Expectations and experiences of pain during medical abortion at home: a secondary, mixed-methods analysis of a patient survey in England and Wales

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ABSTRACT

Objective To explore experiences of pain during medical abortion and provide patient-centred recommendations for improving abortion experience and pain counselling.

Methods We invited patients of British Pregnancy Advisory Service who underwent medical abortion up to 10 weeks' gestation to participate in an online, English language questionnaire from November 2021 to March 2022. Participants answered questions about pain, method preference, abortion experience, advice, and how they would describe pain experienced to a friend. In this secondary analysis, we analysed free-text responses using reflexive thematic analysis techniques. We used descriptive statistics and parametric tests to analyse quantitative responses.

Results Of 11 906 patients invited to participate, 1596 (13.4%) completed the questionnaire, including at least one free-text comment. Participants used a range of descriptors for medical abortion pain across three broad themes: pain severity, pain quality and comparisons to other reproductive pain. Some found the commonly used analogy to period pain misleading. Many felt unprepared for the level of pain they experienced, which they attributed to provider comparisons to period pain, as well as a lack of detailed, realistic anticipatory pain counselling. Qualitative and quantitative results suggest pain experiences impact method preference. Participants recommended better counselling for pain and abortion preparation, including first-hand accounts of medical abortion at home and a wide and accessible range of descriptions of pain.

Conclusions Abortion providers should use patient-centred recommendations to better prepare patients for pain during medical abortion. Setting realistic expectations can improve abortion experience and support informed method choice. Further research is needed to develop and test patient-centred counselling materials.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ While highly acceptable, medical abortion is painful and research is lacking on the best ways of managing pain.
⇒ Expectation management for pain is important for satisfaction with overall abortion experience and perceived quality of care.

WHAT THIS STUDY ADDS

⇒ Reinforcing recent literature, our findings emphasise how using comparisons of medical abortion pain to period pain can be misleading and unhelpful for managing some patients' pain expectations.
⇒ Patients want detailed, realistic anticipatory pain counselling as well as general preparatory advice, including first-hand experiences which reference a wide and accessible range of descriptions of pain.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE AND POLICY

⇒ Services that provide and counsel about medical abortion can use these findings to develop practitioner training tools and patient counselling materials, to better prepare patients for the pain they may experience and, where possible, to ensure informed method choice.

INTRODUCTION

In England and Wales, medical abortion is the most common method up to 10 weeks' gestation, with nearly all medical abortions carried out at home.[1] While highly acceptable, medical abortion is painful for most patients. Studies have yet to identify the best way to manage pain.[2] Trials show patients typically experience moderate to severe pain, with average pain scores between 5 and 8 out of 10.[3–5] For many, pain is the worst feature of this method.[6] Dissatisfaction with medical abortion at home is associated with dissatisfaction with pain control.[7]

Patients report that being well prepared for what to expect during and after an abortion contributes to overall satisfaction and perceived quality of care.[8 9] Several qualitative studies have highlighted the importance of anticipatory counselling about pain management with medical abortion, and the impact that good counselling can have on fear, anxiety and pain experienced.[9–12]

British Pregnancy Advisory Service (BPAS), a non-profit, independent abortion provider, operates clinics throughout England and Wales. Annually BPAS provides approximately 90 000 medical abortions at home up to 10 weeks' gestation.[11] If patients do not require an ultrasound, they can follow a remote pathway,[11] with a teleconsultation and medications mailed for self-administration.[12]

In 2021, BPAS made clinical policy changes in response to trial findings that opioids were no better than ibuprofen in managing medical abortion pain[13] and reflecting increasing concerns about opioid addiction. Instead of providing codeine to all medical abortion patients for use when ibuprofen was insufficient, codeine was offered on an 'opt-in' basis following counselling. An evaluation[14] found that participants in the opt-in group were significantly more likely to be satisfied with pain management than those in the universal group (adjusted odds ratio (aOR) 1.48, 95% CI 1.12 to 1.96, p<0.01). One possible explanation for this difference was that the opt-in group may have been better prepared for pain. Despite higher satisfaction in the opt-in group, patients still reported high pain scores (mean 6.7/10) and experienced more pain than anticipated (45.2%, 362/801). During that evaluation,[14] we also collected qualitative responses about abortion experience. In this secondary analysis, we examined qualitative data to inform counselling guidance and materials, aiming to better prepare BPAS patients for pain management, and provide insights for other abortion services to consider.

METHODS

This is a secondary analysis of a previously published evaluation[14] wherein we invited medical abortion patients up to 10 weeks' gestation to complete an online, anonymous questionnaire about pain management during medical abortion at home. Over a 4-month period (November 2021–March 2022), we invited eligible patients to participate via text or email. We did not offer renumeration. In this analysis, we included questions about future abortion method, as well as three optional free-text questions (table 1).

The Health Research Decision Aid tool did not classify this evaluation as research.[15] On this basis, the BPAS Reseach Ethics Committee granted it exemption from full ethical review.

We used descriptive statistics to summarise quantitative responses. Using a Student's *t*-test, we compared mean pain scores by future method preference. We collated free-text responses from participants who completed the questionnaire with at least one free-text response. Data were stored and analysed using Excel. We followed reflexive thematic qualitative analysis principles.[16 17] All authors participated in the analysis and contributed multidisciplinary perspectives including expertise in clinical, epidemiological and qualitative research methods related to abortion, endometriosis, chronic pelvic pain, and pain within other gynaecological procedures. One researcher (HM) led the analysis, familiarising themselves with the data and following an iterative process of coding. Codes were identified inductively from content and deductively from questions and relevant existing qualitative research. A second researcher (DP) worked with

Table 1 Method preference and pain with abortion variables used in quantitative and qualitative analyses in secondary analysis of evaluation

Variables	Measure
Quantitative variables	
If you had another abortion in the future, what method would you choose?	Used as a proxy for method preference
Was the pain you experienced a factor in why you would choose this method?	Impact of pain on method preference
On the following scale of 0–10, how would you rate the worst pain you recall during your medical abortion?*	Maximum pain experienced during abortion
Qualitative variables (optional free-text responses)	
How would you describe the pain you experienced to a friend?	
Is there anything else you would like to tell us about your experience of pain, or how it was managed?	
Is there anything you know now that you wish you had been told before your abortion?	

*Eleven-point numerical rating scale.

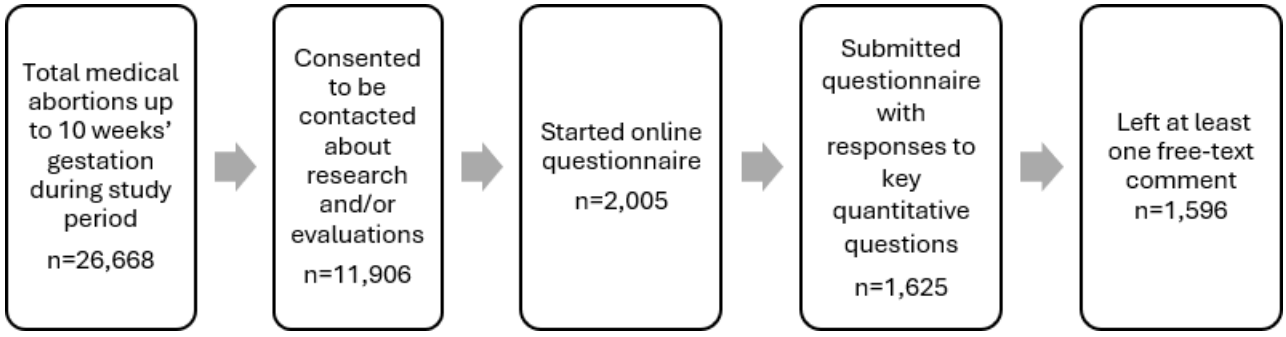

Figure 1 Flow chart for evaluation of pain management for medical abortion up to 10 weeks of gestation at British Pregnancy Advisory Service.

HM to further reflect on these codes, and refine into themes around central organising concepts. All authors met to discuss the coding framework (online supplemental file 1), including exemplar quotes, to come to a consensus on final refined themes. In reporting, we mirror participants' language and refer to pain experienced during menstruation as 'period pain'. Other scientific literature may reference 'menstrual cramping' or 'dysmenorrhea'.

RESULTS

Sample

We invited 11 906 eligible BPAS patients to participate and included 1596 in this secondary analysis (figure 1).

Quantitative results

As shown in table 2, one-third of patients had pregnancies that were 8 weeks and 0 days to 9 weeks and 6 days' gestation (33.2%, n=530) at abortion. Almost half were nulliparous (48.7%, n=777).

About half (48.4%, n=773) of the participants reported experiencing more pain than expected (table 3). Most (92.2%, n=1472) reported experiencing moderate to severe pain (pain score ≥4/10). Of the 12.7% (n=202) who would choose to have a surgical abortion if they needed another abortion in the future, 82.7% (n=167) said that pain was a factor in this decision. Most (65.6%, n=1047) would choose a medical abortion, with just fewer than half (42.7%, n=447) indicating that pain was a deciding factor. Participants who would choose surgical abortion reported an average maximum pain score of 8.5 (SD 1.8), compared with 6.2 (SD 2.2) for those who would choose a medical abortion ($p<0.05$).

Qualitative results

We identified four themes, each of which are described below.

Patient descriptors of medical abortion pain are varied and complex

Participants shared their descriptions of medical abortion pain by recounting how they would describe their pain to a friend. We present these across three subthemes: severity of pain, quality of pain, and comparisons with other reproductive experiences.

Severity of pain

Participants provided descriptions of pain that ranged from no or little pain to severe pain, or the worst pain ever experienced. For example, *"I didn't suffer any pain"*, *"Very mild"*, *"Moderate"*, *"Very strong, but not severe"*, *"Excruciating"* and *"The worst pain I have gone through"*.

Quality of pain

Participants used a wide range of physical sensations to illustrate the quality of their pain. For example,

Table 2 Demographics and health characteristics of participants undergoing medical abortion up to 10 weeks of gestation at British Pregnancy Advisory Service

Characteristic	Participants (N=1596) n (%)
Age (years)	
14–19	131 (8.2)
20–29	790 (49.5)
30–39	564 (35.3)
40–50	111 (7.0)
English as first language	
No	212 (13.3)
Yes	1384 (86.7)
Gestational age	
5 weeks 6 days or less	305 (19.1)
6 weeks 0 days to 7 weeks 6 days	748 (46.9)
8 weeks 0 days or more	530 (33.2)
Unsure/cannot remember	13 (0.8)
Parity	
Nulliparous	777 (48.7)
Parous	819 (51.2)
Previous abortion	
No	1115 (69.9)
Yes (medical)	355 (22.2)
Yes (surgical)	200 (12.5)
Medical history	
Anxiety	550 (34.5)
Depression	347 (21.7)
Chronic pelvic pain	27 (1.7)
Endometriosis	30 (1.9)

Table 3 Pain characteristics, satisfaction with pain management and impact on method preference among participants undergoing medical abortion up to 10 weeks of gestation at British Pregnancy Advisory Service

Parameter	Participants (N=1596) n (%)
Maximum pain score	
0–3	124 (7.8)
4–5	328 (20.9)
6–7	482 (30.2)
8–10	662 (41.5)
Actual versus expected experience of pain	
A lot more than expected	485 (30.4)
A little more than expected	288 (18.0)
About as much than expected	382 (23.9)
A little less than expected	277 (17.4)
A lot less than expected	164 (10.3)
Future method preference	
Medical	1047 (65.6)
Surgical	202 (12.7)
Not sure	347 (21.7)
Pain a factor in method preference	
Would choose medical and pain with medical abortion a factor (n=1047)	447 (42.7)
Would choose surgical and pain with medical abortion a factor (n=202)	167 (82.7)

they described it as "*aching*", "*crunching*", "*pulling*", "*squeezing*", "*stabbing*" or "*twisting*". In some instances "*cramping*" or "*contracting*" were used, or the phrase "*coming in waves*".

Descriptions often included the physical or mental impact of pain or accompanying symptoms, for example, vomiting or feeling faint. They often referred to additional facets of pain, for example, location, severity, intensity and duration.

> *"Like someone squeezing my stomach muscles, like my insides were being twisted."*

> *"The pain was intense and constant, in my lower back. It hurt so much that it made me throw up several times. I felt shaky and faint at points. After the pregnancy passed it became a lot easier."*

Comparisons with other reproductive experiences

Many participants used other reproductive experiences such as period or labour pain as reference points for medical abortion pain. Some did express pain that was like their regular period or a particularly severe period. However, participants often said abortion pain was worse than period pain, using multipliers to describe the difference.

> *"The pain felt like my normal period pains but just a little bit worse. Nothing extreme, but just that bit worse."*

> *"I suffer with endometriosis so have extremely painful and heavy periods normally so to me the pain felt pretty much the same as I would experience during a period."*

Others made comparisons to birth pain, referencing "*contractions*" or labour pains that they had experienced. In some instances, participants anchored medical abortion pain somewhere between the severity of period and labour pain.

> *"Pain was so much stronger than period pain, it was like having contractions in labour. I've given birth three times and the pain really wasn't too much different from that pain, the cramping contraction pain."*

Current counselling leaves some unprepared for pain

Some participants recounted an alignment between expected and experienced pain, suggesting good preparation. Some searched online forums to read first-hand experiences to prepare them while others reported that the service had sufficiently counselled them.

> *"All the help, advice and support I received was exceptional. My expectations were managed perfectly and nothing came as a surprise, I felt fully informed."*

Others said the pain they experienced was far greater than expected. Some directly attributed this to language or detail given to pain in consultations or information leaflets being "*washed over*", "*downplayed*" or "*sugar-coated*". A substantial number of participants reported how provider's descriptions of medical abortion pain as period-like (eg, "*like a period*", or "*a bad period*", "*period cramps*" or "*period cramping*") had played directly into their expectations. This influenced pain management plans, and then ultimately left them unprepared for the pain experienced, which was, for many, more painful or incomparable to their experience of period pain. For a small number, the lack of realistic pain preparation made them feel like they needed emergency help during their abortion.

> *"The pain was really a lot worse than I expected, perhaps because it was compared to bad period pain and my periods have always been fairly pain-free."*

> "[I wish I had been told] *how bad the pain actually would be not just 'cramps' cause it's more than just cramps*".

> *"Pain was so severe, and yet everything I read or heard, and what little there was about the pain on the internet was it was slight cramping like a bad period…well it couldn't be further from the truth…. The amount of pain you could go through is completely played down … I understand they probably don't want to scare many women, but I'd rather know how bad the pain can get."*

Greater-than-expected pain negatively impacts method choice

Several participants said that the pain they experienced would influence method preference if they needed an abortion again. Reflecting on their recent abortion,

Table 4 Participant recommendations for improving the experience of medical abortion with illustrative quotes

Subtheme	Patient recommendation	Illustrative quotes
Pain counselling	Provide comprehensive advice about possible pain, pain management and coping strategies, including timing of analgesia	*"The management of pain before during and after could be explained better, I do feel like it's washed over quickly and this can truly change the whole experience."* *"I wish that it had been made clearer how painful it would be, so I would know to take codeine from the start rather than as a reaction to pain."*
	Reference the broad range of possible pain severity, highlighting the potential for severe pain and reassurance for less painful experiences	*"The extremity of the pain, I would rather someone told me plainly just how painful it would be rather than trying to sugarcoat it."* *"I think it's worth reassuring people that just because it* [pain] *is stated severe it doesn't necessarily mean that it will be. I spent more time worrying about the possibilities of the side effects than needed!"*
	Avoid singular comparisons to period pain or cramps	*"Please stop telling people it's like period pain I've never felt anything like it."*
	Provide first-hand accounts or verbatim experiences of medical abortion at home, ensuring that an accessible range of descriptions are used	*"I did a lot of research and Google searches of people's experiences so I felt well prepared mentally."* *"I felt the pain was slightly downplayed, luckily I read some forums of other people's experiences so felt better prepared."* *"I think the word cramps, which was used during the consultation and on the BPAS website does not describe what happens. I would be more prepared if the term 'contractions' was used."*
Other advice	Encourage patients to consider being accompanied when self-managing abortion at home	*"*[I wish I had been told] *ensure you're with someone you're comfortable with to ensure they can support you throughout it. Having a partner* [or I would have asked a friend] *with me was supportive and I felt safe because at one point the pain was so much I wanted to call for more help in my panic but they were there to support me through it."*
	Suggest creating a comfortable and enabling environment (food, drink, positionality, space) in advance of taking medications	*"*[I wish I had been told] *to have water and light snacks* [fruit, etc.] *on hand as I was too drained to have been able to go and get anything."* *"I'm glad I stayed in a familiar place with a friend. I wish I was reminded to eat lots of food throughout though as I think I may have been sick due to taking codeine without eating."* *"A nurse advised me how to sit/stand up where possible* [as opposed to lying down or sitting crunched up/bent over] *during the medical abortion so that less pressure built up in my uterus. This advice helped greatly and allowed the pregnancy to pass and pain to start decreasing. This advice would have been really helpful in the guidance booklet."*
	Remind patients to review and obtain supplies to manage side effects (pain medication, menstrual pads, hot water bottle)	*"I also used a hot water bottle which helped a lot."* *"I was told to use sanitary towels - I had ones for a light flow. Being advised to get ones for a heavier flow/night ones would have been useful."* *"Also, having blankets was a good way to keep warm as I noticed I was getting chills which increased the pain - keep blankets with you at all times."*

some stated that they would have opted for a surgical abortion if they were aware of the possible severity of medical abortion pain. Two participants highlighted how adequate counselling for pain can influence informed choice to have an abortion.

> *"If I had known it was basically like inducing labour, I would not have taken the medical abortion route."*

> *"From what was on the website and what I was told I had no indication it could be like that* [so painful]…. [Being transparent] *might put some women off from abortion, however, I feel that patients have a right to fully understand the risks and benefits. This should be made absolutely transparent; shared and informed decision making is essential."*

Patient-centred counselling recommendations to improve abortion experience and informed choices

Many participants provided recommendations to improve the abortion experience. Much of this advice, if shared within anticipatory counselling, could aid decision-making processes so that treatment choice is informed. We have divided these into recommendations for pain counselling and other advice to improve the abortion experience. These are outlined in table 4 together with illustrative quotes.

DISCUSSION

This secondary analysis builds on a quantitative evaluation of a medical abortion pain management policy change at BPAS.[14] We identified four key themes, offering insights and recommendations for improved counselling about pain.

We found that many participants experienced more pain than expected during their medical abortion, corroborating existing evidence.[18 19] Qualitative data suggested that some felt that pre-abortion counselling did not focus enough time or detail on pain severity and management. The widespread adoption of telemedicine for abortion in England and Wales[7 11] creates new challenges to ensuring patients are prepared to manage pain. Accurate information that is accessible at different time points is important to those having remote abortion care.[20] This is particularly salient for advice on pain, crucial information that Hoggart *et al* hypothesise could be lost amidst the volume of information typically provided in an abortion teleconsultation.[20]

Some participants, perhaps indicating unmet informational needs, sought information about pain in online forums. Navigating online spaces comes with

the risk of both misinformation and disinformation.[21] Abortion providers should give patients comprehensive, clear information on the full range of possible pain experiences.[18] Counselling could include providing first-hand accounts or signposting to trusted online resources.[21] Offering alternative media or tools that provide information about pain along the patient pathway could satisfy those who desire detail,[18] while also acknowledging the potential for information overload within one teleconsultation.[20]

Some of our participants recounted how comparisons to period pain had unprepared them for pain, showing the limitations of using this as a standalone comparator. This finding reflects and builds on existing evidence. In a multi-country qualitative study of medical abortion experiences, participants said pain was less severe than giving birth but worse than menstruation.[22] In a recent UK study, participants similarly reported that period pain was a misleading comparator for abortion pain that resulted in uncertainty instead of clarifying expectations.[10]

In line with literature on decision-making about abortion methods,[23 24] participants indicated that pain experienced would impact future method preferences. Some also reflected negatively on how informed their method choice was after experiencing more pain than anticipated. Choice of abortion method is a standard of quality care.[25] Abortion providers and commissioners recognise the importance of choice, but also emphasise the complexity and current challenge of practically offering it.[26] Constraining system factors that have eroded method choice, predominantly in the independent sector and particularly for surgical abortion, include commissioning, cost, infrastructure and workforce.[27] Providing accurate, realistic information on pain is not only important for preparing patients for medical abortion, but for supporting informed consent for abortion method choice, in the context of structural constraints. Further to this, while not simple, such structural issues must be confronted, so as to increase the availability of surgical options, ensuring meaningful method choice.[28]

This evaluation has several strengths. The sample analysed is representative of the BPAS population,[14] and the substantial quantity of free-text comments includes a range of pain experiences. The evaluation team included expertise and diverse experience from within and external to BPAS. A multidisciplinary team is a particular strength in reflexive thematic analysis, where reflection on an individual's own interpretive lens is integral.[29] Our primary publication outlines some limitations,[14] namely the potential for recall bias around severity of pain, and limited generalisability due to low response rate. In addition, we recognise the possibility that patients with greater-than-expected pain may be more likely to respond. We also consider the pitfalls of survey methodology. While we gathered qualitative data, we were unable to use prompts, unlike in interview studies which can therefore offer more in-depth analysis.[10 22]

CONCLUSIONS

This evaluation demonstrated that patients described medical abortion pain using varying terms across a wide spectrum of severity and sensations. While many compared it to other reproductive pain, some found comparisons to period pain inaccurate and misleading. Many felt unprepared for pain, which affected future method preference. In response, BPAS has revised patient information to include descriptions of medical abortion pain based on this evaluation. We will assess whether these descriptions better prepare patients, or increase anticipation of pain or anxiety, factors known to be associated with pain.[30]

Considering the permanence of telemedicine and the growing incidence of medical abortion at home,[12 27] providers and researchers must optimise high-quality, patient-centred care.[18] Future work should focus on identifying effective medical abortion analgesia,[2] and developing counselling tools that manage pain expectations, improve abortion experience and ensure informed choice.

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REFERENCES

1 Department of Health and Social Care. GOV.UK. Abortion statistics, England and Wales: 2022. 2024. Available: https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2022/abortion-statistics-england-and-wales-2022
2 Reynolds-Wright JJ, Woldetsadik MA, Morroni C, *et al*. Pain management for medical abortion before 14 weeks' gestation. *Cochrane Database Syst Rev* 2022;5:CD013525.
3 Friedlander EB, Raidoo S, Soon R, *et al*. The experience of pain in real-time during medication abortion. *Contraception* 2022;110:71–5.
4 Raymond EG, Weaver MA, Louie KS, *et al*. Prophylactic compared with therapeutic ibuprofen analgesia in first-trimester medical abortion: a randomized controlled trial. *Obstet Gynecol* 2013;122:558–64.
5 Cavet S, Fiala C, Scemama A, *et al*. Assessment of pain during medical abortion with home use of misoprostol. *Eur J Contracept Reprod Health Care* 2017;22:207–11.
6 Winikoff B, Ellertson C, Elul B, *et al*. Acceptability and feasibility of early pregnancy termination by mifepristone-misoprostol. Results of a large multicenter trial in the United States. Mifepristone Clinical Trials Group. *Arch Fam Med* 1998;7:360–6.
7 Meurice ME, Whitehouse KC, Blaylock R, *et al*. Client satisfaction and experience of telemedicine and home use of mifepristone and misoprostol for abortion up to 10 weeks' gestation at British Pregnancy Advisory Service: A cross-sectional evaluation. *Contraception* 2021;104:61–6.
8 Whitehouse KC, Blaylock R, Makleff S, *et al*. It's a small bit of advice, but actually on the day, made such a difference…: perceptions of quality in abortion care in England and Wales. *Reprod Health* 2021;18:221.
9 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;28:510–8.
10 Purcell C, Newton VL, Bloomer F, *et al*. Foregrounding pain in self-managed early medication abortion: a qualitative study. *BMJ Sex Reprod Health* 2025;51:3–8.
11 Aiken A, Lohr P, Lord J, *et al*. Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study. *BJOG* 2021;128:1464–74.
12 GOV.UK. At home early medical abortions made permanent in England and Wales. 2022. Available: https://www.gov.uk/government/news/at-home-early-medical-abortions-made-permanent-in-england-and-wales
13 Colwill AC, Bayer LL, Bednarek P, *et al*. Opioid Analgesia for Medical Abortion: A Randomized Controlled Trial. *Obstet Gynecol* 2019;134:1163–70.
14 Taghinejadi N, McCulloch H, Krassowski M, *et al*. Opt-in versus universal codeine provision for medical abortion up to 10 weeks of gestation at British Pregnancy Advisory Service: a cross-sectional evaluation. *BMJ Sex Reprod Health* 2024;50:114–21.
15 NHS Health Research Authority, Medical Research Council Regulatory Support Centre. NHS Health Research Authority decision tool: is my study research. 2020. Available: http://www.hra-decisiontools.org.uk/research/
16 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.
17 Braun V, Clarke V. Reflecting on reflexive thematic analysis. *Qual Res Sport Exerc Health* 2019;11:589–97.
18 Baraitser P, Free C, Norman WV, *et al*. Improving experience of medical abortion at home in a changing therapeutic, technological and regulatory landscape: a realist review. *BMJ Open* 2022;12:e066650.
19 Røseth I, Lyberg AM, Sommerseth E, *et al*. "Out of This World": Norwegian Women's Experiences of Medical Abortion Pain. *J Multidiscip Healthc* 2023;16:889–98.
20 Hoggart L, Purcell C, Bloomer F, *et al*. Social connectedness and supported self-management of early medication abortion in the UK: experiences from the COVID-19 pandemic and learning for the future. *Cult Health Sex* 2024;26:855–70.
21 Wilson-Lowe RV, Purcell C, Lewis R, *et al*. Seeking support for abortion online: a qualitative study of women's experiences. *BMJ Sex Reprod Health* 2024;50:172–7.
22 Grossman D, Raifman S, Bessenaar T, *et al*. Experiences with pain of early medical abortion: qualitative results from Nepal, South Africa, and Vietnam. *BMC Womens Health* 2019;19:118.
23 Blaylock R, Makleff S, Whitehouse KC, *et al*. Client perspectives on choice of abortion method in England and Wales. *BMJ Sex Reprod Health* 2022;48:246–51.
24 Teal SB, Dempsey-Fanning A, Westhoff C. Predictors of acceptability of medication abortion. *Contraception* 2007;75:224–9.
25 National Institute for Health and Care Excellence (NICE). Abortion care. NICE guideline [NG140]. Recommendations. NICE. 2019 Available: https://www.nice.org.uk/guidance/ng140/chapter/Recommendations#choice-of-procedure-for-abortion
26 Footman K. Revolution in abortion care? Perspectives of key informants on the importance of abortion method choice in the era of telemedicine. *Sex Reprod Health Matters* 2023;31:2149379.
27 Footman K. Structural barriers or patient preference? A mixed methods appraisal of medical abortion use in England and Wales. *Health Policy* 2023;132.
28 General Medical Council. The seven principles of decision making and consent. 2020. Available: https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/decision-making-and-consent/the-seven-principles-of-decision-making-and-consent
29 Taghinejadi N, Ayomoh FI, Ahmed W, *et al*. Pain experiences during intrauterine device procedures: a thematic analysis of tweets. *BMJ Sex Reprod Health* 2024;50:271–7.
30 Arena A, Moro E, Degli Esposti E, *et al*. How much will it hurt? Factors associated with pain experience in women undergoing medication abortion during the first trimester. *Contraception* 2023;119.