Table 1 List of search terms used

Search term sets		Terms
1	Abortion	*Abortion OR induced abortion OR pregnancy termination OR termination of pregnancy OR medical abortion OR abortifacient OR mifepristone-misoprostol OR misoprostol OR mifepristone OR methotrexate OR gemeprost OR dinoprost OR meteneprost OR onapristone OR epostane OR cytotec OR oxytocin OR mifegyne OR "Abortion, Induced"[Mesh])(Pubmed and Embase only)*
2	Pharmacy/ Pharmacy worker/Self-medication	*pharmacy OR pharmacist OR chemist OR dispensary OR medicine shop OR drug shop OR drug seller OR medicine seller OR drug vendor OR medicine vendor OR drug store OR medicine store OR apothecary OR druggist OR drug retailer OR medicine retailer OR retail market OR over the counter OR over-the-counter OR self-administ* OR self administ* OR self-medicat* OR self medicat* OR home use OR home-use OR home-medicat* OR home medicat* OR home-administ* OR home administ* OR home-based OR home based OR self-use OR self use OR self-induced OR self induced OR home manag** *OR "Pharmacies"[Mesh] OR "Pharmacists"[Mesh] OR "Pharmacists' Aides"[Mesh] (Pubmed/Embase databases only)*
3	Intervention	*detailing OR academic detailing OR educational outreach OR IEC OR BCC OR ' information, education and communication' OR 'behaviour change communication' OR 'behavior change communication' OR practice change OR call centre OR call center OR call-centre OR support OR pamphlet OR leaflet OR instruction OR education* OR advice OR guidance OR recommendation OR social marketing OR training OR train* intervention OR trial OR telemedicine OR telephone nursing, telenurs* OR telephone triage OR telehealth OR remote support OR remote technolog* OR mobile health OR telephone follow-up OR mhealth* OR telehealth OR eHealth* *OR "Education"[Mesh] OR "Telemedicine"[Mesh] OR "Consumer Health Information"[Mesh] OR "Information Dissemination"[Mesh]) OR "Social Marketing"[Mesh] OR "Controlled Before-After Studies"[Mesh] OR "Intervention Studies"[Mesh]* (Pubmed/Embase databases only)

Table 2 Individual item quality scores for methodological quality, objective 1

0=not met 1= partially met 2=fully met

	Item number (key below)											
Study	1	2	3	4	5	6	7	8	9	10	Total	Overall [1]
(Adinma & Adinma, 2013)	0	0	0	1	2	1	0	1	1	1	7	Low
(Akiode et al., 2010)	2	1	2	1	2	1	1	0	1	1	12	Medium
(Billings, Walker, Mainero del Paso, Clark, & Dayananda, 2009)	2	2	2	2	2	2	2	2	2	2	20	High
(Bonnema & Dalebout, 1992)	2	2	0	2	1	2	1	1	1	n/a	12	Medium
(De Oddone, Shedlin, Welsh, Potts, & Feldblum, 1991)	1	1	2	1	0	1	0	1	2	0	9	Low
(Fetters et al., 2015)	0	0	0	2	0	1	0	2	2	2	9	Low
(Ganatra, Manning, & Pallipamulla, 2005)	2	2	2	1	2	2	1	0	1	1	14	Medium
(Hendrickson et al., 2015)	1	0	0	1	0	2	2	2	1	2	11	Medium
(Huda, Ngo, Ahmed, Alam, & Reichenbach, 2014)	1	2	2	2	2	2	1	1	1	2	15	Medium
(Lara, Abuabara, Grossman, & Díaz-Olavarrieta, 2006)	2	2	2	1	2	2	2	2	1	1	17	High
(Lara, Garcia, Wilson, & Paz, 2011)	2	2	2	2	2	2	2	2	2	2	20	High
(Miller et al., 2005)	1	2	2	1	2	2	2	1	1	0	14	Medium
(Mishra, Yadav, Malik, Purwar, & Kumari, 2016)	1	1	0	1	2	1	1	2	n/a	n/a	9	Medium
(Ngo, Park, & Nguyen, 2012)	2	2	2	1	2	2	0	1	n/a	n/a	12	Medium
(Powell-Jackson, Acharya, Filippi, & Ronsmans, 2015)	2	2	2	2	2	2	2	2	2	2	20	High
(Reiss, Aung, Aung, & Ngo, 2014)	2	1	2	1	2	2	2	2	1	2	16	High
(Reiss et al., 2017)	2	2	0	2	2	1	1	1	n/a	2	13	Medium
(Reiss, Keenan, et al., 2015)a	1	1	2	2	2	1	2	2	1	2	16	High
(Reiss, Footman, Akora, Liambila, & Ngo, 2016)	2	1	1	1	2	1	2	1	1	2	14	Medium
(Tamang & Tamang, 2005)	2	2	1	2	1	2	2	1	1	2	16	High
(Tamang, Puri, Lama, & Shrestha, 2015)	1	1	0	1	2	1	0	1	1	2	10	Medium
(Zamberlin, 2007)	0	0	0	1	1	1	2	0	n/a	n/a	5	Low

[1] The quality level considered to be 'low' if score was <50%, medium if 50-75%, and high if >75%.

Key to items:

1. Was the sample representative of the target population?

2. Were study participants recruited in an appropriate way?

3. Was the sample size adequate?

NB. (This was assessed by calculating the sample size requirements for estimating a single proportion, as suggested by (Munn, Moola et al. 2014), using the following formula: $n = \frac{Z^2 P(1-P)}{d^2}$ where Z (Z statistic for level of confidence) was chosen as 1.96, P (the expected prevalence) was assumed to be 0.5, and d (precision) was chosen as 0.05. This yielded a minimum sample size of 384.

4. Were the study subjects and setting described in detail?

5. Is the data analysis conducted with sufficient coverage of the identified sample?

6. Were objective, standard criteria used for measurement of the condition?

7. Was the condition measured reliably?

8. Was there appropriate statistical analysis?

9. Are all important confounding factors/ subgroups/differences identified and accounted for?

10. Were subpopulations identified using objective criteria?

Table 3 Individual item quality scores for intervention studies, objective 2

0=not met 1= partially met 2=fully met

Study	1	2	3	4	5	6	7	8	9	10	11	Total	Overall[1]
(Fetters et al., 2015)	2	0	0	0	0	0	2	0	2	1	0	7	Low
(Reiss, Keenan, et al., 2015a)	2	0	0	0	2	0	2	1	1	2	0	10	Low
(Tamang et al., 2015)	2	0	0	0	0	2	2	1	1	2	0	10	Low

[1] Study quality was graded with the following scores: 0–11, low quality; 12–17, medium quality; and 18–22, high quality.

Items (adapted) used for quality assessment	**Original CASP criteria**
1. Did the study address a clearly focused issue?	1. Did the trial address a clearly focused issue?
2. Were the intervention groups randomised? (apply to pharmacies as well as individuals, if applicable)	2. Was the assignment of patients to treatments randomised?
3. Were study participants and study personnel blinded?	3. Were patients, health workers study personnel blinded?
4. Were the groups similar before the study and intervention?	4. Were the groups similar at the start of the trial?
5. Aside from the study intervention, were the groups treated equally?	5. Aside from the experimental intervention, were the groups treated equally?
6. Were all of the study participants properly accounted for at its conclusion?	6. Were all of the patients who entered the trial properly accounted for at its conclusion?
7. How large was the intervention effect?	7. How large was the treatment effect?
8. How precise was the estimate of the intervention effect?	8. How precise was the estimate of the treatment effect?
9. Can the results be applied in the local population?	9. Can the results be applied in your context/the local population?
10. Were all clinically important outcomes considered?	10. Were all clinically important outcomes considered?
11. Have the costs or harms been assessed and weighed against the benefits?	11. Are the benefits worth the harms and costs?

Table 4 Summary of studies meeting inclusion criteria for objective 1

Study	Year	Setting	Abortion legality [1]	Study design (sample size) [2]	Sampling	Outlet type	Population	Outcomes measured	Methodological quality score[2]	Main methodological limitations
(Adinma & Adinma, 2013)[3]	2009	Nigeria (Anambra and Delta states)	2	PW survey (n=22)	Convenience	Registered community pharmacies	Pharmacists	Scale of abortifacient provision, demand for abortifacients	Low (7/20)	Non-representative sample, small sample size, outcomes self-reported
(Akiode et al., 2010)[3]	2006	Nigeria (Lagos and Abuja)	2	PW survey (n=591)	Census in Abuja. StRS+ SRS+PPS in Lagos.	Registered pharmacy shops and patent medicine stores	Pharmacists, proprietors or vendors	Scale of abortifacient provision, demand for abortifacients	Medium (12/20)	Sub-optimal recruitment, outcomes self-reported, inappropriate statistical analysis
(Billings, Walker, Mainero del Paso, Clark, & Dayananda, 2009)[3]	2006	Mexico (one unnamed state, rural and urban)	2	MC survey (n=153)	StRS	Registered pharmacies, chain and independent	Pharmacy workers	Scale of abortifacient provision, quality of provision	High (20/20)	None
(Bonnema & Dalebout, 1992)[3]	1987	Peru (Cusco)	3	PW survey (n=26), MC survey (n=29)	Census	Pharmacies (not stated whether registered)	'Salesman behind the counter'	Scale of abortifacient provision, knowledge and quality of provision	Medium (12/18)	Sub-optimal statistical analysis, no confounding analysis, self-reported outcomes
(De Oddone, Shedlin, Welsh, Potts, & Feldblum, 1991)[3]	1985	Paraguay (Asuncion)	3	PW survey (n=80), FG	Convenience	Registered pharmacies	Pharmacists	Demand for abortifacients	Low (9/20)	Insufficient sample coverage, outcomes self-reported, sub-optimal statistical analysis
(Fetters et al., 2015)[3]	2010-2012	Zambia (Lusaka and Copperbelt province)	4	PW survey (n=55) (baseline survey)	Census	Registered pharmacies with at least one registered pharmacy worker	Pharmacists and pharmacy technologists	Scale of abortifacient provision, knowledge, demand for abortifacients	Low (9/20)	Non-representative sample, inadequate recruitment technique, small sample size, insufficient sample coverage, outcomes self-reported
(Ganatra, Manning, & Pallipamulla, 2005)[3]	2004	India (2 state capitals and 10 district towns in Bihar and Jharkland)	4	PW survey (n=209), IDIs (n=9)	Two stage: SRS+ StRS (pharmacies that stocked and sold abortion drugs were selected)	Registered and unregistered chemists	Tried to interview 'main person', often had to interview person 'available at counter'	Scale of abortifacient provision, knowledge, demand for abortifacients	Medium (14/20)	Inadequate statistical analysis, outcomes self-reported

Study	Year	Setting	Abortion legality [1]	Study design (sample size) [2]	Sampling	Outlet type	Population	Outcomes measured	Methodological quality score[2]	Main methodological limitations
(Hendrickson et al., 2015)[3]	2009 & 2011	Zambia (3 provinces, urban and rural settings)	4	MC survey (n=76 (2009), n=80 (2011))	SRS	Government-certified pharmacies	Pharmacy workers	Scale of abortifacient provision, quality of provision, demand for abortifacients	Medium (11/20)	Small sample size, inadequate recruitment, insufficient sample coverage, potentially non-representative
(Huda, Ngo, Ahmed, Alam, & Reichenbach, 2014)[3]	2011	Bangladesh (Dhaka and Gazipur)	2	MC survey (n=331)	Mapping + SRS	Registered and unregistered premises clearly selling medicines	Pharmacy workers	Scale of abortifacient provision, quality of provision	Medium (15/20)	Potentially non-representative, outcomes self-reported, inadequate statistical analysis
(Lara, Abuabara, Grossman, & Díaz-Olavarrieta, 2006)[3]	2004	Latin American city	-	PW survey (n=97), MC survey (n=100)	SRS	Registered pharmacies (63% independent, 37% chain)	Vendor/cashiers (46%), owners (17%) and managers (31%)	Scale of abortifacient provision, knowledge and quality of provision, demand for abortifacients	High (17/20)	Minimal description of setting and participants, not all important confounding factors, differences accounted for
(Lara, Garcia, Wilson, & Paz, 2011)[3]	2007	Mexico (8 cities)	2	MC survey (n=576)	StRS	Registered independent and chain pharmacies	Vendors (73%), managers (16%) and owners (11%)	Scale of abortifacient provision, quality of provision	High (20/20)	None
(Miller et al., 2005)[3]	Nr	Dominican Republic (Santa Domingo)	1	MC survey (n=80)	Convenience, selected based on their location in different socio-economic neighbourhoods	Pharmacies (not stated whether registered)	Sales person or pharmacy technician	Scale of abortifacient provision, quality of provision	Medium (14/20)	Potentially non-representative, minimal description of setting and participants, inadequate statistical analysis, subgroups not defined objectively
(Mishra, Yadav, Malik, Purwar, & Kumari, 2016)[3]	2016	India (urban areas of Delhi)	4	Pharmacist/ PW survey (n=110)	StRS of pharmacies within 6 districts	Nr	Pharmacists and pharmacy workers	Scale of abortifacient provision Knowledge about legality of MA, drugs and regimen, side effects, provision practices	Medium (9/16)	Small sample size, inadequate recruitment, outcomes self-reported
(Ngo, Park, & Nguyen, 2012)[3]	2010-11	Vietnam (Ho Chi Minh city)	5	PW survey (n=100), MC survey (n=30)	SRS	Registered pharmacies	Pharmacy workers responsible for provision of medicine with >	Scale of abortifacient provision, knowledge and quality of	Medium (12/16)	Minimal description of setting and participants, outcomes self-reported, inadequate statistical analysis

Study	Year	Setting	Abortion legality [1]	Study design (sample size) [2]	Sampling	Outlet type	Population	Outcomes measured	Methodological quality score[2]	Main methodological limitations
							6 months of work experience	provision, demand for abortifacients		
(Powell-Jackson, Acharya, Filippi, & Ronsmans, 2015)[3]	2013	India (Madhya Pradesh, rural and urban districts)	4	PW survey (n=591), MC survey (n=359)	StRS of districts + SRS PPS selection of sampling units + mapping + systematic sample of pharmacies	Registered and unregistered drug sellers	'Person behind the counter'	Scale of abortifacient provision, knowledge and quality of provision	High (20/20)	None
(K Reiss, Aung, Aung, & Ngo, 2014)[3]	2012	South East Asian city	2	PW survey (n=170), MC survey (n=193)	Mapping of 4 purposively selected study areas + census	Registered and unregistered pharmacies	Pharmacy workers who sold medications and worked at pharmacy >6 months. Most senior was invited for survey	Scale of abortifacient provision, knowledge and quality of provision, demand for abortifacients	High (16/20)	Inadequate recruitment, minimal description of setting and participants, not all confounding factors and differences accounted for
(Kate Reiss et al., 2017)[3]	2013	Senegal (Dakar)	1	PW survey (n=110)	SRS	Registered pharmacies	Pharmacy workers who sold medications and were over age 18. Owner or manager approached first, followed by next most senior staff member	Scale of abortifacient provision, knowledge, demand for abortifacients	Medium (13/18)	Small sample size, insufficient sample coverage, outcomes self-reported
(K Reiss et al., 2015)[4]	2013	Bangladesh	2	PW survey (n=779)	SRS	Registered pharmacies supplied by one pharmaceutical company	Pharmacy workers who sold medications and worked at pharmacy for >6 months. Longest-serving or owner interviewed	Scale of abortifacient provision, knowledge, demand for abortifacients	High (16/20)	Non-representative sample, inadequate recruitment, outcomes self-reported, not all confounding factors and differences accounted for
(K Reiss, Footman, Akora, Liambila, & Ngo, 2016)[3]	2013	Kenya (3 cities)	3	PW survey (n=235), MC survey (n=401)	SRS	Registered private pharmacies	Pharmacy workers who dispensed medicines and had worked at pharmacy for >6	Scale of abortifacient provision, knowledge and quality of provision, demand	Medium (14/20)	Inadequate recruitment, small sample size (for survey), minimal description of setting and participants

Study	Year	Setting	Abortion legality [1]	Study design (sample size) [2]	Sampling	Outlet type	Population	Outcomes measured	Methodological quality score[2]	Main methodological limitations
							months	for abortifacients		
(Tamang & Tamang, 2005)[3]	Nr	Nepal (urban and peri-urban areas across the country)	5	PW survey (n=177)	Purposive + SRS	Registered chemists	Pharmacy workers	Awareness of misoprostol and mifepristone (used as proxies for provision)	High (16/20)	Small sample size, insufficient sample coverage, inadequate statistical analysis, not all confounding factors and differences accounted for
(Tamang, Puri, Lama, & Shrestha, 2015)[3]	2011	Nepal (2 districts)	5	PW survey (n=414) (baseline survey)	Cluster sampling	Registered pharmacies	Main person responsible for looking after the shop	Scale of abortifacient provision, knowledge, demand for abortifacients	Medium (10/20)	Non-representative sample, inadequate recruitment, outcomes self-reported
(Zamberlin, 2007)[5]	Nr	Argentina (Buenos Aires)	3	MC survey (n=40)	Convenience	'Commercial pharmacies'	Pharmacists and pharmacy workers	Scale of abortifacient provision, quality of provision	Low (5/16)	Non-representative sample, inadequate recruitment, small sample size, inappropriate statistical analysis

Notes:
Key to acronyms: Nr= not reported PW= pharmacy worker/drug seller; MC= mystery client FG= Focus group; SRS= simple random sampling; StRS= stratified random sampling; PPS= probability proportional to size
[1] Key : 1: Prohibited completely 2: To save life of woman 3: To save life/preserve health of woman 4: To save woman's life, preserve physical and mental health, and on socioeconomic grounds 5: On request [2] Denominator may be less than 20 where items were non-applicable.[3] Peer-reviewed journal article. [4]Conference paper. [5] Published government report.

Table 5 Extent of MA provision and provision practices of pharmacy workers and drug sellers: data extracted from 22 studies meeting inclusion criteria for objective 1

Study/ setting	Study design	Education/ qualifications of respondents	% respondents offering abortifacients	% respondents offering – mife-miso combination	% respondents offering misoprostol only	Other drugs sold for MA	% respondents knew/ advised effective MA regimen
Studies of HIGH methodological quality							
(Billings, Walker, Mainero del Paso, Clark, & Dayananda, 2009)/ *Mexico*	MC (n=153)	Nr	54% (spontaneously recommended)	n/a	19% (spontaneous) (90% when prompted by client)	Metrigen (48%), other hormonal contraceptives, vitamin B, EC.	16% (misoprostol only regimen)
(Lara, Abuabara, Grossman, & Díaz-Olavarrieta, 2006)/ *Latin American city*	Survey (n=97), MC (n=100)	45% 10 yrs education; 29% received training on RH medications	74% (MC) (recommended miso)	0% (survey and MC)	60% (survey), 39% (MC) (recommended miso)	Hormonal injections (71% recommended to MCs), OC (19%), other (7%) including EC, oxytocin, quinine, gluconate, curettage.	6% (survey), 17% (MC) (misoprostol only regimen)
(Lara, Garcia, Wilson, & Paz, 2011)/ *Mexico*	MC (n=576)	Nr	24% (spontaneously recommended)	Nr	18% (spontaneously recommended) (78% overall including prompted)	Miso and methotrexate (19%), hormonal injectables, oxytocin, EC (4%).	3% (misoprostol only regimen)
(Powell-Jackson, Acharya, Filippi, & Ronsmans, 2015)/ *India*	Survey (n=591), MC (n=359)	96% higher education	32% (survey), 71% (MC)	31% (survey), 67% (MC)	3% (survey), 4% (MC)	Ayurvedic, homeopathic medicines (MC)	68% (survey) 35% (MC) (mife-miso regimen)
(K Reiss, Aung, Aung, & Ngo, 2014)/ *South East Asian city*	Survey (n=170), MC (n=193)	67% had certificate or bachelors qualification in pharmacy	2% (survey), 49% (MC)	Nr	2% (survey), 9% (MC)	Penorit (24%), OC and EC (1%), traditional medicines (14%) (MC)	0% (MC) (miso regimen)
(K Reiss et al., 2015)a/ *Bangladesh*	Survey (n=779)	26% higher education; 93% professional qualification	96%	27%	95%	OC, EC (28%)	23% (miso regimen)
(Tamang & Tamang, 2005)/ *Nepal*	Survey (n=177)	Nr	Nr	Nr (aware 5%)	Nr (aware 4%)	Ayurvedic (21% aware), EP Forte, OC.	Nr
Studies of MEDIUM methodological quality							
(Akiode et al., 2010)/ *Nigeria*	Survey (n=599)	Nr	Nr	Nr	3% (stock)	Nr	Nr
(Bonnema & Dalebout, 1992)/ *Peru*	Survey (n=26), MC (n=29)	50% pharmacist, 50% non-trained pharmacy assistant.	90% (MC)	Nr	Nr	High-dose estrogen/ progestin (miso and mife not mentioned)	N/A

(Ganatra, Manning, & Pallipamulla, 2005)/ *India*	Survey (n=209)	Nr	Nr	34%	51%	Ayurvedic medicines (75%), EC (14%), OC (14%), prostaglandin injections (9%), other hormonal preparations (5%).	16% (mife-miso regimen)
(Hendrickson et al., 2015)/ *Zambia*	MC (n=76 (2009), n=80 (2011))	Nr	24% (2009); 48% (2011)	0% (2009 and 2011)	51% (2009); 72% (2011)	None	0% (2009); 21% (2011) (miso regimen)
(Huda, Ngo, Ahmed, Alam, & Reichenbach, 2014)/ *Bangladesh*	MC (n=331)	'Limited training in general'	76%	n/a	39%	EC, herbal medicines, OC, hormonal preparations, combination of methylestrenolone and methylestradiol	7% (miso regimen)
(Miller et al., 2005)/ *Dominican Republic*	MC (n=80)	'Generally … a salesperson or pharmacy technician, and not the pharmacist'	Nr	Nr	64%	Nr	Nr
(Mishra, Yadav, Malik, Purwar, & Kumari, 2016) *India*	Survey (n=110)	22% graduates, 68% have 'B.Pharma' (pharmacy qualification)	22% sold over the counter drugs	Nr	Nr	Nr	41% (mife-miso)
(Ngo, Park, & Nguyen, 2012)/ *Vietnam*	Survey (n=100), MC (n=30)	89% with college education or higher	30% (survey), 3% (MC)	4% (survey), 0% (MC)	17% (survey), 3% (MC)	Mife alone	Nr
(K Reiss, Footman, Akora, Liambila, & Ngo, 2016) /*Kenya*	Survey (n=235), MC (n=401)	95% trained to dispense medicines	4% (survey), 42% (MC)	3% (MC)	26% (MC)	Surgical methods (27%) (MC)	19% (survey) (miso regimen)
(Kate Reiss et al., 2017)/ *Senegal*	Survey (110)	82% with degree/professional training.	Nr	Nr	25% sold misoprostol, but <1% sold misoprostol for MA	Nr	4% (misoregimen)
(Tamang, Puri, Lama, & Shrestha, 2015)/ *Nepal*	Survey (n=414)	5% had pharmacy/medical training. Majority of pharmacy workers were mid-level providers	42%	Do sell it, % not reported	Do sell it, % not reported	None	23% (unspecified drugs)
Studies of LOW methodological quality							
(Adinma & Adinma, 2013)/ *Nigeria*	Survey (n=22)	100% qualified pharmacists	Nr	Nr	27% (currently stock for any indication)	Nr	Nr
(De Oddone, Shedlin, Welsh, Potts, &	Survey (n=80)	Nr	Nr	Nr	Nr	High dose OC, progesterone injections (miso and mife not	N/A

Feldblum, 1991)/ *Paraguay*						mentioned)	
(Fetters et al., 2015)/ *Zambia*	Survey (n=53)	55% pharmacists, 45% pharmacy technologists	21% mifepristone or misoprostol	7%	Nr	EC, contraceptives or uterotonics (30%)	Nr
(Zamberlin, 2007)/ *Argentina*	MC (n=80)	Nr	55%	Nr	55%	Norgestrel Max, Mistrogen Forte	Nr

Notes: Guide to acronyms: Nr= not reported, OC= oral contraceptives, EC= emergency contraceptives, Mife = mifepristone, Miso = misoprostol, N/A= not applicable (because product/service not available)

Table 6 Intervention studies aimed at improving access to and knowledge of pharmacy/drug shop provision of MA: data extracted from 3 studies meeting inclusion criteria for objective 2

Study and setting	Nature of intervention	Population (sample size)	Study design	Sampling and comparison group	Outcome	Analysis	Intervention findings	Overall quality grade
(Fetters et al., 2015)[1] *Zambia*	1 day training session for pharmacy workers on MA (misoprostol-only)	Pharmacies with registered pharmacy workers (n=53)	Cohort (baseline and post-intervention interview)	Selected all pharmacies within intervention area; no comparison group	Attitudes, dispensing behaviours, harm reduction principles (including referrals, providing information))	Descriptive statistics	Increases in: referrals (47% to 68%*); providing information (55% to 75%*), selling misoprostol (9% to 32% sold to at least 1 client in past 3 months).	Low (7/22)
(Reiss, Keenan, et al., 2015a)[2] *Bangladesh*	i) Face-to-face training sessions with NGO; ii) in-pharmacy detailing; iii) call centre for pharmacy workers and end-users on misoprostol for MR	Pharmacy workers (n=714)	Post-intervention survey (retrospective reporting of intervention exposure)	SRS from list of pharmacies ; no comparison group	Knowledge of correct regimen for misoprostol-only among pharmacy workers who sold misoprostol in past 3 months	Multivariable logistic regression	Regimen knowledge associated with: call centre use (aOR 1.95,95%CI 1.08-3.13); receipt of NGO training (aOR 2.03, 95%CI 1.08-3.80.	Low (10/22)
(Tamang et al., 2015)[1] *Nepal*	2 day training course and 1 day refresher course 10 months later. Printed materials and referral vouchers. Interactive meeting between pharmacy workers and qualified abortion providers to encourage referrals.	Pharmacy workers (n=414- 202 intervention, 212 control)	Controlled pre-/post-test, using independent baseline and post-intervention cross-sectional surveys	Mapping and cluster sampling, comparison group in different geographic area	Knowledge of: upper gestational limit; correct regimen; route of administration; assessment of completeness of abortion; symptoms requiring referral.	Descriptive statistics	Improvement in: knowledge of regimen (22% to 88% intervention, 23% to 41% control); identifying complete abortion (65% to 77% intervention, 51% to 49% control).	Low (10/22)

Notes: Guide to acronyms: OC= oral contraceptives, EC= emergency contraceptives, SRS =simple random sampling, IEC=Information and educational materials, FP=family planning, STIs=sexually transmitted infections, NGO=non-governmental organisation, MC=mystery client, OR= odds ratio, CI= confidence intervals, MA=medical abortion [1] Published peer-reviewed journal article. [2] Conference paper. * P<0.05