Study Protocol: Choice within abortion care pathways - Perspectives of service providers, managers and commissioners

Protocol version: 1.0

Investigator: Katy Footman, PhD Candidate, Department of Social Policy, London School of Economics and Political Science

PhD Supervisors: Professor Ernestina Coast and Dr Tiziana Leone

Date: 3 June 2021

Project period: March 2021-December 2022

LSE Ethics reference: 23691

ABSTRACT

In England and Wales, medical abortions accounted for 74% of abortions in 2019, and this figure has doubled over the last decade. Both medical and surgical abortion are highly safe and effective, have few contraindications and can be provided in an outpatient setting. The 2019 NICE guidelines for abortion state that women should be offered an informed choice of both methods, but choice of methods has been identified as an area of care that requires improvement in previous studies. The aim of this study is to explore how the financing, management and organisation of abortion services can expand or limit abortion method choice, and how providers' perceptions of abortion and abortion methods influence their provision of services and information. Key informant interviews will be conducted with 15-20 providers of abortion care (including nurses, midwives, obstetricians and gynaecologists), 5-10 managers of abortion services and 5-10 commissioners of abortion services. Participants will be purposively recruited through email and snowballing sampling with support from two professional associations. Interviews will be conducted by phone or web-call by myself, depending on the preference of the participant. Interviews will be semi-structured, using a topic guide. Interviews will be audio-recorded and transcribed. Data will be analysed using thematic analysis and findings will be disseminated through conference presentations, peer-reviewed journal articles, and a PhD thesis. Research results are intended to inform policies and practice surrounding the provision of choice within abortion care pathways in the UK, and in other countries where medical methods of abortion are increasingly replacing surgical methods.

Choice within abortion care pathways: perspectives of service providers, managers and commissioners

1. BACKGROUND

In recent years, there have been significant changes in the way women and pregnant people[1] can access abortion care due to service developments such as medical abortion pills, home use, local anaesthesia for surgical abortions, and the recent temporary introduction of telemedicine during the coronavirus pandemic. With evolving abortion technologies, women theoretically have greater choice within their abortion care pathways. But structural factors may undermine choice within abortion care pathways, including choice of abortion methods: medical (using pills) or surgical.[1] Trends in use of medical versus surgical abortion over the past two decades reflect a diversity of experiences for those countries with data available.[2] In some countries, surgical abortion has been almost entirely replaced by medical abortion, while others have seen limited decline in use of surgical methods. Both medical and surgical methods are highly safe and effective, have few contraindications, are highly acceptable to patients, and can be provided in outpatient settings at early gestations, and at later gestations in most cases.[3] However, when studies have compared acceptability of medical and surgical methods, acceptability of surgical abortion is generally higher due to less pain and a faster process.[3]

Choice of abortion methods is therefore one of the six quality standards for abortion care published by the National Institute of Health and Care Excellence (NICE) in the UK and is also recommended in the World Health Organisation (WHO) safe abortion guidelines. This recommendation is driven by evidence that women tend to have strong preferences about their abortion method, that the experience associated with each method is very different, and that acceptability (usually measured by the proportion who would choose the same method again) is greatest when women can choose their preferred method.[3–10] Yet studies that have assessed abortion method choice in England and Wales have consistently identified choice of methods as an area of care that requires improvement.[4,11,12] However, two[4,11] of these studies were conducted before 2010, when access to medical abortion was still limited by over-regulation and method choice was skewed towards surgical abortion, and the third[12] was limited to one NHS hospital (when most abortions in England and Wales are provided in the independent sector). Medical abortion has now become the most commonly used abortion method in England and Wales (73% in 2019), almost doubling since 2008.[13] The recent temporary approval for both stages of the medical abortion process to take place at home during the Covid-19 pandemic has further increased the proportion of abortions that are medical, to 88% in April 2020.

Beyond the choice of abortion method, recent adaptations to abortion care in the UK have also opened more options within abortion care pathways, including the choice of surgical abortion using local or general anaesthesia, medical abortion at home or in a facility, and medical abortion through telemedicine or in-person care. Ensuring a range of options is available to service users is also important to cater to varying needs. A telemedicine

[1] 'Women' is sometimes used as shorthand for 'women and pregnant people' in this document, or 'service users' is used as gender-neutral language inclusive of all pregnant persons who may seek abortion care such as women, non-binary and trans individuals.

evaluation in Australia highlighted that women using telemedicine still felt having the choice of medical or surgical was important as well as having the choice of on-site or remote care.[14] New innovations within abortion care can provide benefits for some while excluding others, in the case of home use and telemedicine – those who may not feel comfortable or safe at home, or who need to hide their abortions from people they live with.[15] Evidence has suggested that these choices about abortion care pathways can also be constrained. For example when the option of self-management of medical abortion at home was introduced, a qualitative study of women's experiences found that some understood day ward treatment only to be for 'exceptional' cases, while home use was the 'normal way', and others felt they were not given any choice.[16]

Most research about choice within abortion care pathways has compared the experiences and preferences of abortion patients receiving a medical or surgical abortion.[6] Few studies have assessed the changing nature of abortion services from the perspective of health providers[17–21], or from the perspective of service managers or funding bodies.[22] Understanding the perspectives of those who hold power and influence over patient choice in abortion care is important, in order to identify structural factors that may be limiting patient choice and autonomy. System-level factors can have a significant influence on choice within abortion care pathways. A survey of health professionals in Europe found that women's options for abortion methods tend to be influenced by system-level factors such as availability of products, which types of providers can perform abortions, how abortion is funded, availability of training and whether abortions are predominantly provided in the public or private sector.[21] A published roundtable of views on medication abortion also identified that at the national level, whether medication abortion or surgical abortion dominates is affected by erosion of provider skills in surgical methods, as well as providers' desire to retain skills and specialty, lack of abortion providers, perception that medication abortion is "what women want", and provider unwillingness to offer surgical abortion due to abortion stigma.[22]

Medical abortion involves a shift in the bodily work of abortion down the medical hierarchy, with reduced involvement of doctors, increased involvement of nurses, and increased involvement of the patient themself.[15] This can create tensions in providers' understanding and support of medical abortion[28], particularly as the work in question holds an ambiguous status in the healthcare hierarchy due to its association with stigma.[15] While the hands-on body work of providers has been replaced by emotional labour of managing women's expectations, the overall framing of the medical abortion experience remain in the hands of health professionals[14,15], as does the provision of information about method choice. Provider perceptions of each method can therefore have a powerful influence on the accessibility of information and methods.[16,17] Their preferences can be shaped by multiple factors: in studies from the USA, Pakistan and South Africa, providers described feeling more comfortable providing MA because it involved simply writing a prescription[19] and their diminished role was equated to less responsibility and stigma.[14] However, providers may also be more comfortable offering surgical abortion if they prefer to know the abortion is complete.[14,20] Research from the USA and Australia has also identified how providers make judgements about which clients will suit each method based on their age, education and socio-economic status[17,21], perceived personality type[14], presence of a support network, mental health status, and previous experience of pain and bleeding.[17] In early research about MA in the USA, clients who were comfortable feeling involved, didn't mind waiting for the process to be

completed and were happy to ‘give up’ control were considered to be better suited to MA, but these clients were also considered to be more ‘demanding’ by encroaching on medical professionals’ turf.[14] Although health providers may make efforts to offer unbiassed information, the manner in which information is conveyed can also impact women’s decisions.[17] An over-focus on biomedical aspects of each method without adequate information about the practical and personal experience associated with each method can also affect abortion experiences.[6]

The organisation of abortion services also influences choice of abortion care pathways. NICE Guidelines state that abortion services should provide information about both medical and surgical abortion (including the benefits and risks), taking account of the woman's needs and preferences, and without being directive, so that women can make their own choice (up to 24 weeks).[25] This recommendation, published in 2019, was expected to lead to a change in practice because many services offer only one method.[26] Ensuring method choice is expected to require greater collaboration across sectors, because there are few doctors trained to provide surgical abortion in the second trimester in the NHS, and most independent sector services are not set up to provide inpatient medical abortion. However, abortion services currently face a workforce crisis, with most gynaecological surgeons who offer second trimester surgical abortion reaching retirement age, meaning that medical abortion may become the only option for later gestation abortions across the NHS and independent sectors.[27] The guidelines also state that it is not practical for all services to offer all abortion options, so onward referral may be needed if local services do not provide the full range of options.

Choice of abortion care pathways is also affected by financial factors. Since 1991, provider competition and the ‘internal market’ has characterised governance of the NHS in England, with selective contracting driven by clinical commissioning groups (CCGs) (Primary Care Trusts prior to 2012) or local authorities. In Wales, the purchaser-provider split model was abandoned in 2009, and the NHS is now a traditional state monopoly funded to deliver care[28]. However, in England, CCGs are thought to play an important role in setting the abortion agenda and standards for quality and access in abortion care.[29] Commercialisation of health services also means that economic interests of commissioning bodies likely have an important influence on the provision of abortion care. There are substantial cost savings associated with provision of medical rather than surgical abortion[1,9], which creates an implicit financial incentive for funders and providers to increase use of MA.[25] An audit of service provision in Wales in 2009 concluded cost and local expertise likely influenced service provision to a greater extent than women’s choice.[26] In addition, the health system explicitly targets the reduction of gestational age as a key quality metric, as a means of increasing efficiency in abortion services and reducing waiting times and delays, and this likely creates an incentive to provide greater access to medication abortion as it can be provided earlier in pregnancy by lower-cadre health professionals and therefore has lower waiting times. There are also explicit financial incentives for providers to increase use of MA. In April 2009, the Department of Health launched the Commissioning for Quality and Innovation (CQUIN) payment framework to enable commissioners to reward excellence, by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals. Clinical commissioning groups (CCGs) set CQUIN targets and goals locally so these vary by locality, but CQUIN goals reported by the provider MS UK include an increase in early medical abortion uptake, LARC uptake and chlamydia screening.[30] Financial pressures also

limit women's choices of post-abortion contraception, as commissioning groups' reluctance to include contraceptive methods in abortion service contracts limits women's access to their desired contraceptive method.[15]

2. RATIONALE

Although there has been a dramatic shift in abortion method choice in many countries, including England and Wales, over the past decade, research has not assessed whether the factors that are driving this shift reflect structural influences or patient preferences in any country.[6] The literature on abortion method choice has focussed on individual patient choice and preferences, with very limited research assessing factors at the provider, institutional and health system level that may drive shifts in abortion method use. Few studies have assessed the changing nature of abortion services from the perspective of health providers[22,34,38,39], or from the perspective of service managers or funding bodies.[40]

Although method choice is one of six NICE quality standards for abortion care, choice of methods has been identified as an area of care that requires improvement in the UK[11,31] and a recent literature review on method choice identified that more support for informed choice is needed, along with more high-quality studies on the topic.[32]

While medical abortion use is known to have increased significantly over time in England and Wales, the impact of changing health policies and regulations that may have prevented or encouraged the provision of medical abortion methods on these trends have also not been assessed. The recent introduction of telemedicine for abortion care also poses new questions about choice within abortion care, including the feasibility of offering choice of methods and pathways for abortion care. Understanding the perspectives of providers, managers and commissioners on choice within abortion care pathways is important for informing policies and implementation of NICE quality standards for abortion care.

Finally, the relationship between abortion stigma and abortion method choice has not been fully explored, though some studies from the UK and internationally have identified that stigmatising attitudes to abortion can influence providers' method preferences and women's understandings of their abortion method experiences.[21–26]

3. RESEARCH QUESTION / AIM

The aim of the key informant interviews is to explore how the financing, management and organisation of abortion services can expand or limit abortion method choice, and how providers' perceptions of abortion and abortion methods influence their provision of services and information. The key informant interviews will also be used to identify key time points when policy changes or interventions may have resulted in significant changes in abortion method use in England and Wales.

The specific research questions are:

- How does the financing, management and organisation of abortion services expand or limit choice in abortion care pathways?

- How do providers' perceptions of abortion and abortion methods influence their provision of services and information?
- How have clinical and commissioning policy changes affected medical abortion use?
- How do commissioning groups understand and incentivise quality in abortion care and what influences commissioners' understanding of quality care?
- What role (if any) does abortion stigma play in the provision of choice within abortion care pathways?
- How do inequalities influence differences in choice within abortion care pathways?

Broader Research Project

This qualitative study is one component of a broader PhD research project, which will also include the following components:

- Analysis of routine national abortion statistics to assess how trends in medical abortion use vary by sub-group, how clinical policy changes have affected these trends (using interrupted time series analysis), and to examine commissioning, clinic and patient-level effects on medical abortion use (using multilevel modelling).
- In-depth interviews to explore abortion service users' perceptions and comparative experiences of abortion methods and choice within abortion care pathways.

The analysis of routine national abortion statistics has already received approval from the LSE research ethics committee (REC). The in-depth interviews protocol will require approval from an NHS REC and it has also been submitted to the British Pregnancy Advisory Service (BPAS) REC and has been exempted from full review by the LSE REC.

4. STUDY DESIGN AND METHODS

Research Design

This study will use qualitative key informant interviews to gather data on the structural factors influencing choice within abortion care pathways from the perspective of abortion providers, service managers and commissioners.

Data collection method

I will conduct interviews by phone, web or videocall (depending on participants' preferences). Interviews are anticipated to last for 40-60 minutes. Participants will be asked to confirm that they are in a private space where they cannot be overheard before the interview begins.

Participants will be asked whether they would be willing to take part in a follow up interview within the next month, in case there are topics that were not adequately explored in the first interview.

Topic guide

In-depth interviews will be semi-structured and conducted using a topic guide (Appendix 9.5). The topic guide and interview approach will be piloted in 1-2 interviews with consenting

participants prior to full data collection commencing, following the same procedures as outlined in the remainder of this protocol.

Participants who provide abortion care or are involved in management and organisation of abortion services will be asked about their professional background and pathway to working in abortion care, their perceptions of the advantages and disadvantages of each method, how decisions about method choice are reached within their service and the criteria considered for each client, how abortion methods are explained to clients and their personal preferences around abortion methods. These participants will also be asked about the structural factors within their service that limit choices of methods and will be asked about their perspectives on choice in other aspects of abortion care, including home use versus clinic use of MA and remote delivery of abortion care. Participants involved in commissioning of abortion care will be asked about their professional background, the role of commissioning groups in the evolution of abortion services, and their perspectives on how commissioning practices and incentives are shaping choice within abortion services in England and Wales.

Data management

All data relating to the study will be stored in password protected folders on the LSE encrypted server, which will be accessed through my encrypted laptop or an LSE encrypted computer. I will be the only person with access to potentially identifiable data.

A Microsoft Form will be used to record contact information about participants and this database will include identifying information. Microsoft Forms are encrypted at rest and in transit and are GDPR compliant. Participant contact information will be stored in a password protected folder in the LSE H: drive, and kept separately from the interview data (recordings, notes and transcripts), which will be stored on the LSE OneDrive. It will not be possible to directly link the participant database to the interview data.

Consent will be recorded electronically using a Qualtrics form. Consent data will be downloaded and stored separately from interview data as it will be identifiable.

Calls will take place either by mobile phone or by web call using Microsoft Teams. Web calls will be recorded using Microsoft Teams and (if video is used) the video recording will be turned into an audio recording using the software Audacity. The video recording will then be deleted from OneDrive. Mobile phone calls will be recorded using an encrypted recording device which will be placed next to the mobile phone. Video recordings on Teams will be identifiable data. Audio recordings may include identifiable data, though participants will be asked not to use names or other details that could be used to identify themselves during the interviews. Audio recordings can also be considered identifiable as a participant's voice may be recognisable to others.

I will initially transcribe the data using the software Trint, which I will then edit myself. Trint is GDPR compliant, but I will also contact Trint prior to using their services to ensure that my data will not be transferred outside of the UK. Transcriptions of interviews and interviewer notes will not include any identifying information from participants and will only include study ID numbers. Any identifying information that participants mention in the audio-recordings will be excluded from the transcriptions. Inconsequential details may be changed to prevent potential indirect identification of participants.

De-identified transcriptions will be shared with my PhD supervisors as needed for purposes of quality assurance or review.

De-identified transcriptions will be imported to Dedoose or Nvivo qualitative analysis software and data will be coded by myself using thematic analysis methods. Analysis will be completed on the LSE encrypted server and on an encrypted laptop.

Identifiable data (including contact information, consent data and audio recordings) will be deleted 3 years after the completion of data collection. Transcriptions (excluding any potentially identifying or sensitive information) will be archived in a data repository according to ESRC requirements.

5. SAMPLE AND RECRUITMENT

Sample

Key informant interviews will be conducted with the following individuals:

- Providers of abortion care (n=15-20), including nurses, midwives, obstetricians and gynaecologists, and other health professionals involved in abortion care
- Individuals involved in management and organisation of abortion services (n=5-10)
- Individuals involved in commissioning of abortion care (n=5-10)

The total sample is expected to be 35-40, but this number may be increased in order to reach saturation.

The inclusion criteria for key informant interviews are:

1. Worked as a provider of medical or surgical abortion services, or in the management, organisation or commissioning of abortion services in England or Wales in the past 5 years.
2. Aged 18 or over
3. Speak English (due to language limitations of interviewer)
4. Give informed consent to be interviewed and audio-recorded

A purposive, convenience sample will be selected, based on membership of professional associations who can circulate information about the study to potential participants, and using snowball sampling.

During recruitment, I will try to purposively recruit individuals from a range of professional backgrounds, involved in abortion care provision within both the NHS and independent service providers and from a variety of geographic regions of England and Wales

Recruitment procedures

Participants will be recruited via email and snowball sampling. An email invitation to participate in the research (Appendix 9.1) will be circulated to members of two professional associations: the British Society of Abortion Care Providers (BSACP) and Doctors for Choice. These emails will be sent to the members by administrators of each association. Interested participants will be invited to reply by email directly to the researcher or to follow a link to find more information about the study, with the option to fill out a Microsoft Form to express interest. Participants will be asked to recommend other individuals who may be eligible and interested in participating. The memberships of these professional associations

will include both abortion providers and individuals involved in management and organisation of abortion services. Individuals already known by the researcher who work in the management and organisation of abortion services will also be directly approached and invited to participate via email. Potential participants will also be identified and directly approached by searching academic literature and published reports and conference abstracts. Individuals involved in commissioning of abortion care will be identified through recommendation of the researcher's contacts who work at independent service providers. Potential participants will be asked by the mutual contact whether they are willing to be contacted by the researcher, and potential participants who give permission for their email address to be shared will then be emailed directly by the researcher.

Participants who are interested in taking part will be provided additional information about the study by email or phone, depending on their preference. An online informed consent form will be used to provide full information about the study and record informed consent. A time will be arranged for the interview to take place with consenting participants.

There will be no financial reimbursement for taking part in the study.

Consent

Participants who express interest in being contacted by the researcher through the study form (Appendix 9.2) will be asked to consent (by ticking a box) that the information they have entered in the form will be stored and processed by the researcher before they can submit it.

Participants will then be contacted by the researcher who will either email a participant information sheet (Appendix 9.3) to the participant or talk them through the information sheet on the phone if preferred by the participant. Participants will be encouraged to ask questions about the research, and their understanding of the process will be confirmed through questions asked by the researcher prior to starting the interview. It will be emphasised in the information sheet and consent process that participation in the study is completely voluntary. Participants will be reassured that their employer will not be informed about their participation in the study and that their identity and their employer's identity will not be revealed in any study outputs. Participants will be given the opportunity to make the decision that is right for them and will be able to consult with others if they prefer. Participants can take as long as needed to decide whether to participate, up to the end of the data collection period (estimated 3 months). Participants will be informed that they can change their mind about taking part at any time. Participants will be told that they can address any questions about the study to the researcher by phone or email. Participants will also be given the contact details for the LSE research ethics committee in case of any concerns that they have.

As interviews will take place by phone or video call, participants will be sent a link to a Qualtrics form (Appendix 9.4) where they can indicate their agreement with each statement in the consent form, and their overall consent. These data will be downloaded and stored securely and separately from interview data. The participant's verbal consent will then be audio-recorded at the beginning of each interview.

6. ETHICAL CONSIDERATIONS

8.1 Assessment and management of risk

The main risks raised by this protocol are consent, discomfort, confidentiality, data privacy, organisational risk and risk to the researcher. Potential risks to participants include the risk of feeling pressurised to take part in the study (consent), the risk of feeling discomfort or distress during or after the interview, and risks to their reputation or employment if their personal information is accidentally disclosed through their participation in the study (confidentiality and data privacy). There are organisational risks to the organisations whose employees may take part in the research, including potential reputational risk and the misuse of research findings by opposition groups. Finally, while the use of remote data collection removes the potential risk for the researcher's physical safety, there is some reputational risk and risk of conflict for the researcher if findings are disputed or if the findings create challenges for organisations within the sector.

These potential risks will be carefully managed and prevented, in the following ways:

Consent:

- Participants will be initially informed about the study through an email, which will reduce the risk of feeling pressured to take part in the study as an email request can be easily ignored or declined. A maximum of 2 follow up emails will be sent to potential participants if they do not respond to initial contact.
- A clear and thorough participant information sheet has been developed, and the researcher will verify that the participant has understood the contents of this information sheet prior to commencing the interview.
- The interviewer has received training in informed consent for qualitative research and will be responsive to the participant's needs during the consent process.
- Participants may feel pressure to take part in the study out of professional duty, social pressure or to represent their employer. Information about the study will be disseminated through professional associations rather than employers to reduce the risk of participants feeling pressurised by their employer to take part. Participants will be reminded that they are completely free to decline to take part in the study, that they can take time to decide and consult others to inform their decision if needed, and that they can change their mind at any time. Participants will be informed that no one else will find out whether or not they personally took part in the study.

Discomfort or distress:

- The research will not address specifically sensitive topics, as abortion is not considered a sensitive topic for professionals who work on this issue every day. However, participants may feel uncomfortable speaking openly about views that do not conform to their organisation's culture or values and may feel concerned about potential negative impacts on their employment.
- Participants who consent to take part in the study will be reminded before the interview begins that they can withdraw at any time and that they can decline to answer any questions.
- Participants will be reassured that their employer will not be informed about their participation, that their organisational affiliation will not be identifiable in the study outputs, and that they will not be personally identifiable in any study outputs.

- The interviewer has received training in conducting sensitive interviews and will be responsive to the participant's needs during the interview process.

Confidentiality:

- Participants' privacy and confidentiality will be explicitly outlined in the participant information sheet and will be verbally explained prior to enrolment.
- Interviews will take place via phone or video call, so the interviewer will ensure she is in a space where she cannot be overheard and is using a secure internet connection, and the participant will be asked to ensure they are in a space where they cannot be overheard.
- Study outputs will protect the anonymity of both the individual participant and the organisation where the participant works, and this will be made clear in the participant information sheet. Organisational affiliation will be grouped by employer / role type e.g. 'NHS provider', 'Independent sector provider', 'Clinical commissioning group employee', 'NHS service manager'.

Data privacy:

- All data will be securely stored in password protected folders within encrypted servers and accessed on encrypted laptops. Only I will have access to potentially identifiable data. Participant names and contact information (used to facilitate contact with participants and to record consent) will be securely stored separately from transcripts and any other data about the participants. Calls will be audio-recorded using secure software and any identifiable data in the recordings will not be transcribed. Inconsequential details may be changed to prevent potential indirect identification of participants.

Organisational risk:

- There is an organisational risk for service delivery organisations or commissioning groups if their staff take part in the study and reveal issues with patient choice in the services they provide or commission. This could create reputational risk for these groups, which will be managed by anonymising the specific organisation, NHS trust or commissioning group that the participant is employed by.
- There is also wider risk for the abortion sector, as findings about limited patient choice can increase the risk of abortion opposition groups promoting negative stories about abortion. This risk will be managed by careful and sensitive dissemination of research findings, with awareness of these issues. The researcher has 6 years of experience disseminating potentially sensitive findings from abortion research in a carefully managed way. The Department of Health and Social Care and the main independent service providers will receive a copy of any dissemination outputs prior to their dissemination and will have adequate time to review and provide feedback prior to publication.

Risk for the researcher:

- There is no expected risk to the participant's physical safety as interviews will be conducted by phone. There is a reputational risk to the researcher if findings are disputed or cause a negative backlash from abortion opposition groups. This risk will

be managed by careful dissemination of findings, with findings initially disseminated informally to research participants and other key stakeholders, prior to wider external dissemination.

There are no direct benefits of the research to the study participant, though participants may benefit from speaking about their views and experiences. The findings of this study is intended to inform policies and practices surrounding choice in abortion care in the UK, and as such may contribute to improved quality of care in the future. Participants may feel satisfaction knowing that participation in this study may help inform future improvements in abortion care.

8.2. Research Ethics Committee (REC) review

Ethical approval will be sought from the LSE research ethics committee for the study protocol, informed consent forms and other relevant documents.

8.6 Data protection and patient confidentiality

The study will safeguard patient confidentiality and will ensure compliance with the requirements of the Data Protection Act 1998 and of the General Data Protection Regulation (GDPR) legislation. The researcher(s) will comply with the requirements of the Data Protection Act 1998 with regards to the collection, storage, processing and disclosure of personal information and will uphold the Act's core principles. Data storage and protection will be in line with GDPR legislation.

A data management plan for this research has been reviewed by the LSE Data Librarian and LSE Cyber Security.

All data relating to the study will be stored in password protected folders on the LSE encrypted server, which will be accessed through my encrypted laptop or an LSE encrypted computer. I will be the only person with access to potentially identifiable data.

A participant database will be used to record contact information about participants. This database will include identifying information. This document will be stored in a password protected folder, separately from transcripts and from any other data that is held about participants.

Participants' informed consent will be recorded using a Qualtrics form. Data will be downloaded and stored securely, and separately from interview data.

Calls will be recorded using an encrypted device. Transcriptions of interviews and interviewer notes will not include any identifying information from participants and will only include study ID numbers. Study ID numbers will be an unrelated sequence of characters used to identify transcripts. Any identifying information that participants mention in the audio-recordings will be excluded from the transcriptions.

Identifiable data (including contact information, records of participant consent, and audio recordings) will be deleted 3 years after the completion of data collection.

Transcriptions (excluding any potentially identifying or sensitive information) will be archived in a data repository according to ESRC requirements, with the participants' consent. The participant information sheet and consent process reflect this future use of the data (Appendix 9.3 and 9.4).

7. DISSEMINATION POLICY

On completion of the study, a study report will be prepared. The findings in this report will initially be shared with the participants who took part in the research, if they consent to being re-contacted about the research findings. Results will be shared through a research brief or through an online meeting (if participants are willing to take part and therefore willing to no longer be anonymised to each other). Feedback and reflections from research participants will be sought and will be incorporated into the dissemination of the main research findings. If participants do not consent to being re-contacted, they will be informed that they can request a copy of the preliminary results or the final publication from the researcher directly.

The research findings will then be disseminated through one or more peer-reviewed publications, conference presentations and eventually a PhD thesis.

Study outputs will be made publicly available online, and all peer-reviewed publications will be published in open access journals. Funding from the Economic and Social Research Council will be acknowledged within publications, but the funder will not have review and publication rights of the data from the study.

The study protocol and anonymised participant level dataset will be stored in an online data repository according to Economic and Social Research Council guidelines after publication of the results of the study in a peer-reviewed journal.

8. TIMELINE

Timeline:

	2021									2022											
	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
Protocol development																					
Ethical review																					
Pilot interviews																					
Data collection																					
Analysis																					
Dissemination																					

9. Appendices:

9.1. Email for initial recruitment

Subject: Invitation to participate in key informant interview about choice in abortion care pathways

A PhD student at the London School of Economics is conducting research about choice within abortion care pathways in England and Wales and is seeking key informants to interview, including: providers of abortion care, service managers, commissioners and others involved in the delivery of abortion care across the NHS and independent sector.

The aim of the study is to explore how the organisation and funding of abortion services is affecting choice within abortion care pathways, and particularly choice of abortion methods. The study also aims to understand how provider perspectives on abortion methods can influence their provision of services and information.

The research is intended to support abortion services to offer a choice of abortion methods and care pathways, and to inform policies for how abortion care is accessed.

Interviews will take place by phone or online and are expected to last 40-60 minutes.

This study has undergone ethics review in accordance with the LSE Research Ethics Policy and Procedure.

For more information about the study and to register your interest in taking part, click here or email the researcher, Katy Footman, directly at: k.footman@lse.ac.uk

9.2. Web form for recruitment

Choice within abortion care pathways: perspectives of service providers, managers and commissioners

About this study:

This research study will be exploring the factors that are driving the shift towards medical abortion within abortion services in England and Wales. The study will assess how the organisation and funding of abortion services is affecting choice within abortion care pathways, and particularly choice of abortion methods. The study also aims to understand how provider perspectives on abortion and abortion methods can influence their provision of services and information.

The research is intended to support abortion services to offer a choice of abortion methods and care pathways, and to inform policies for how abortion care is accessed.

You are invited to take part in this research if:

- You currently work as a provider of abortion care, or in the management, organisation or commissioning of abortion services in England or Wales.

- You are age 18 or over
- You are happy to be interviewed in English (due to language limitations of interviewer)
- You consent to being interviewed and audio-recorded

About the research:

- The research will involve a phone or online interview, lasting up to 1 hour.
- Your participation is completely voluntary and if you choose to take part in the study you can withdraw at any time. You can choose to skip any questions during the interview.
- All data collected from the survey will be stored securely.
- It will not be possible to identify you or the organisation where you work in the study report.
- No one else will be informed whether or not you personally decide to take part in the study.
- If you are interested in taking part in the research, please complete the form below.
- You will then receive a phone call or email (based on your preferences) from the researcher with more information about the study, and if you agree to take part, we will arrange a time for the interview that suits you.
- This study has been reviewed and approved by the LSE research ethics committee. *[Draft text while awaiting review by the LSE REC].*

The research is being conducted by Katy Footman, a PhD student at the London School of Economics, who will be conducting the interviews. If you have more questions about the research, you can request a phone call or email using the form below.

Please complete this form if you are interested in finding out more about the research.
Questions are optional, but the data you provide will be used to make sure that people from a range of professional backgrounds and regions are interviewed.

If you would just like to be contacted with more information about the study, please provide your contact details below.

What is your current professional role? [please include both your current job title and employer] *[Open-ended]*

How would you prefer to be contacted?

- Phone call, please provide phone number:
- SMS, please provide phone number:
- WhatsApp, please provide phone number:
- Email, please provide email address:

Please provide any further details about how you prefer to be contacted or any specific communication needs: *[text box]*

Please provide any additional comments or questions here: *[text box]*

Do you consent to your personal data being stored and processed by the researcher for the purposes of contacting you to discuss your involvement in this research study?

- Yes
- No

If you wish to withdraw your consent at any time, please fill out this form again, using the 'Additional comments' box to request for your consent to be withdrawn, and all data relating to you will be deleted.

9.3. Participant information sheet

Title: Choice within abortion care pathways: perspectives of service providers, managers and commissioners

Researcher: Katy Footman, PhD student, London School of Economics
PhD Supervisors: Professor Ernestina Coast, Dr Tiziana Leone
Funding: Economic and Social Research Council

What is the research about?

In this research, we are trying to understand the factors that are driving the shift towards medical abortion within abortion services in England and Wales. The study will assess how the organisation and funding of abortion services is affecting choice within abortion care pathways, and particularly choice of abortion methods. The study also aims to understand how provider perspectives on abortion and abortion methods can influence their provision of services and information.

The research is intended to support abortion services to offer a choice of abortion methods and options, and to inform the policies for how abortion care is accessed.

Who is being interviewed?

We are interviewing about 40 people and are trying to include people with a range of professional backgrounds and from a range of regions within England and Wales.

Deciding whether to take part

This interview is voluntary, so you are completely free to decline to take part in the study. You can take time to think about whether you want to take part, and feel free to talk to others about the study if you wish.

You can also withdraw from the study before or after your interview if you change your mind at a later stage. If you choose to withdraw from the study up to six months after your interview, your data will be deleted. After that point, we may need to continue to use all your previously collected data because it will have already been included in the analysis.

Nobody (apart from the researcher) will know whether or not you personally decided to take part, or if you decide to withdraw from the study.

What's involved?

If you choose to take part in the study, we will arrange a time for the interview to take place by phone or online. The interview is expected to last between 40-60 minutes and will be audio recorded.

If you are willing to be contacted again, I may then re-contact you for a follow up interview up to one month after your initial interview, in case there are any areas we did not cover in the first interview.

If you are willing for me to keep your contact information on file, I can also contact you again in about 9-12 months to share findings from the research with you, if you are interested.

How will my information be used?

After the interview, I will type up the audio recording and will exclude any information that could be used to identify you personally. I will also change any small details that might be used to identify you personally (for example, if you mentioned the name of a previous employer or role).

The data from your interview will be analysed together with data from interviews with other people. You will not be personally identifiable in any study reports, so no one can work out who you are. Your employer will also not be identifiable in any study reports and your role will just be identified within a broad category e.g. 'independent sector provider', 'NHS provider', 'commissioner', 'independent sector service manager'.

If you consent to this, the anonymised transcript from the interview will eventually be saved in a data archive (a website where anonymised data from research studies are stored) so that it may be used for future research. Researchers that request access to the anonymised transcript through the data archive would only be granted access if I approve that their aims and credentials are appropriate.

What are the possible benefits of taking part?

There are no direct benefits for you of taking part in this research. The research is intended to contribute to improving patient choice within abortion services in the future so you may feel some satisfaction from knowing that you have contributed to the study and you may want your views and experiences to be represented in this research.

What are the possible disadvantages and risks of taking part?

There are some potential disadvantages or risks of taking part. The interview will take about an hour of your time. During the interview, you might feel uncomfortable talking about some topics, but you can tell me if there are questions that you want to skip and you can stop the interview at any time. You can also choose to withdraw from the study after the interview (for up to 6 months) and all your data will be deleted.

How will you ensure my confidentiality?

Your data will be kept safe and secure, following all privacy rules. I will be ensuring that all the information about you and your interview are stored very securely in password protected folders, and on an encrypted server and computer. I will be the only person to have access to data that could be used to identify you, like your name and contact details. Data that identifies you, like your phone number or email address, will be stored separately from the

interview recording and transcript. These data that identify you will be completely deleted within 3 years.

Limits to confidentiality

Confidentiality will be maintained as far as it is possible, unless you tell me something which implies that you or someone you mention might be in significant danger of harm and unable to act for themselves; in this case, I may have to inform the relevant agencies of this, but I would discuss this with you first.

Data protection privacy notice

The LSE Research Privacy Policy can be found at this link: https://info.lse.ac.uk/staff/divisions/SecretarysDivision/Assets/Documents/Information-Records-Management/Privacy-Notice-for-Researchv1.2.pdf?from_serp=1

The legal basis used to process your personal data will be "Legitimate interests". The legal basis used to process special category personal data (e.g. data that reveals racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, health, sex life or sexual orientation, genetic or biometric data) will be for scientific and historical research or statistical purposes. To request a copy of the data held about you please contact: glpd.info.rights@lse.ac.uk

What if I have a question or complaint?

If you have any questions regarding this study, please contact the researcher, Katy Footman, on k.footman@lse.ac.uk.

If you remain unhappy and wish to complain formally, you can contact the LSE Research Governance Manager at research.ethics@lse.ac.uk.

What will happen to the results?

This research is part of a PhD study and will be written up as a PhD thesis. It will also be published in journal articles and shared with interested parties through a research brief and presentations.

If you consent for me to get back in touch with you in about 9-12 months' time, I will share the findings of the research with you directly as well, and you will have the opportunity to provide feedback prior to wider dissemination of the report.

Who is organising and funding the study?

This research is organised by the researcher Katy Footman for her PhD research, and the study sponsor is the London School of Economics. The research is funded by the Economic and Social Research Council.

Who has reviewed this study?

This study has undergone ethics review in accordance with the LSE Research Ethics Policy and Procedure.

9.4. Consent form

Title: Choice within abortion care pathways: perspectives of service providers, managers and commissioners

Please read through each statement and mark whether or not you agree to each statement.

Consent statements	**Yes/No**
I have read and understood the study information sheet, or it has been read to me. I have been able to ask questions about the study and my questions have been answered to my satisfaction.	
I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions and that I can withdraw from the study at any time up until six months after the interview, without having to give a reason.	
I agree to the interview being recorded.	
I understand that the information I provide will be used for a PhD thesis, research publications and other research outputs, and that my information will be anonymized so that I cannot be identified in any written outputs.	
I understand that my employer will be anonymized in any written outputs.	
I agree that my (anonymized) information can be quoted in research outputs.	
I understand that any personal information that can identify me – such as my name, address, will be kept confidential and not shared with anyone other than the interviewer.	
I understand that all information I provide will be treated confidentially. It will be stored securely in accordance with the General Data Protection Regulation. Personal information (e.g. name, contact details) and will not be stored with my interview data.	
I give permission for the (anonymized) information I provide to be deposited in a data archive so that it may be used for future research.	
Do you agree for me to contact you about a possible second interview if there are any topics we do not cover in the first interview?	
Are you willing to be contacted again in about 9 months with the findings from the study?	

Please sign the form by typing your name in the box below.

Participant name:

Date:

9.5. Topic guides

Topic guide: Providers

Thank you for taking part in this interview today. I want to start by reminding you that you can withdraw from the study at any time and that you can ask me to skip any questions you do not feel comfortable answering.

Before we start, are you in a space where you cannot be overheard?

Do you understand that the interview is completely voluntary and you are free to decide whether or not to go ahead with the interview?

Are you still willing to take part in this interview today?

Topic	Topic question	Potential probes
Ice breaker	**Could you tell me why you were interested in taking part in this interview?**	-
Career background	**Could you tell me about your career to date, and the history of how you came to be working in your current role?**	- How long have you been working as an abortion provider? - What motivated you to go into this area of health care? - What made you want to work at your current employer? - How does it compare to previous roles?
Current role	**Could you tell me about your current role(s), and what it involves?**	
Changes in abortion provision	**How has the provision of abortion care changed since you started working in this area?**	-
Changes in abortion methods	**How has your provision changed in terms of the methods you provide?**	- How has it changed for you personally? - How has it changed for your wider organization / service? - What has been driving these changes do you think? - Are there any particular changes in policy or practice that have

		affected the methods you provide?
Impact of changing abortion methods	**What impact do you think the change in abortion methods has had?**	- For patients - in terms of access, experience? - How does it vary between different types of patients (e.g. age, existing children, living situation)? - For providers? Do you have any preference for either method? What about your colleagues? - For the organization / service? - For funders / commissioners?
Decision-making	**How are decisions about abortion methods reached in your service?**	- Who makes the decision? - Does it vary between different types of patients? - Have patients usually decided on their preference before they see you? - How do you support patients' decision? - How do you explain the methods to each client? - What criteria do you consider when guiding their decisions?
Choice of methods	**How much choice is there for patients in your service about the method they receive?**	- What sorts of things limit their choices (at the patient level, provider level, organization level, policy level)? - How has this changed? - How do you think it could be improved? - Do you see any risks for patient choice? - Do you think choice of abortion methods matters? - Are there any metrics or targets that influence whether or not you can provide a choice?
Wider choices of care pathways	**How about wider choices about <u>how</u> patients access abortion care – how much choice do patients have about whether they access**	- Are patients currently able to choose how they access their abortion care? - Do you think this is important? - What are the main challenges to ensure there is a choice?

	abortion services at home or through a clinic?	- What sorts of things are limiting choice?
The future of abortion care	**How do you think abortion services will continue to change in the next five years?**	- Why do you think we will see these changes? - What do you think will be the effects of these changes (for patients, for providers, for the health system)? - What changes would you like to see?
Any final thoughts	**Is there anything that you would have liked me to ask about that I didn't?** **How did this interview compare to what you were expecting?** **Is there anything that you were surprised I did or didn't ask you?**	-
Thank you – wrap up		

Topic guide: Service managers

Thank you for taking part in this interview today. I want to start by reminding you that you can withdraw from the study at any time and that you can ask me to skip any questions you do not feel comfortable answering.

Before we start, are you in a space where you cannot be overheard?

Do you understand that the interview is completely voluntary and you are free to decide whether or not to go ahead with the interview?

Are you still willing to take part in this interview today?

Topic	Topic question	Potential probes
Ice breaker	**Could you tell me why you were interested in taking part in this interview?**	

Career background	**Could you tell me about your career to date, and the history of how you came to be working in your current role?**	- How long have you been working at an abortion provider? - What motivated you to go into this area of health care? - What made you want to work at your current employer? - How does it compare to previous roles?
Current role	**Could you tell me about your current role(s), and what it involves?**	
Changes in abortion provision	**How has the provision of abortion care changed since you started working in this area?**	
Changes in abortion methods	**How has the organization / service that you manage changed in terms of the abortion methods you provide?**	- What do you think has been driving these changes? - Are there any particular changes in policy or practice that have affected the methods you provide? - Are there any quality indicators or targets that influence what methods you can provide?
Impact of changing abortion methods	**What impact do you think the change in abortion methods has had?**	- For patients - in terms of access, experience? - How does it vary between different types of patients (e.g. age, existing children, living situation)? - For providers? - For the organization / service? - For commissioners?
Decision-making	**What is the policy within your service / organization for how decisions about abortion methods are reached?**	- Who makes the decision? - Does it vary between different types of patients? - How are patients' decisions guided? - How are providers expected to explain the methods to each client? - What criteria should they consider when supporting patients' decisions?
Choice of methods	**How much choice is there for patients in your**	- What sorts of things limit their choices (at the patient level, provider

	service about the method they receive?	level, organization level, policy level)? - How has this changed? - How do you think it could be improved? - Do you see any risks for patient choice? - Do you think choice of abortion methods matters?
Wider choices of care pathways	**How about wider choices about <u>how</u> patients access abortion care – how much choice do patients have about whether they access abortion services at home or through a clinic?**	- Are patients currently able to choose how they access their abortion care? - Do you think this is important? - What are the main challenges to ensure there is a choice? - What sorts of things are limiting choice?
Choice of providers	**What about choice of provider – how much choice do patients have about the provider they see?**	- Do you think this is important? - What are the main challenges to ensure there is a choice? - What sorts of things are limiting choice?
The future of abortion care	**How do you think abortion services will continue to change in the next five years?**	- Why do you think we will see these changes? - What do you think will be the effects of these changes (for patients, for providers, for the health system)? - What changes would you like to see?
Anything final thoughts	**Is there anything that you would have liked me to ask about that I didn't?** **How did this interview compare to what you were expecting?** **Is there anything that you were surprised I did or didn't ask you?**	
Thank you – wrap up		

Topic guide: Commissioners

Thank you for taking part in this interview today. I want to start by reminding you that you can withdraw from the study at any time and that you can ask me to skip any questions you do not feel comfortable answering.

Before we start, are you in a space where you cannot be overheard?

Do you understand that the interview is completely voluntary and you are free to decide whether or not to go ahead with the interview?

Are you still willing to take part in this interview today?

Topic	Topic question	Potential probes
Ice breaker	**Could you tell me why you were interested in taking part in this interview?**	
Career background	**Could you tell me about your career to date, and the history of how you came to be working in your current role?**	
Current role	**Could you tell me about your current role(s), and what it involves?**	
Changes in abortion commissioning	**How has the commissioning of abortion care changed since you started working in this area?**	
Changes in abortion methods	**How has the shift towards medical abortion affected commissioning of abortion services?**	- In terms of provider competition? - In terms of costs? - How has the shift to telemedicine affected commissioning of abortion services?
Impact of changing abortion methods	**What would you say have been the main impacts of the shift to medical abortion in England and Wales?**	- For patients - in terms of access, experience? - How does it vary between different types of patients (e.g. age, existing children, living situation)? - For providers?

		- For commissioners?
Quality of care	**How do commissioners measure and influence quality of care in abortion services?**	- How do commissioning groups define quality of abortion care? - How does that vary from other health services? - What metrics or targets are used by commissioners to encourage quality services?
Choice of methods	**How do commissioners influence choice within abortion services, particularly for abortion methods?**	- How much choice do you think patients have? - What sorts of things limit their choices (at the patient level, provider level, organization level, policy level)? - How has this changed? - How do you think it could be improved? - Do you see any risks for patient choice? - Do you think choice of abortion methods matters?
Wider choices of care pathways	**How about wider choices about <u>how</u> patients access abortion care – how do commissioners influence whether patients can choose between abortion at home or through a clinic?**	- Are patients currently able to choose how they access their abortion care? - Do you think this is important? - What are the main challenges to ensure there is a choice? - What sorts of things are limiting choice?
Choice of providers	**What about choice of provider – how do commissioners influence patient choice of abortion provider?**	- Do you think this is important? - What are the main challenges to ensure there is a choice? - What sorts of things are limiting choice?
The future of abortion care	**How do you think abortion services will continue to change in the next five years?**	- Why do you think we will see these changes? - What do you think will be the effects of these changes (for patients, for providers, for commissioners)? - What changes would you like to see?

Anything final thoughts	**Is there anything that you would have liked me to ask about that I didn't?** **How did this interview compare to what you were expecting?** **Is there anything that you were surprised I did or didn't ask you?**	-
Thank you – wrap up		

References

1. O'Shea LE, Hawkins JE, Lord J, et al. Access to and sustainability of abortion services: a systematic review and meta-analysis for the National Institute of Health and Care Excellence-new clinical guidelines for England. *Hum Reprod Update*. 2020;26(6):886-903. doi:10.1093/humupd/dmaa026
2. Popinchalk A, Sedgh G. Trends in the method and gestational age of abortion in high-income countries. *BMJ Sex Reprod Heal*. 2019;45(2):95-103. doi:10.1136/bmjsrh-2018-200149
3. Kapp N, Lohr PA. Modern methods to induce abortion: safety, efficacy and choice. *Best Pract Res Clin Obstet Gynaecol*. 2020.
4. Slade P, Heke S, Fletcher J, Stewart P. A comparison of medical and surgical termination of pregnancy: choice, emotional impact and satisfaction with care. *BJOG An Int J Obstet Gynaecol*. 1998;105(12):1288-1295.
5. Rodriguez MI, Seuc A, Kapp N, et al. Acceptability of misoprostol-only medical termination of pregnancy compared with vacuum aspiration: an international, multicentre trial. *BJOG An Int J Obstet Gynaecol*. 2012;119(7):817-823.
6. Kanstrup C, Mäkelä M, Hauskov Graungaard A. Women's reasons for choosing abortion method: a systematic literature review. *Scand J Public Health*. 2018;46(8):835-845.
7. Moreau C, Trussell J, Desfreres J, Bajos N. Medical vs. surgical abortion: the importance of women's choice. *Contraception*. 2011;84(3):224-229.
8. Henshaw RC, Naji SA, Russell IT, Templeton AA. Comparison of medical abortion with surgical vacuum aspiration: women's preferences and acceptability of treatment. *Bmj*. 1993;307(6906):714-717.
9. Robson SC, Kelly T, Howel D, et al. Randomised preference trial of medical versus surgical termination of pregnancy less than 14 weeks' gestation. *Health Technol Assess (Rockv)*. 2009;13(53):i-148.
10. Rørbye C, Nørgaard M, Nilas L. Medical versus surgical abortion: Comparing satisfaction and potential confounders in a partly randomized study. *Hum Reprod*. 2005;20(3):834-838. doi:10.1093/humrep/deh643
11. Thomas J, Paranjothy S, Templeton A. An audit of the management of induced abortion in England and Wales. *Int J Gynecol Obstet*. 2003;83(3):327-334.
12. Heath J, Mitchell N, Fletcher J. A comparison of termination of pregnancy procedures: Patient choice, emotional impact and satisfaction with care. *Sex Reprod Healthc*. 2019;19(December 2018):42-49. doi:10.1016/j.srhc.2018.12.002
13. Department of Health and Social Care. Abortion Statistics in England and Wales: 2019. 2020.
14. Fix L, Seymour JW, Sandhu MV, Melville C, Mazza D, Thompson T-A. At-home telemedicine for medical abortion in Australia: a qualitative study of patient experiences and recommendations. *BMJ Sex & Reprod Heal*. 2020;46(3):172 LP - 176. doi:10.1136/bmjsrh-2020-200612
15. APPG on Sexual & Reproductive health. *Women's Lives, Women's Rights: Strengthening Access to Contraception Beyond the Pandemic*. London; 2020. https://hertscc365.sharepoint.com/Sites/intranet-JointStrategicNeedsAssessmentWorkingGroup/Shared Documents/Forms/AllItems.aspx?viewpath=%252FSites%252Fintranet-JointStrategicNeedsAssessmentWorkingGroup%252FShared Documents%252FForms%252FAllItems.aspx&id=.
16. Purcell C, Cameron S, Lawton J, Glasier A, Harden J. Self-management of first trimester medical termination of pregnancy: a qualitative study of women's experiences. *BJOG An Int J Obstet Gynaecol*. 2017;124(13):2001-2008. doi:10.1111/1471-0528.14690
17. Simonds W, Ellertson C, Springer K, Winikoff B. Abortion, revised: participants in the US clinical trials evaluate mifepristone. *Soc Sci Med*. 1998;46(10):1313-1323.
18. Purcell C, Cameron S, Lawton J, Glasier A, Harden J. The changing body work of abortion: a

qualitative study of the experiences of health professionals. *Sociol Heal Illn*. 2017;39(1):78-94. doi:10.1111/1467-9566.12479

19. Loeber OE. Motivation and satisfaction with early medical vs. surgical abortion in the Netherlands. *Reprod Health Matters*. 2010;18(35):145-153. doi:10.1016/S0968-8080(10)35501-7

20. Newton D, Bayly C, McNamee K, et al. How do women seeking abortion choose between surgical and medical abortion? Perspectives from abortion service providers. *Aust New Zeal J Obstet Gynaecol*. 2016;56(5):523-529. doi:10.1111/ajo.12506

21. Ramos R. Women's choice regarding abortion methods. In: *4th International Congress on Women's Health and Unsafe Abortion, February 19-22 2019*. ; 2019.

22. Oppegaard KS, Sparrow M, Hyland P, et al. What if medical abortion becomes the main or only method of first-trimester abortion? A roundtable of views. *Contraception*. 2018;97(2):82-85.

23. Lince-Deroche N, Harries J, Constant D, et al. Doing more for less: identifying opportunities to expand public sector access to safe abortion in South Africa through budget impact analysis. *Contraception*. 2018;97(2):167-176.

24. Chavkin W, Stifani BM, Bridgman-Packer D, Greenberg JMS, Favier M. Implementing and expanding safe abortion care: An international comparative case study of six countries. *Int J Gynecol Obstet*. 2018;143:3-11.

25. NICE. *Abortion Care NICE Guideline NG140*.; 2019.

26. Lipp A. Service provision for women undergoing termination of pregnancy: Progress in Wales, UK. *J Fam Plan Reprod Heal Care*. 2009;35(1):15-19. doi:10.1783/147118909787072324

27. Pillai M. Second-trimester abortion: women often lack the choice they should be offered. *J Fam Plan Reprod Heal Care*. 2017. doi:10.1136/jfprhc-2017-101907

28. Bevan G, Karanikolos M, Exley J, Nolte E, Connolly S, Mays N. *The Four Health Systems of the United Kingdom: How Do They Compare?* London; 2014.

29. Astbury-Ward E. Abortion 'on the NHS': the National Health Service and abortion stigma. *J Fam Plan Reprod Heal Care*. 2015;41(3):168 LP - 169. doi:10.1136/jfprhc-2014-101104

30. Marie Stopes UK. *Quality Account 2019/20*. London; 2020.

31. Wong SSM, Bekker HL, Thornton JG, Gbolade BA. Choices about abortion method: assessing the quality of patient information leaflets in England and Wales. *BJOG an Int J Obstet Gynaecol*. 2003;110(3):263-266.

32. Winikoff B. Acceptability of medical abortion in early pregnancy. *Fam Plann Perspect*. 1995;27(4):142-148. doi:10.2307/2136257

33. Alam B, Kaler A, Mumtaz Z. Women's voices and medical abortions: A review of the literature. *Eur J Obstet Gynecol Reprod Biol*. 2020.

34. Love G. Abortion stigma, class and embodiment in neoliberal England. *Cult Heal Sex*. 2020;0(0):1-16. doi:10.1080/13691058.2019.1709659

35. Lie MLS, Robson SC, May CR. Experiences of abortion: A narrative review of qualitative studies. *BMC Health Serv Res*. 2008;8(9):1-9.

36. Ross L, Solinger R. *Reproductive Justice An Introduction*.; 2008.

37. Ross LJ. Reproductive justice as intersectional feminist activism. *Souls*. 2017. doi:10.1080/10999949.2017.1389634

38. Wiebe ER. Choosing between surgical abortions and medical abortions induced with methotrexate and misoprostol. *Contraception*. 1997. doi:10.1016/S0010-7824(96)00274-0

39. Cameron ST, Glasier AF, Logan J, Benton L, Baird DT. Impact of the introduction of new medical methods on therapeutic abortions at the Royal Infirmary of Edinburgh. *BJOG An Int J Obstet Gynaecol*. 1996;103(12):1222-1229.

40. Lohr PA, Wade J, Riley L, Fitzgibbon A, Furedi A. Women's opinions on the home

management of early medical abortion in the UK. *J Fam Plan Reprod Heal Care*. 2010;36(1):21-25. doi:10.1783/147118910790290894

41. Taylor D, Postlethwaite D, Desai S, et al. Multiple Determinants of the Abortion Care Experience: From the Patient's Perspective. *Am J Med Qual*. 2013;28(6):510-518. doi:10.1177/1062860613484295

42. Teal SB, Dempsey-Fanning A, Westhoff C. Predictors of acceptability of medication abortion. *Contraception*. 2007;75(3):224-229. doi:10.1016/j.contraception.2006.10.008

43. Schaff EA, Fielding SL, Westhoff C. Randomized trial of oral versus vaginal misoprostol at one day after mifepristone for early medical abortion. *Contraception*. 2001;64(2):81-85. doi:10.1016/S0010-7824(01)00229-3

44. Schaff EA, Fielding SL, Eisinger SH, Stadalius LS, Fuller L. Low-dose mifepristone followed by vaginal misoprostol at 48 hours for abortion up to 63 days. *Contraception*. 2000;61(1):41-46. doi:10.1016/S0010-7824(99)00119-5

45. Schaff EA, Fielding SL, Westhoff C, et al. Vaginal misoprostol administered 1, 2, or 3 days after mifepristone for early medical abortion: a randomized trial. *Jama*. 2000;284(15):1948-1953.

46. Harvey SM, Beckman LJ, Satre SJ. Choice of and satisfaction with methods of medical and surgical abortion among U.S. clinic patients. *Fam Plann Perspect*. 2001;33(5):212-216. doi:10.2307/2673784

47. Ho PC. Women's perceptions on medical abortion. *Contraception*. 2006;74(1):11-15. doi:10.1016/j.contraception.2006.02.012

48. Porter C, Lord J, Church K. Early medical abortion using telemedicine-acceptability to patients. *BMJ Sex Reprod Heal*. 2021.

49. Mcleroy KR, Bibeau D, Steckler A, Glanz K. An Ecological Perspective on Health Promotion Programs. *Heal Educ Behav*. 1988. doi:10.1177/109019818801500401

50. Rothman BK. The meanings of choice in reproductive technology. In: Jaggar A, ed. *Living With Contradictions: Controversies In Feminist Social Ethics*. New York: Routledge; 1994:325-329.

51. Winikoff B, Hassoun D, Bracken H. Introduction and provision of medical abortion: A tale of two countries in which technology is necessary but not sufficient. *Contraception*. 2011;83(4):322-329. doi:10.1016/j.contraception.2010.08.009

52. Ganatra B, Kalyanwala S, Elul B, Coyaji K, Tewari S. Understanding women's experiences with medical abortion: In-depth interviews with women in two Indian clinics. *Glob Public Health*. 2010;5(4):335-347.

53. Coast E, Norris AH, Moore AM, Freeman E. Trajectories of women's abortion-related care: A conceptual framework. *Soc Sci Med*. 2018. doi:10.1016/j.socscimed.2018.01.035

54. Kumar A, Hessini L, Mitchell EMH. Conceptualising abortion stigma. *Cult Heal Sex*. 2009;11(6):625-639.

55. Goffman E. *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice Hall; 1963.

56. Hessini L. A learning agenda for abortion stigma: recommendations from the Bellagio expert group meeting. *Women Health*. 2014;54(7):617-621.

57. Cockrill K, Herold S, Blanchard K, Grossman D, Upadhyay UD, Baum S. Addressing abortion stigma through service delivery: A white paper. *Sea Chang Program https//www stigmatoolkit org/publications*. 2013.

58. Millar E. Abortion stigma as a social process. In: *Women's Studies International Forum*. Vol 78. Elsevier; 2020:102328.

59. Tyler I, Slater T. Rethinking the sociology of stigma. *Sociol Rev*. 2018. doi:10.1177/0038026118777425

60. Tyler I. Resituating Erving Goffman: From stigma power to black power. *Sociol Rev*. 2018. doi:10.1177/0038026118777450

61. Cooper D, Dickson K, Blanchard K, et al. Medical abortion: the possibilities for introduction in the public sector in South Africa. *Reprod Health Matters*. 2005;13(26):35-43.

62. Baum S. *Personal Communication*.; 2018.

63. Broussard K. The changing landscape of abortion care: Embodied experiences of structural stigma in the Republic of Ireland and Northern Ireland. *Soc Sci Med*. 2020;245(November 2019):112686. doi:10.1016/j.socscimed.2019.112686

64. Stone N, Ingham R. Who presents more than once? Repeat abortion among women in Britain. *J Fam Plan Reprod Heal Care*. 2011;37(4):209-215. doi:10.1136/jfprhc-2011-0063