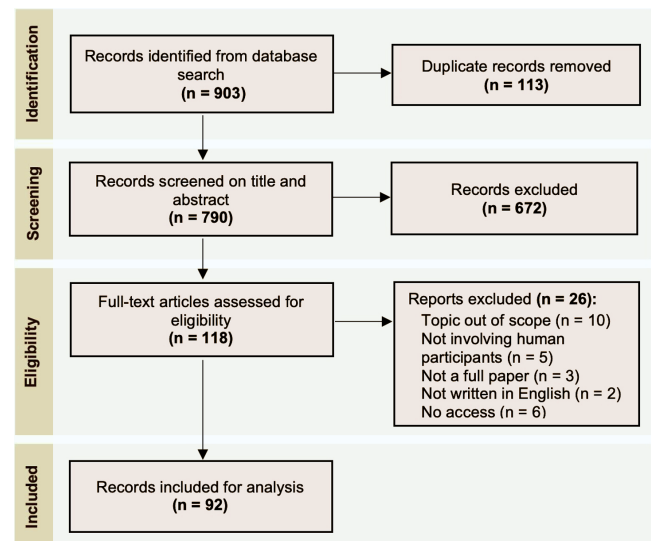


Figure 1: PRISMA flow diagram.

Our corpus shows a steady increase in publications from 2013 to 2024, as illustrated in Figure 2. Peaks in 2021 and 2024 may reflect growing interest in telemedicine abortion care during the COVID-19 pandemic [9, 15, 24, 39, 53, 60, 67, 71, 72, 82, 90, 102, 107, 109, 121, 146, 156, 156, 163, 165, 170, 177] and renewed focus following the Dobbs decision [10, 18, 66, 93–95, 107, 126, 152, 154, 159, 164, 170, 177], respectively.

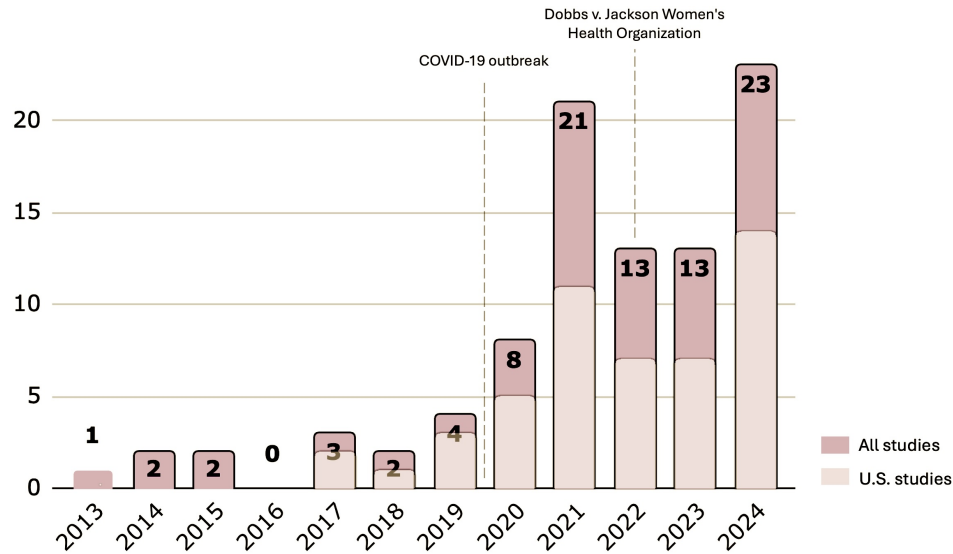


Figure 2: Distribution of studies in the corpus by publication year, with U.S.-based studies highlighted.

Of the 92 articles in our corpus, the majority were published in medical or health-centered journals ($n=80$). A smaller portion were published in HCI and digital health venues ($n=10$), including ToCHI [118], Nordi CHI [111], and e-health journals [68, 69, 75, 93, 120, 155, 159, 162]. One study was a geography article [131].

4.2 Research Contexts

As illustrated by Figure 3, the majority of studies were conducted in the United States (51 out of 92). Fifteen studies included data from multiple countries, including a 10-year review of Women on Web’s telemedicine abortion services, which spanned as many as 183 countries [132]. Most studies were conducted in regions where abortion was legal at the time, as presented in Table 1.

Context	Studies
Abortion (at time of study)	
Legal	34
Restricted	15
Banned	3
Various laws	25
Not reported	15
Research aims	
Understanding people	32
Designing technology	2
Evaluating technology	30
Integrating technology	41
Other	1
COVID-19 pandemic	28

Table 1: Distribution of included studies by abortion legislation, research aims, and focus on the COVID-19 period.

Cross-country studies, and some U.S. and Australian studies, spanned various legal contexts. Only three studies took place

in regions where abortion was banned: Senegal [171], the Philippines [131], and the U.S. state of Mississippi [107]. The majority of studies focused on evaluating or integrating telemedicine systems supporting self-managed abortion, either under clinical supervision or fully self-managed. Fewer publications examined the experiences, needs, and contexts of abortion seekers and providers. Notably, despite the growing role of technology in abortion care, only 2 out of 92 studies explored the design of new technologies [69, 111], highlighting a significant gap in design-oriented research in this space.

4.3 Technologies’ Contexts of Use

The corpus predominantly explored technologies for accessing care and providing telemedicine services (see Table 2). Examples include established web platforms specifically designed for telemedicine, such as Aid Access (www.aidaccess.org) [8, 72, 88, 112] and Women on Web (www.womenonweb.org) [7, 25, 63, 90, 108, 132, 182]. Several studies evaluated newer tools developed to support these services, such as mobile applications [42, 165] and text-message-based platforms [45, 46], and three studies explored abortion seekers’ preferences for models of care [102, 107, 164]. A smaller proportion of the corpus explored technologies supporting continuity of care, including post-abortion management [38, 45, 46, 53, 68, 69, 77, 111, 120, 131, 165, 180], and guidance on contraception [53, 68] – reflecting a more holistic orientation toward abortion and reproductive health. Papers in the ‘Other’ category explored healthcare professionals’ privacy concerns [118], and individuals’ preferences regarding models of care [102, 107, 164]. Abortion seekers (i.e., the primary recipients of care) were the most frequently represented user group. Healthcare providers were the next most studied, followed by staff of non-profit and not-for-profit organizations. Notably, one study explicitly included abortion seekers and their partners as target users [68].

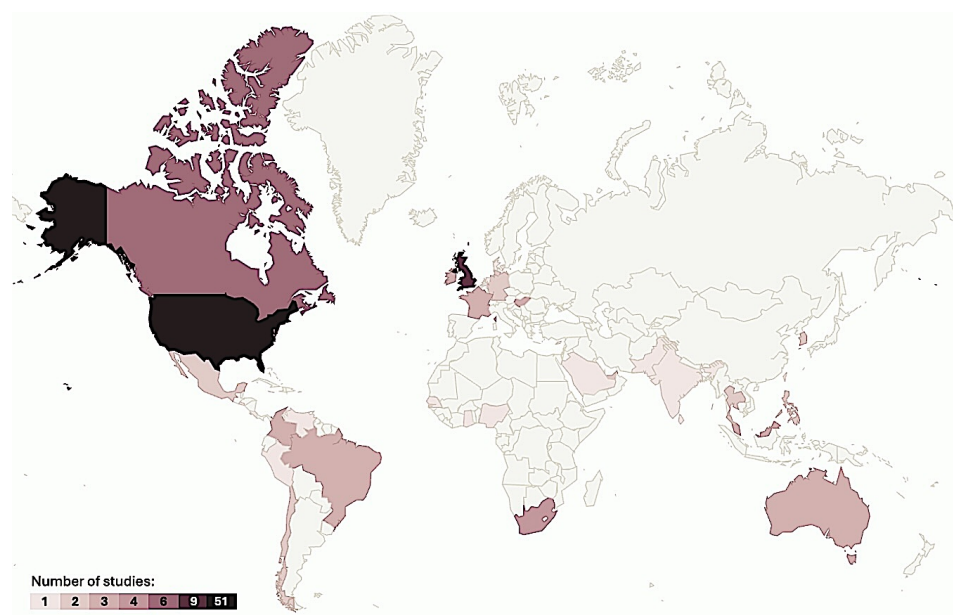


Figure 3: Spatial distribution of studies in the corpus.

	Care journey				
	Information-seeking	Access to services	Abortion procedure	Continuity of care	Other
User groups					
Abortion seekers	5	27	56	12	3
Clinicians	0	11	33	5	1
Non-profits	0	3	12	2	0
General population	0	0	1	0	1
Technology aims					
Telemedicine	3	26	59	8	3
Education	0	0	1	2	0
Mental health support	0	0	0	3	0
Physical health support	0	0	0	1	0
Peer-support	1	1	0	1	0
Other	1	0	1	3	1

Table 2: Distribution of studies in the corpus by user group and technology aim across care journey stages.

4.4 Research Methods in Abortion Care Studies

Methodologies reported on included qualitative (n=27), quantitative (n=37), and mixed methods (n=28). The majority of studies reported on data regarding abortion seekers only (n=64), with a further 9 studies including clinicians only. A minority of studies (n=15) included multiple stakeholders in their participant sample. A considerable number of quantitative studies (n=29) reported on patient survey data collected by telemedicine services as a means of evaluating patient outcomes. The rest of the studies had direct involvement from participants, including data collection (n=60), and one study involving participants in study design [157], or one in data analysis [111]. Sample sizes ranged from 8 to 98 participants for qualitative studies (mean 31, SD 23), 125 to 112,513 (mean 9,851, SD 21,315), and 534 to 809 (mean 672, SD 194). About

one third of the corpus employed gender-inclusive language. However, it is unknown whether the technologies themselves adopted such language – an important consideration, as inclusive terminology is “key to the provision of safe and accessible abortion care, and imperative to overcoming generations of mistrust held by the LGBTIQ+ community” [22].

There were no dominant theories across the papers, but theoretical frameworks adopted included the Consolidated Framework for Implementation Research [70], Person-Centered Framework For Reproductive Health Equity [89], Abortion Trajectory framework [116], Socio-technical Systems framing [171], normalisation process theory [150] – all used in interview studies – and the Technology Acceptance Model in two mixed method studies [68, 69]. Epistemological positions reported

included phenomenological [131], human-centred [68], and intersectional [163] approaches. Frameworks and tools reported included metaphor-led design [111], the Miller patient-provider communication framework [177], Chen and Reay's model of professional identity restructuring [146], and the Medical Abortion Reporting Efficacy (MARE) guidelines [132]. Nine (qualitative) studies included positionality statement [70, 71, 103, 107, 111, 118, 131, 168, 177].

Of the studies reviewed, 59 reported obtaining ethics approval from an Institutional Review Board (IRB), 25 from a Health Authority, and 17 did not report or were considered exempt from ethics approval. However, IRB approval alone does not guarantee comprehensive protection for participants or their data. Some American studies reported securing NIH Certificates of Confidentiality to further safeguard participant privacy – protections that are vulnerable to political shifts. In the next section, we unpack the strategies and precautions researchers employed to protect the safety of abortion technology users.

4.5 Reported Ethical Considerations in Technology-Supported Abortion Care

The integration of technology into abortion care brings not only opportunities for expanding access, but also complex ethical challenges. These challenges are deeply entangled with the sociopolitical and legal contexts in which abortion care is provided and received. This section unpacks ethical concerns related to legal and regulatory constraints on abortion technologies, risks faced by care recipients, and the potential misuse of these technologies in contexts where anti-abortion groups are particularly influent.

4.5.1 Legal and Regulatory Challenges. Legal and regulatory frameworks heavily shape how technology is designed, implemented, and accessed in abortion care. Restrictive abortion laws not only limit or prohibit care provision, they also create ethical dilemmas for both abortion seekers and providers navigating technology-mediated services. In Senegal, where abortion seekers and providers face the risk of imprisonment, termination of pregnancy services depend entirely on international organizations. A 2015 study notes:

"Laws and policies that reject abortion as a legitimate form of reproductive health and isolate abortion technology from routine obstetric practice reinforce the marginalization of women's sexual and reproductive health in national and global health policies and programs." [171]

In the United States, a 2021 study highlights that providers seeking to offer telemedicine abortion services must navigate a complex web of federal, state, and organizational requirements [70]. Legal constraints also shape clinical workflows. For example, informed consent requirements have posed barriers to implementing telemedicine abortion services; a 2022 U.S. study advocates for the integration of remote consent tools to address this challenge [115].

Restrictive laws compel abortion seekers to undertake complex logistical and legal manoeuvres to access care. Two American studies report that abortion seekers resorted to establishing an

address in another state to receive abortion medications [84] or avoid prosecution in their home state [93].

These shifting legal landscapes also raise concerns for researchers developing abortion care technologies. In the U.S., where restrictions and bans have intensified following the *Dobbs v. Jackson Women's Health Organization* ruling, researchers stress the uncertainty this creates for the future of abortion care technologies and the people who rely on them [107].

4.5.2 Barriers to Timely Abortion Care Provision. Abortion care is a time-sensitive context where delays carry important clinical and ethical implications. Two studies reported delays – ranging from minor to up to three weeks – related to the mailing of abortion medications in telemedicine settings [33, 95]. In some cases, this led to restricting telemedicine access for individuals at more advanced gestational ages:

"[Abortion] kit delivery and medication intake could take up to three weeks, which could exceed the twelve-week threshold" [33]

We emphasize Koenig et al.'s finding that researchers must clearly communicate potential delays and account for logistical constraints in designs to empower people to manage their abortion experiences. Privacy-related barriers also contributed to delays. Individuals receiving medication abortion via telemedicine sometimes postponed medication intake due to a lack of privacy (especially in the COVID-19 pandemic context) or because of unsafe domestic environments [24, 121].

4.5.3 Lack of Social and Institutional Support and Safeguarding Measures. Technology-supported abortion care can introduce or exacerbate risks for abortion seekers when social and institutional support is lacking. Examples from the corpus illustrate how the absence of logistical, medical, and legal safeguards can shape abortion seekers' experiences, particularly within hybrid models of care. Hybrid delivery models – where individuals receive remote consultations followed by in-clinic procedures – imply individuals' ability to travel. However, this requirement can pose significant challenges. A 2019 U.S. study [54] highlights that travel-related challenges can greatly impact abortion seekers' wellbeing, with participants reporting long journeys, limited support, and difficult trade-offs between effective pain management and the ability to return home safely. One participant, for instance, described deliberately limiting her pain medication to retain the capacity to drive herself after undergoing a surgical abortion:

"I knew going in [...] I cannot be given pain killers that cannot let me drive after. [...] I'm here alone and I have no other choice. And you have to give me the least amount you can give me. [...] I can handle the pain. The pain's not unbearable. I have to be able to drive." (Participant 2, traveled 280 miles, surgical abortion) [54]

Beyond logistical barriers, integrating technology-supported abortion care into unsupportive or hostile healthcare contexts can increase risks for care recipients. A study from Australia underscores how provider bias and institutional gatekeeping may undermine abortion seekers' autonomy:

"Finding facilities that would administer Rh(D) immunoglobulin to Rh-negative women promptly and nonjudgmentally has been problematic. Some surgical abortion providers dissuaded women from choosing medical abortion, citing excessive pain and bleeding." [84]

Furthermore, in contexts where individuals face intimate partner violence, the absence of institutional safeguards can result in abortion technologies being weaponized against vulnerable users. A 2022 study from Colombia [115] highlights how such gaps in protection may enable coercion, with some individuals pressured into terminating pregnancies against their will. The same study also raises concerns about the risk for telemedicine services to be intentionally sabotaged by anti-abortion actors – ordering pills only to discard them – in an effort to discredit and disrupt services in politically hostile environments [115].

These examples illustrate how individuals' experiences with technology-supported abortion care are profoundly shaped by the social and institutional contexts in which these technologies are deployed. Without robust safeguards and equitable access to supportive services, even well-intentioned technological interventions can reinforce or deepen existing inequalities.

4.6 Reported Ethical Considerations for Research on Abortion Care Technologies

Conducting research in abortion care technologies presented significant ethical challenges for researchers, shaped by legal, social, institutional, and technological factors. These challenges spanned from ensuring participant safety, to navigating abortion stigma and complex legal landscapes, and addressing structural inequalities. The following sections unpack how researchers navigate these tensions in practice.

4.6.1 Risks for Study Participants. Ensuring participants' physical and emotional safety was an important concern in nine studies. Researchers noted that conducting interviews immediately after a person had a termination of pregnancy risked inducing emotional distress [68], and that participants might be reluctant to take part in "in-depth" interviews that required revisiting their experience [168]. Another study acknowledged potential risks that the screening intervention under investigation might pose for individuals presenting a clinical concern: these participants were excluded from the study and directed to an alternative care pathway [154].

Participants living in abusive or violent domestic environments were considered particularly vulnerable, leading researchers to implement strict recruitment protocols, as an Irish study reports:

"only two contact attempts were made to recruit. We were mindful that some women may be living in family violence situations and would not have control over their mobile phone or email accounts." [86]

Protecting participants from legal repercussions was a critical concern in multiple studies conducted in regions where abortion access was restricted or criminalized, including Venezuela [42], the U.K [109, 146], and certain U.S. states [76, 88, 112, 118, 170]. To address these risks, researchers implemented strict privacy policies and data protection protocols. In a study conducted in

Venezuela [42], researchers connected abortion seekers with providers through a WhatsApp line, deliberately circumventing official healthcare channels to mitigate legal risks for providers. The study also reported canceling initial plans to involve participants in the dissemination of findings. In another study involving healthcare professionals, participants were approached by researchers external to their workplaces to prevent coercion and minimize power imbalances [150]. Elsewhere, researchers implemented extensive digital security protocols to ensure complete participant anonymity by avoiding the collection or storage of any personally identifiable information, summarizing rather than detailing demographic and medical data [170], and using non-internet-connect devices for data collection and analysis [118].

4.6.2 Navigating Abortion Stigma. In 14 studies across both liberal and restrictive jurisdictions, abortion stigma posed a significant challenge, particularly for participant recruitment and data collection. To navigate these barriers, researchers employed various strategies. These included omitting any direct mention of abortion in recruitment materials and instead relying on word-of-mouth referrals [118], using remote and anonymous engagement through social media platforms to reach participants more discreetly [69], and allowing participants to keep their cameras turned off during remote interviews, helping to reduce discomfort and preserve anonymity [182].

4.6.3 Complying with Abortion Legislation. Legal frameworks surrounding abortion vary significantly across jurisdictions, directly influencing research design and implementation. For instance, researchers evaluating a telemedicine abortion service in Minnesota adjusted their study protocol to comply with a state law requiring an in-person consultation with a physician to deliver state-mandated information [154]. Similarly, studies conducted across multiple jurisdictions in Australia and the US highlighted the extensive planning required to navigate and comply with differing legal requirements in each state [84, 126]. When reporting research on highly restrictive contexts researchers sometimes employed "strategic silences" to protect the participant anonymity. For instance, a 2024 study examining the online posts of abortion seekers in the Philippines deliberately withheld the name of the forum to safeguard user identities [131].

4.6.4 Participant Diversity and Representativeness. Researchers often sought to recruit participants with diverse backgrounds and experiences of care, for instance purposively including in their sample individuals who experienced post-abortion complications [168]. However, large part of the corpus mentioned lack of diversity and/or representativeness as a study limitation. Researchers encountered challenges in recruiting participant samples that reflected the full diversity of individuals seeking or accessing abortion care – a longstanding issue highlighted by a study from Venezuela [42]. Systemic barriers meant that those experiencing the greatest challenges (such as individuals in abusive relationships or unstable housing) were often underrepresented [24]. Furthermore, some studies highlighted the significant underrepresentation of non-white populations, such as Koenig et al. who emphasized that "*Black and Hispanic patients, who face the greatest barriers to abortion care, were greatly*

underrepresented compared to the population of US patients who obtained abortions" [93]. Studies also rarely include minors due to parental consent requirements [70, 152]. This lack of representation is a critical concern, as it overlooks the experiences of those most affected by disparities in access to care.

Socioeconomic disparities and digital literacy also shaped participation, with some studies mentioning a skew toward individuals from higher-income backgrounds or those more comfortable with technology [68, 182].

Geographical representation was also a key consideration in abortion care research, as it is in healthcare studies more broadly. While large studies often succeeded in capturing data from participants living in diverse geographical settings, some smaller studies in our corpus also achieved this. For example, Gill et al. [69] explored the perspectives of healthcare providers and administrative staff working in urban and rural areas.

In studies conducted across multiple countries (particularly those where English is not the primary language) researchers sometimes faced challenges related to inclusion criteria. Requiring English-language fluency, often necessary for cross-country collaboration and consistency in data collection, tended to result in participant samples with higher levels of education [154, 182]. While practical, these criteria sometimes limited the range of geographical and social contexts represented in the research.

In some contexts, the absence of reliable population data made it difficult to assess sample representativeness at all, such as in Canada where the number of abortion providers was unknown [155].

4.7 Reported Pathways to Impact for Research in Abortion Care Technologies

In the corpus analyzed, researchers position their work as a means to create impact across various aspects of abortion care. The most prominent theme was the potential of telemedicine to increase access to abortion services, by extending their geographic reach and addressing inequities faced by under-served and marginalized populations. Beyond service delivery, research also sought to enhance the care experience for abortion seekers, improve clinical and institutional practices and inform policy debates around abortion care, often incorporating some degree of activism.

4.7.1 Extending the Geographic Reach of Abortion Services. A key dimension of increasing access to abortion services is overcoming geographical barriers by facilitating service provision through technology – especially in contexts where abortion facilities are sparse or difficult to reach. For instance, a 2023 U.S. study across 32 states emphasized that *"abortion care is largely siloed to abortion facilities, which are few and far between and are now closing in record numbers"*, highlighting that the impact of telemedicine on equitable access is *"even greater than for other health care services"* [93]. Similarly, another U.S.-based study found that over half of the 190 participants lived more than 150 miles from an abortion provider or resided on Hawaiian islands without any abortion facilities, illustrating that telemedicine addressed *"an evident need"* [153]. Additional research from South Africa and Australia identified rural abortion seekers as key beneficiaries of telemedicine services [56, 84], while a study in the U.S. noted its

role in expanding access to medication abortion in states with limited care options [162].

4.7.2 Providing Abortion Care to Underserved and Structurally Marginalized Populations. Beyond extending geographic reach, telemedicine abortion is also seen as a means of improving access to abortion care for underserved or structurally marginalized populations – groups affected by structural inequities perpetuating social exclusion and health disparities. As Koenig et al. observed in the post *Dobbs v Jackson U.S.* context,

"while currently, White, urban patients might prefer telehealth due to its convenience or privacy, many patients from groups facing structural barriers to abortion care – such as people of color, those living on lower incomes, younger people, and rural residents – may rely on telehealth for abortion access" [93]

Other studies found that low-income abortion seekers were disproportionately impacted by legislation mandating a waiting period.

Telemedicine was shown to reduce travel-related burdens while also improving accommodation of childcare responsibilities [24, 49, 57, 88]. And indeed, in some contexts, telemedicine constitutes the only accessible pathway to abortion care. For example, a 2023 study from Ghana reported that over one-third of participants – approximately 900 individuals seeking abortion – perceived telemedicine as their sole option for accessing early medication abortion. The authors described this group as forming *"a new patient base"* for abortion services [3]. This point also resonates with a 2018 U.K. study exploring abortion seekers' perspectives on at-home medication abortion. The study reported that:

"despite the presence of safe, legal abortion services in Britain, these services are not universally accessible. [...] some groups of women still experience particularly challenging, if not impossible, circumstances when seeking abortion access. Challenges highlighted in this study include health system barriers, fear of breach of confidentiality, stigma, and risk of serious consequences for personal safety by attempting to access services." [5]

The corpus evidence shows the promise of telemedicine to increase access to abortion, no paper addressed how to design tele-medicine systems to navigate barriers or manage possible complications – leaving this as an open and important area for future investigation.

4.7.3 Improving Abortion Seekers' Care Experience. The studies reviewed explored various ways to enhance the care experiences of individuals having a termination of pregnancy, with many anticipating the positive impact of telemedicine medication abortion. Indeed, a key benefit emphasized across several studies is how at-home medication abortion can promote autonomy, privacy, and comfort for those seeking early abortion care. A French study examining practice changes in abortion care provision following the COVID-19 pandemic noted the potential of telemedicine to empower women and others seeking abortion by enabling them to manage the process in a private setting [67]. A 2021 study conducted in Scotland further highlighted *"women's competence to*

self-administer both mifepristone and misoprostol at home without in-person clinical supervision" [24], and a 2023 study in Ghana reported that the telemedicine service "*successfully equip[ed] women to self-manage their early medical abortion*" [3].

Beyond promoting autonomy, studies highlight how the integration of technology into abortion services has opened up new pathways to care and reshaped existing ones. During the COVID-19 pandemic, many countries rolled out telemedicine services to ensure the continued provision of safe abortion care. Studies in our corpus advocated for the maintain of this model of care beyond the pandemic, in France [15, 67], Mexico [149], Scotland [156], and the U.S. [70, 71, 90, 102, 107, 181]. Additionally, American studies suggest that telemedicine can support the timely delivery of abortion services, benefiting in particular individuals close to the gestational limit for medication abortion, those preferring medication over surgical abortion [162], or unable to afford in-clinic care [70, 88].

While technology may enable no-contact provision of abortion services, several studies in the corpus emphasize the importance of clinician involvement in service delivery and its positive impact on abortion seekers' experiences. Promoting a clinician-supported telemedicine approach, a 2021 study conducted in Scotland noted that abortion seekers

"described feeling 'cared for' (during and after) the telephone consultation. The sensitive, caring and holistic approach of staff was emphasised, specifically the attention given to their personal circumstances, attunement to their emotional state, and the support and reassurance offered." [24]

Another study highlighted the importance of clinical support in establishing a contraceptive plan and helping individuals feel confident that they would not need to seek future abortions [71]. Other studies argue that the integration of telemedicine into abortion care pathways should not result in the discontinuation of in-person abortion services [3, 75, 120, 162, 170]. Telemedicine may not be suitable for all abortion seekers, some may prefer in-person care, and in-person consultations can offer additional benefits, such as higher uptake of long-acting reversible contraception [53].

Finally, abortion stigma remains a pervasive barrier for abortion seekers, cutting across political and legal contexts. A 2022 study found that even in U.S. states where abortion is less restricted or legally protected, individuals "*still experienced hostility and demonstrated both perceived and internalized abortion stigma*" [89]. Telemedicine abortion offers a promising pathway to reduce stigma by enabling access to abortion outside traditional healthcare settings [108], allowing abortion seekers to avoid confrontations with protesters at clinics, and empowering them to self-manage their abortion when asking family or friends for support is not safe [18]. Furthermore, a 2023 French study noted that younger populations, facing both heightened stigma and financial challenges, often preferred self-managed medication abortion via telemedicine [15].

4.7.4 Supporting Healthcare Professionals' Training. A recurring theme in the corpus was the need to equip healthcare professionals with appropriate knowledge and skills to deliver technology-supported abortion care effectively and safely. In response, researchers have

proposed best practices for patient-clinician communication specific to the telemedicine abortion context [71]. Efforts have also included the development of targeted training resources, such as the *Access, Delivered Provider Toolkit*: a step-by-step guide created to support U.S. providers and clinics in implementing telemedicine abortion care [70].

Other studies stressed the importance of improving healthcare providers' awareness of new models of abortion care [120], particularly telemedicine services, which can have the greatest impact in non-urban areas. A 2018 Australian study found that while patients in urban regions often accessed telemedicine abortion services via websites, those in non-urban regions relied heavily on medical referrals. The authors emphasized that "*ensuring that health professionals in non-urban settings inform patients about the option of telemedicine is key*" to expanding access [84]. Two years later, this gap persisted:

"many GPs were unaware of the existence of telehealth-at-home abortion service until they were asked for a referral ... and, even after referring patients, lacked understanding of what is involved in medical abortion service delivery" [86]

A 2021 Australian study further stressed the need to strengthen GPs' ability to discuss medication abortion with patients and reduce discomfort around telemedicine referrals through targeted training [116]. A 2023 Colombian study further emphasized the need for referral systems to help prevent coercion of abortion seekers in telemedicine contexts [150].

A 2024 U.S. study highlighted clinicians' ethical responsibilities around record-keeping for abortion seekers crossing state lines, noting that while informing patients of digital privacy risks is not legally required, doing so would support more holistic and standardized privacy care [118].

Finally, training needs also extend beyond telemedicine competencies, such as equipping abortion providers to fit long-acting reversible contraception to improve post-abortion contraceptive uptake and support continuity of care [53].

4.7.5 Research-Driven Advocacy for Abortion Access. Several publications incorporated elements of activism, with authors using their findings to advocate for legislative reforms, regulatory change, and broader health equity in abortion care. These studies frame technology-supported abortion as both a practical innovation and a political act, particularly in contexts where abortion is prohibited, access is restricted, or telemedicine abortion is banned.

A number of papers explicitly advocate for policy change to improve access to abortion medication and telemedicine services. For example, a 2023 American study notes that "*important restrictions remain in place that limit access*" to abortion medications, constraining the implementation of self-managed medication abortion models. The authors argue that their findings support

"regulatory shifts to expand pharmacy access to the medication abortion regimen by demonstrating that patients take the abortion medications at a clinically acceptable time and early in pregnancy, regardless of how they receive the medications" [95].

Similarly, U.S.-based studies from 2023 and 2024 calls for a shift away from further restrictions toward actively expanding access to telemedicine abortion [152, 159]. This also resonates with a 2024 Colombian study, which aimed to "*inform political institutions, health service providers, and healthcare staff about the importance of implementing and strengthening information and access strategies*" [33].

A 2022 study from Brazil (where abortion is legal only in cases of rape) advocates for large-scale legal reforms, including decriminalizing abortion and establishing public abortion care services, to ensure equitable access to abortion services for all, not just those eligible for or able to use telemedicine [104]. Equity-focused advocacy also surfaces in calls to advance sexual and reproductive rights globally. For instance, authors of a 2023 study from Colombia suggest using their findings to implement telemedicine abortion services in other regions towards "*realising sexual and reproductive health and rights for all*" [150].

The need to frame telemedicine abortion as a safe and effective option was emphasized by numerous studies. For instance, [9] argues for its integration into formal healthcare settings. A 2023 U.S. study further notes that "*telemedicine abortion continues to be desirable, safe, and effective*" and argues for its potential to improve access "*in a political climate where its accessibility is continually threatened*" [161].

Finally, a 2024 U.S. study centers trust as a key principle in abortion care. Aligning their work with the abortion rights movement *Trust Women*, the authors argue that providers can and should trust abortion seekers

"[to] decide for themselves whether obtaining medication abortion pills by mail makes sense in their specific context [...] and [to] pay what they are able to afford without being required to justify their need." [66].

This framing challenges paternalistic medical and legal structures, instead grounding abortion care in respect for individuals' autonomy.

4.8 Reported Challenges to Achieving Impact with Research in Abortion Care Technologies

Across diverse settings, researchers and abortion providers encounter barriers that constrain the integration, expansion, and equity of technology-supported abortion services.

4.8.1 Rapid and Profound Shifts in Abortion Legislation. Researchers and healthcare providers have had to navigate the profound impact of rapid and dramatic shifts in abortion legislation, which have reshaped the landscape of abortion care delivery. This was particularly evident in the United States following the 2022 Dobbs v. Jackson Women's Health Organization decision, which "*drastically altered the abortion access landscape in the U.S.*" [18].

Providers have expressed reluctance to offer telemedicine abortion services amid this rapidly changing abortion legislation, due to fears of legal repercussions and increased targeting. One study highlighted that

"[D]oing something new or innovative like telehealth abortion could bring unwanted attention from anti-abortion activists or legislators and in turn jeopardize their ability to provide in-person services [...] Many participants expressed that the risk of placing an 'even larger target' on their backs ultimately outweighed the benefits of telehealth abortion." [18].

This fear of increased scrutiny and potential backlash therefore emerges as a barrier to the expansion of telemedicine abortion, despite its potential to improve access.

Significant legal shifts also force a new interpretation of existing research. Studies conducted before legislative reversals such as Dobbs v. Jackson are now situated in entirely different legal and social contexts. As one study noted,

"in many states represented in the sample, abortion is now banned" [18].

These shifts reframed not only the context but also the implications of existing research. For example, a study conducted in Mississippi (U.S.) while abortion was still legal originally aimed to explore abortion seekers' preferences regarding pathways to care [107]. In the aftermath of legal restrictions, the authors reframed their findings as evidence in support of telemedicine to improve access in regions where abortion is now heavily restricted.

4.8.2 Digital Divides and Structural Barriers. A common theme across the corpus is that introducing technology into abortion care is not, on its own, enough to ensure equitable access. While digital interventions can extend and support pathways to care, without intentional efforts to address structural barriers, they risk inadvertently reproducing or exacerbating existing inequities. Structural inequities shape who can access technology-supported abortion care. A 2022 study from Brazil cautions that "*inequalities based on age, race, income, and formal education, can be reproduced even in a remote, Internet-based service*" [104]. Echoing this concern, U.S. researchers stress the need to "*dismantle the structural systems that prevent access to telehealth*" and address inequitable policies and practices that limit its reach [162]. In Canada, two studies (2019 and 2024) similarly warn that optimism about technology's impact must be tempered by recognition of existing social gradients. As Gill et al. write:

"though many developers of technology-based health interventions are optimistic about their impact, this needs to be balanced by the fact that the pattern of adoption is along social gradients [29]. New technologies like myPostCare.ca may further reinforce these social divides." [68, 69]

To mitigate these risks, they recommend conducting health equity impact assessments informed by expert consultation and literature review. This call for proactive evaluation is echoed in a 2024 U.S. study, which argues that further research is needed to ensure telemedicine abortion "*does not exacerbate access disparities*" [170].

Socio-spatial inequalities also limit telemedicine's reach. As a 2023 study from Colombia reports, most abortion-seekers from low-resource, rural, or marginalized communities – including adolescents and girls – were unable to access telemedicine

services due to limited technology access and poor Internet connectivity [150]. The authors also highlight that, for rural and Indigenous communities, the time-sensitive nature of medication abortion is compounded by logistical challenges such as adverse weather events and social unrest, which disrupt abortion medications' delivery. Similar patterns were found in a more recent study, underscoring persistent "*socio-spatial inequalities*" in access in Colombia [33]. Other studies echo these findings, citing poor and inconsistent internet connectivity as a barrier to telemedicine abortion services in Pakistan [165], and the cost of medication shipping as a challenge in Australia [103].

Legal, institutional, and infrastructural barriers further constrain telemedicine abortion. Reflecting on restrictive abortion laws and uneven regulations in the U.S., researchers caution that while tele-medicine could expand access to medication abortion, "*it will do so unequally, continuing a long trajectory of inequitable access to abortion care in the U.S. and creating a two-tiered system of medication abortion access*" [112]. Other studies in the U.S. and Canada identify barriers such as pharmacies unwilling to dispense abortion medications [70], complex paperwork for abortion drugs prescription [155]. These structural constraints are compounded by challenges in how access is operationalized. Inaccurate eligibility assessments can lead to individuals being wrongly excluded from abortion services. A 2024 U.S. study raised concerns that the screening tool used for telemedicine abortion may be overly selective, inadvertently disqualifying eligible users [154].

Privacy and knowledge gaps further restrict access for some populations. For many abortion-seekers, especially in crowded or unsafe living conditions, the privacy required to safely use telemedicine (such as access to a private phone line) is not guaranteed [163, 168]. Limited menstrual health education also emerged as a barrier in the Colombian context, where researchers note that many potential users, particularly adolescents, "*would not be eligible for the [telemedicine abortion] service without being able to give details about their last menstrual period*" [150].

Together, these findings underscore that while telemedicine holds potential to expand access to abortion services, it cannot do so equitably without addressing the broader structural, social, and educational barriers that shape abortion care delivery.

4.8.3 Evolution of Clinical Practice and Logistics Challenges for Abortion Providers. The lack of national and international standards for telemedicine abortion was a concern for some providers, contributing to hesitancy in offering these services. In Colombia, the absence of clear guidelines was seen as both a barrier and an opportunity for organizations like Profamilia to take a leadership role in establishing best practices for telemedicine abortion [115]. Introducing telemedicine services also imply adapting clinical practice to digital, remote settings, which raised concerns among Canadian providers in a 2019 study [155]. The authors reported that most participants expressed discomfort with forgoing ultrasounds when offering telemedicine medication abortion. While extensive evidence support no-ultrasound telemedicine models of care, a 2024 U.K. study argues that training on new models of care is needed and should be offered to abortion providers [120].

Abortion providers practicing in restrictive legal and institutional frameworks faced additional logistical challenges in expanding

their services through telemedicine. For instance, in the U.S., a 2021 study [70] found that, while securing professional liability insurance for medication abortion is already difficult, the introduction of telemedicine added another layer of complexity. The authors report that abortion providers seeking to expand their services through telemedicine faced uncertainty over whether such services would be covered by their professional liability insurance. Lack of resources and limited capacity presented further barriers to telemedicine implementation. Studies from Canada [155] and Colombia [115] described shortages of staff and telehealth equipment, which limited the scalability of telemedicine services, particularly in under-resourced clinical settings.

5 Discussion

We now examine the implications of our review for HCI research. Recognizing that technology alone cannot solve abortion access, and that even well-intentioned designs may reproduce harm or exclusion, we propose a series of calls to action. These calls are directed to the HCI community to ensure that technological interventions supporting abortion care are responsive to diverse and rapidly changing political, legal, and social contexts worldwide.

5.1 Rethinking Telemedicine

One of the most striking findings of our research is the predominance of telemedicine in abortion technologies: our review found that 85 out of 92 studies focused on this modality, collectively establishing it as a safe and effective method for delivering abortion care. The move to telemedicine abortion has accelerated significantly since the COVID-19 pandemic and the Dobbs decision in the U.S., as both events exposed existing barriers to in-person care, in turn prompting rapid policy shifts and technological adaptation in healthcare, and increased demand for remote access to abortion services in particular [9]. The benefits of telemedicine care have been seen in other HCI work on digital health, and are similar here – telemedicine increases access to healthcare services [114], reduces travel burdens for those with mobility issues or those living in rural areas [174], and allows user-centered care through tailoring digital health interventions and care [186]. Our review similarly shows that telemedicine can improve access for abortion care, is the preference for many abortion seekers, can improve the abortion seeker's care experience, and can improve clinicians' efficiency and workflows.

Despite the evident benefits of telemedicine, it can be argued that, in the face of much technological innovation, it is a somewhat limiting focus, as telemedicine is primarily used to facilitate early-stage appointments, and as such lacks the ability to fully cater for essential physical aspects such as in-person clinical assessment, management of complications, and embodied experiences of care. Our review highlights an opportunity for the HCI community to better support the lived experience of *having* an abortion – a process that affects both one's body and mind, and one that people may go through in a range of environments, including at home, in clinical settings, or in contexts lacking privacy or safety. To help address the experiential limitations of telemedicine, abortion care technologies could build on innovations in health monitoring and Femtech. Yet, given the tendency of these fields to "avoid

direct contact and touch with the ‘messy’ or ‘fleshy’ materials of the body" including menstrual blood and discharge [31], we argue for drawing on soma-design approaches to rethink what such technologies could become. By foregrounding affect, fluidity, and other experiential qualities, soma design is not only well-suited to attend to non-Western perspectives on health and care, but also to provide critical alternatives to traditional clinical design. Examples include Park et al.'s exploration of touch technologies for menstrual discomfort [145], and Søndergaard et al.'s research centering adolescents experiences with newly menstruating bodies and societal stigma [169]. Campo Woytuk et al. also emphasize the emotional and embodied realities often excluded from telemedical systems [30]. They note that *"as designers, we are thus confronted with a complex web of regulations (or lack thereof) and misguided information when it comes to designing new interactions with the vagina"* [27], highlighting the need for more deliberate engagement in this space. Building on this work, telemedicine could not only attend to procedural or informational needs, but also to the bodily and psychological dimensions of the abortion experience.

Beyond the clear opportunities for innovation, we argue that an overemphasis on telemedicine risks narrowing the scope of health equity discussions. While about a quarter of our corpus examines telemedicine through an advocacy or political lens, most other telemedicine studies do not explicitly address structural inequalities – such as the digital divide – suggesting that critical equity issues remain underexplored in the field. Veinot et al. posit that (in the wake of the COVID-19 pandemic) *"broadband Internet access ... must be recognized as a social determinant of health. Disparities in access should be treated as a public health issue"* [17]. Beyond this, previous work has identified sociotechnical and cultural factors impacting patients and providers' use and adoption of telemedicine [13, 19, 20, 35]. Difficulties arise especially when the non-verbal, relational, and emotional aspects of in-person consultations are highly valued, as these elements may not translate effectively to telemedicine [4, 20]. Finally, barriers to accessing telemedicine services (including lack of private space, domestic violence, unstable housing, and homelessness [13]) also apply to telemedicine abortion, potentially preventing the most vulnerable populations from receiving care. Thus, our first call to action for HCI research and design is to **impel researchers to either 1) move outside of this focus of telemedicine care to include a wider breadth of design possibilities, or, if not, to 2) ensure that the telehealth systems we design and build are grounded in real-life user experiences and contexts through the application of interaction design methods and inclusion of marginalized populations.** Abortion seekers often have little control over their own care due to restrictive legal frameworks or mandatory medical supervision. Co-design offers a means to redress these imbalances by empowering abortion seekers to shape how abortion care and post-care services are delivered. This approach aligns with anarchist HCI principles, which advocate that *"methods and outputs should be driven by the interests and desires of the individuals and communities impacted by the work"* [91]. Moreover, incorporating the perspectives of users from diverse social backgrounds, as well as those with disabilities, chronic illness, and neurodivergent people [48] can help ensure that these systems account for structural inequalities and diverse

needs, ultimately broadening access to comprehensive abortion services. Finally, by partnering with telemedicine services, the HCI community has a unique opportunity to leverage telemedicine data, which can provide large-scale insights, while limiting participants' exposure by reusing information already collected. With patients' informed consent and robust measures to ensure data protection and confidentiality, such data can be particularly valuable for understanding the abortion journey of vulnerable populations who rely on telemedicine, enabling research that is both more ethically sensitive and inclusive.

5.2 Interacting with Digital Divides

Our review reveals a strong concentration of studies in the United States (51 out of 92), reflecting broader patterns in HCI research shaped by WEIRD (Western, Educated, Industrialized, Rich, and Democratic) biases [110]. Such a focus risks producing technologies and insights that may not translate well across diverse global contexts [110], particularly in areas like reproductive care where cultural, legal, and infrastructural conditions vary. Our findings further indicate that when studies are situated in the Global South, the limitations of such conditions are often especially pronounced – for instance, there may be a total dependence on non-governmental organizations or telemedicine may be the only option for participants to access abortion care at all. In this way, marginalized participants are particularly affected.

However, this may be countered by design practices within the long history of work in HCI4D in women's health. Research in this area bolsters findings around limitations to innovation in this area. In many regions of the Global South, patriarchal gatekeeping of reproductive knowledge, limited digital literacy among marginalized groups, and stigma surrounding sexual and reproductive health create significant obstacles to abortion care via technology. For instance, [172] describes 'Socheton', a culturally grounded AI tool co-designed in Bangladesh to counter misinformation and support reproductive well-being. Despite clear need for intervention in this area (*"ten women told us stories of them or someone in their families where ... secretly arranged abortions at home severely damaged their bodies"*), the authors noted that conservative social norms and low trust often constrained meaningful engagement with the platform. Similarly, studies of post-abortion mobile health interventions in Iran reveal that technical usability, privacy concerns, and social shame around abortion heavily influence both acceptance and use of digital care tools [191]. Such cultural factors may hinder the equitable design, deployment, and uptake of abortion technologies in the Global South.

However, HCI research in this area may also offer a way forward. In 2020, Kumar et al, writing on taking *"the long, holistic and intersectional view to women's wellbeing"* in HCI [99], indicate that women's health research in the Global South lacks a social justice approach, and that, in this context, women's health can be tied to cultural values, and impacted negatively by patriarchal power structures. They propose 1) a focus on capabilities rather than deficiencies, 2) a deeper engagement with theories of intersectionality, and 3) longitudinal interventions as possible routes to improve outcomes for women's health in this area.

Similarly focusing on context rather than disruption, Muthelo et al [129] propose the integration of traditional healers in the design of technologies for maternal health, though – given existing stigma and patriarchal power structures – their suggestions of fathers’ involvement and leveraging public media platforms may be less relevant. Examining attitudes towards technologies for Muslim women’s health in Bangladesh, Pakistan and Malaysia, Mustafa et al. [128] highlight (as in our above review) the lack of physical personal space many women in the Global South face, and suggest designing with the concept of ‘purdah’ (women’s modesty or seclusion). In this way, **our second call to action to the HCI community is to develop infrastructures that enable the design of reproductive and abortion-related technologies in Global South contexts, with careful attention to the cultural, infrastructural, and legal conditions that shape the experiences of abortion seekers’ and providers’**. As demonstrated throughout our review, users are often not included as co-designers, and technologies are frequently imported from Western contexts with a lack of documentation on how local norms or lived realities were translated. To redress this, we advocate for culturally competent, contextually grounded design approaches that prioritize meaningful co-design and long-term engagement with abortion advocacy groups and providers.

5.3 Working Within and Without Legal Frameworks

Several scholars in feminist HCI and digital health have argued that designing for women’s health must be a political act to acknowledge and resist systems of control that regulate bodies, knowledge, and access across the world [11, 80, 92, 173]. In abortion care specifically, the ethical imperative to support bodily autonomy, safety, and informed choice requires advocacy in the face of rapidly overturning regulations; drawing on WHO data, in 2016, an Amnesty International report confirmed that *"restrictive abortion laws do not reduce the number of induced abortions, as women will undergo abortions regardless of its legal status and lawful availability"* [85]. However, our findings show that abortion technologies are frequently developed and deployed in legal gray zones, with laws that are contested, fluctuating, or regionally divergent. Some demographic groups, including racialized women and women with lower socio-economic status, are disproportionately targeted by criminal justice systems, and therefore may face a higher risk of prosecution for terminating a pregnancy in regions where abortion is criminalized [104]. Researchers must consider how HCI work can develop technologies that operate under legal precarity while explicitly addressing and mitigating these inequities.

One response may be to draw inspiration from activist and anarchist strands of HCI, which prioritizes autonomy, contestation of power, and local conditions [91]. This has precedence in societal and community-based responses to restrictive abortion legislation. For instance, in 2015, activist group ROSA distributed abortion pills from a bus in Ireland prior to the legalization of some forms of abortion, and the groups Women on Waves and Women on Web facilitated the delivery of abortion medication via sea voyage [160], drones [117], and shipping [6]. These organizations demonstrate

how care can be enacted outside or in spite of restrictive legal systems. HCI has a precedent for this kind of work: for instance, design justice [47] points to ways designers can act in solidarity with communities, such as in refusing to create technologies for restrictive regimes, or in eschewing large platforms for DIY and DIT (do-it-together) spaces. In abortion care, this could mean designing tools that explicitly support advocacy [106], resistance to local laws, or cross-border solidarity networks.

A second strategy in this area might be to design for contingency and scalability through strategic ambiguity. Platforms might use euphemistic or coded language, or multipurpose interfaces (common in telehealth) to improve plausibility and scale across multiple jurisdictions. Like other activist platforms who do not log user metadata, resist state surveillance, and use onion routing (e.g., Riseup, SecureDrop), abortion care platforms and apps might adopt similar tactics through temporarily disabling features, shifting servers, or hiding sensitive content when targeted. However, these systems must prioritize data security, as the criminalization of abortion often extends to digital surveillance, as seen in highly publicized cases of police forces accessing menstrual app data to provide evidence of abortion procurement in the UK [179]. While such techno-anarchist approaches can enhance privacy, they are not without limitations. The use of euphemistic or coded language may reduce the visibility of abortion care platforms, making them harder to access, particularly for those in urgent need or those lacking social capital. Our review also highlights challenges in reporting abortion care research in legally restricted contexts, including the use of "strategic silences" [131]. We suggest that *ethical fabrication*, the creative transfiguration of original data into composite accounts, could offer a complementary approach for responsibly presenting sensitive data [113].

A final way forward therefore may be to move beyond activist delivery models like pill-by-post, to instead engage the broader ecology of abortion care. From an extensive history in digital health and HCI, many people go online to learn about their health in concert with others, especially in the area of reproductive health [73, 125, 190]. Online forums and peer-led communities in particular play a key role in how people access, learn about, procure, and recover from abortion [188], and featured in one study in our corpus [131]. Future HCI research that engages with these informal infrastructures could help sustain abortion knowledge as collective care, working in tandem with the DIY and DIT practices noted above, while remaining attentive to ethical considerations [61].

Whatever the approach, we offer a third call to action: **HCI should re-politicize its engagement with abortion technologies**. HCI has increasingly embraced qualitative, interpretivist, and constructivist epistemologies [23, 167], alongside a growing commitment to social justice [16, 41]. In doing so, much of our field acknowledges that technology is not neutral, and that design cannot be divorced from the social and political contexts in which it operates [123]. With this in mind, we argue that designing for digital health, particularly reproductive health, must be recognized as inherently political, and to design for abortion care, for instance, is to make a claim in support of bodily autonomy, reproductive justice, and human rights. At the same time, we suggest that such commitments should also encompass working with participants who express regret about

their abortions, understanding these accounts as part of the complex realities of reproductive life rather than as challenges to the legitimacy of abortion, and situating them within a broader politics of reproductive justice. With a concomitant reflexive turn in HCI [166], if researchers and designers believe in these values, we argue that we should be willing to assert them explicitly in our work, even when doing so involves operating in legal or ethical gray areas. This may also require us to reflect on the institutional structures that provide our employment and support our research, and ask: if we are to take risks in the name of justice and autonomy, how will our organizations and universities support us? This question is especially relevant in light of recent actions by the Trump administration in the U.S., which aggressively sought to roll back Diversity, Equity, and Inclusion policies at universities (pressuring institutions to dismantle these initiatives or risk losing funding [183]) and implemented measures that placed tenured faculty under heightened scrutiny, thereby threatening their autonomy and job security [134, 135]. **In light of these pressures, we call on the HCI community to take a principled stand. Recognizing the legal constraints that organizations like ACM and SIGCHI face, we urge the community to actively support researchers working at or beyond the limits of legality in pursuit of ethically grounded work** [136]. This could include organizing collective statements of support, establishing advisory boards to ensure research and design practices remain ethically accountable, and more broadly affirming the importance of safeguarding all participants and practitioners involved in sensitive areas such as reproductive justice. As a first step, we include a Statement of Support in Appendix A, intended to become a live petition upon publication of this paper.

5.4 Temporal Technologies and Continuity of Care

A final consideration from our work is the notion of temporality, which emerged as a critical constraint in abortion care, both legally and embodied. Legal gestational limits – for example, 6 weeks in Florida (U.S.), 14 weeks in France, 20 weeks in India, and no limit in Canada [65] – create urgency for abortion seekers. We posit this might lead designers to make conservative decisions that prioritize speed over care; for instance, deploying chatbots instead of human support [36], or omitting opportunities for personalization and tailoring in intake forms. Telemedicine, in particular, must manage the temporal logistics of shipping medications [33, 95] and coordinating safe times and private spaces for their use [24, 121]. Delays can push seekers beyond legal gestational limits or lead them to postpone taking medication [121] – introducing clinical risks, as the efficacy of misoprostol drops significantly if taken more than 48 hours after mifepristone. In such cases, there is a higher likelihood of failed termination or continued pregnancy with fetal abnormalities, especially when gestational age has not been accurately determined prior to the procedure.

Embodied notions of time in abortion care can indeed prove to be ambiguous. For those with irregular menstrual cycles, estimating gestational age can be imprecise [188], and limited menstrual health education can leave abortion seekers without the knowledge needed to interpret their cycles accurately [150]. In telemedicine

contexts, this duty is left to the user, who has to self-calculate their pregnancy stage, which defines their eligibility: minor errors can push someone past legal thresholds. Beyond this, in some countries, mandatory waiting periods further delay access [58], despite being medically unnecessary and disproportionately impacting marginalized groups [144]. These timelines reinforce control over the abortion process while offering no added care benefit. From an HCI perspective, temporality might be understood not just as a constraint, but as a design material [187]. Taking inspiration from the slow technology movement – where slowness is not just a matter of speed, but a quality of interaction [133] – we argue that there is potential for technologies to support time-sensitive autonomy by better incorporating user data and providing clearer, safer feedback loops, while also prioritizing care and carefulness. For example, menstrual tracking data could, with strong privacy protections, estimate gestational stage more accurately; at-home bodily fluid analysis could also facilitate self-knowledge in this way, and the above-cited work of Campo Woytuk et al may be generative in this area of HCI [28]. Telemedicine systems have proven effective in reducing logistical barriers imposed by mandatory waiting periods [24, 49, 57, 88]. Future developments could focus on optimizing these systems to prioritize early-stage consultations or fast-track services for users close to legal limits. Additionally, user interfaces could also better communicate how abortion pills work over time [165], what to expect physically (e.g., normal amount of bleeding and pain [120, 158]), and whether and when users should seek medical assistance.

Closely linked to temporality is the continuity of care. In the words of the community-led charity Cysters: *"Abortion care shouldn't end when the procedure does"* [48]. While much of the literature focuses on the procedure itself, fewer studies consider the challenges of ensuring safe and consistent follow-up care, particularly when abortions occur across jurisdictions with differing legal regimes (see [6] for an example). Not attending to continuity of care can have serious medical consequences, for instance in the case of rhesus negative abortion seekers who may require an injection to safeguard future pregnancies – a need addressed in only one study in our corpus [84]. Beyond clinical considerations, continuity of care raises ethical challenges around safeguarding patient privacy, preventing legal exposure, and protecting sensitive digital records from surveillance or subpoena. Holistic approaches are needed that integrate post-abortion interventions into broader reproductive health services, connecting patients not only to medical follow-up but also to mental health support, community resources, and reproductive health education. For the HCI community, this underscores the importance of building tools and infrastructures that extend beyond guiding people through the abortion procedure to facilitating ongoing, locally grounded support. For example, telemedicine systems could better support abortion seekers in unsafe environments by detecting signs of abusive relationships in form responses and connecting individuals with relevant local resources. Abortion technologies therefore must attend to the wider ecology of care – including the availability of trusted services, peer networks, and culturally relevant resources – to ensure that continuity of care after abortion is accessible, safe, and equitable.

This leads to our final call: we ask HCI researchers to consider time not only as a factor in individual user interactions (though this should be deeply considered), but also in the broader political landscape, while simultaneously attending to continuity of care. As legal access to abortion becomes increasingly volatile across many regions, there is an urgency in designing and deploying technologies now, before further restrictions emerge. Systems that foster self-knowledge, clearly communicate timelines, and are embedded in a holistic ecology of care will be essential to shaping safe and just abortion care in changing legal landscapes.

6 Limitations

This review includes medical, HCI, and digital health publications, which differ in their perspectives on health technology and research reporting standards. While this heterogeneity poses challenges for synthesis, the interdisciplinary expertise of the co-authors helped mitigate these differences. We also acknowledge that there is a growing body of research examining abortion-related experiences in online forums, highlighting how digital platforms such as social media and online forums [87, 151, 185, 189] are used for information seeking and peer support, particularly in contexts where formal care is constrained or stigmatized. Such online spaces might also be used for discussing abortion care technologies. Our focus on studies directly examining technologies designed to support abortion care placed this body of work outside the scope of this review. Future research could explore how technologies not explicitly designed for abortion care (such as social media) are used in this context, as well as how abortion care technologies are discussed within online platforms. Such work may help surface perspectives from individuals who rely on these spaces because of stigma, legal concerns, or barriers to accessing care.

Finally, the corpus primarily focused on telemedicine services, often proprietary systems, while offering relatively few reported design contributions. This gap highlights a significant opportunity for future HCI research to explore and advance the design of technologies supporting abortion care, particularly given the current limited state of the art.

7 Conclusion

This scoping review analyzed 92 studies dealing with abortion care technologies and published in medical, HCI, and digital health venues up to 2024. Our work provides a detailed analysis of the contexts of use, technological applications, research methods, and researchers' strategies to navigate ethical challenges and create impact. We highlight future avenues for research, and propose calls to action for the HCI community to ensure that technological interventions supporting abortion care are responsive to diverse and rapidly changing political, legal, and social contexts worldwide.

Acknowledgments

We thank the researchers whose work is reviewed in this paper, especially those conducting research under legal, institutional, or social pressures in regions where abortion is stigmatized, restricted, or criminalized.

A Statement of Support

As members of the Human-Computer Interaction (HCI) research community, we recognize the urgent need to defend and advance sociotechnical research that centers on reproductive justice, bodily autonomy, and equitable access to abortion care. We acknowledge that researchers working in this domain often face profound legal, institutional, and social pressures, especially in regions where abortion is restricted, criminalized, or stigmatized.

We affirm that ethically grounded research – especially work that seeks to improve access to safe abortion care through technology – is essential to the health, dignity, and human rights of all people. We recognize that legal constraints may limit the actions of professional organizations, however as independent researchers we believe that our community must act to ensure safe, equitable access for all people to health services.

Therefore, we collectively commit to:

- Publicly support HCI researchers who work at or beyond the limits of legality in pursuit of ethically grounded research and design for reproductive care including abortion care.
- Advocate for the protection of researchers, participants, and practitioners involved in sensitive areas such as reproductive justice, including safeguarding their privacy, safety, and academic freedom.
- Encourage the formation of advisory boards and networks to provide guidance, solidarity, and accountability for research and design practices in legally and ethically complex contexts.
- Affirm the importance of research and design that centers the needs, autonomy, and lived experiences of abortion seekers and providers, especially those from marginalized and underserved communities.
- Stand in solidarity with all those who pursue ethically responsible work in reproductive health, even when doing so requires operating in legal gray areas.

We call on our colleagues to join us in this commitment, and to actively foster an environment where research for reproductive justice is supported, protected, and celebrated.

The undersigned are researchers in human centered computing who are signing as individuals. Affiliations are collected for identification purposes, but not publicly provided. Anonymous counted signers are verified and kept internally, but provided in the count below.

Signed,

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