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Social connectedness and supported self-management of early medication abortion in the UK: experiences from the COVID-19 pandemic and learning for the future

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ABSTRACT

Medication abortion has been established globally as safe and effective. This modality has increased accessibility and the opportunity to centre individual autonomy at the heart of abortion care, by facilitating self-managed abortion. Previous research has shown how self-managed abortion is beneficial in myriad settings ranging from problematic to (relatively) unproblematic contexts of access. In this paper we explore the relationship between self-management and sources of support (including health professionals, family, and friends); as well as considering issues of reproductive control and autonomy. Drawing on qualitative, experience-centred interviews, we utilise the concept of social connectedness to examine how supported self-managed abortion was experienced in the United Kingdom during the COVID-19 pandemic. Overall, self-management was welcomed, with participants speaking positively about managing their own abortion at home. However, a sense of connectedness was crucial in helping participants deal with difficult experiences; and functioned to support individual autonomy in self-care. This paper is the first to examine factors of connection, support, and isolation, as experienced by those undergoing self-managed abortion in the UK in detail. Our research suggests a continued need to advocate for high quality support for self-managed abortion, as well as for choice of abortion method, to support patient-centered care.

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Introduction

There is considerable debate and research about self-managed abortion using medication. Typically known as 'medical' or 'medication' abortion, this most commonly involves ending a pregnancy using the medications mifepristone and misoprostol.

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These medications make safe abortion feasible outside of clinical settings. Throughout this paper we understand the phrase 'self-managed abortion' to describe the use of medication by a pregnant person to induce their abortion, with no (or very limited) involvement of a medical professional (Royal College of Obstetricians and Gynaecologists 2022). In other words, the procedure involves ending a pregnancy outside of a clinical setting and without the immediate supervision of a health professional (Pizzarossa and Nandagiri 2021). In the UK, this means those undergoing abortion while managing the process at home.

Global debate about self-management in sexual and reproductive health (SRH) has addressed how it challenges medical paternalism, and the degree to which it places individual autonomy at the heart of SRH care (Erdman, Jelinska and Yanow 2018; Jelinska and Yanow 2018). Self-management can, theoretically, contribute to a redistribution of power over who can have an abortion—and where and when they might do so—(re)locating it within a context of reproductive autonomy (Simonds et al. 1998). This is particularly important in countries with the most restricted access (Wainwright et al. 2016; Atay 2021; Yanow 2022).

However, issues of reproductive control and autonomy are far from settled. Further attention is needed to understand what forms of support can facilitate autonomy and control. Drawing on a recently conducted study of abortion access in the UK during the COVID-19 pandemic, this paper addresses different forms of support. Whilst abortion in the UK is relatively easy to access (except in Northern Ireland), it remains controversial, stigmatised, and subject to medical control (Yanow 2022). This paper explores how self-managed abortion, when facilitated by medical providers *via* telemedicine, was navigated and experienced in a UK cultural context. We place a particular focus on the relationship between self-management and various sources of support, including health professionals, family and friends.

As a means of understanding and explaining what we identify as key components of this support, we develop the concept of 'social connectedness' (Haslam et al. 2015; Hare-Duke et al. 2019). Drawing on other areas of health (primarily mental health), social connectedness is a broad and complex concept, which formulates a sense of belonging and closeness with others and the perceived availability of support (regardless of whether that support is drawn upon). Building on these theorisations, we use this conceptual lens as a means of understanding key elements of the relationship between those experiencing self-managed abortion and abortion providers, when there is no physical co-presence.

Self-managed abortion: past and present

Self-managed abortion was initially pioneered as early as the 1980s, by informal networks of women in legally restricted settings such as Argentina, Brazil, Peru and Venezuela, where at the time there was no, or extremely limited, medically supervised provision (Pizzarossa and Nandagiri 2021). Abortion telephone support lines offered information, advice and emotional support. Some arranged companions (or 'abortion *doulas*') at considerable risk to the activists involved (Bloomer, Pierson and Claudio 2019; Drovetta 2015). In parallel, medication abortion became available through formal

clinical provision, endorsed by the World Health Organization in 2005 (see WHO 2018). Self-managed abortion is now established in many settings globally as a safe, effective means of abortion (Raymond et al. 2019).

Before COVID-19, the standard practice for medication abortion in England, Wales and Scotland was the administration of the first medication, mifepristone, in a clinic setting. Following this, the second medication, misoprostol, could be self-administered at home.

During the COVID-19 pandemic, countries which provided medication abortion through formal healthcare systems quickly adapted protocols for medication abortion *via* telemedicine with no in-person contact (Tschann et al. 2021; Moreau et al. 2021; Chong et al. 2021). This included in England, Wales and Scotland (Meurice et al. 2021). Another important change was the requirement for a pre-abortion scan unless medically indicated. In Northern Ireland, a hostile Department of Health refused to extend the newly introduced abortion regulation, but telemedical abortion remained available through online providers such as Women on Web and Women Help Women via provision established in the decade prior to the decriminalisation of abortion in 2019 (Aiken and Bloomer 2019; Pierson et al. 2022).

Self-managed abortion has thus, to varying degrees, become a reality in the UK. Although not a new development in the global politics of abortion more broadly, this shift in provision from direct to indirect medical supervision offers an interesting case study from which to generate insight into self-managed abortion, facilitated by telemedicine and supported by health professionals. Quantitative evaluations of this model in the UK have found safety and efficacy to be on a par with in-person care (Aiken et al. 2021; Porter, Lord, and Church 2021; Meurice et al. 2021; Reynolds-Wright et al. 2021, 2022). They also found high levels of what can be framed as acceptability (albeit using varying measures), with between 66% and 80% of respondents saying they would choose telemedicine self-managed abortion again (Aiken et al. 2021; Meurice et al. 2021; Porter, Lord and Church 2021). Reynolds-Wright et al. (2021) found that 95% of 663 respondents rated their care as very (78%) or somewhat (17%) acceptable.

While acceptability predominates, findings also reveal that a minority of women would *not* choose telemedicine SMA for a subsequent abortion. While research evidence on why this may be the case is sparse, Porter, Lord and Church (2021) found that those stating a preference for face-to-face care mainly cited a desire for emotional and practical reassurance. This echoes an earlier study on web-based provision, in which women accessing services provided by health professionals reported high satisfaction rates, but some distress was reported by those for whom medical guidance and reassurance were lacking (Endler, Cleeve and Gemzell-Danielsson 2020). While also finding the majority experience was positive, a recent Scottish study (Harden et al. 2021) noted that, when they had no one on hand to ask, some women undergoing SMA at home experienced 'panic', 'fear' and difficulty distinguishing 'normal' from 'abnormal' effects of the medications. Those who used the available support phoneline did so mainly for advice about pain or bleeding.

This paper presents an analysis of data from a qualitative research study conducted in Northern Ireland, Scotland, England and Wales to explore factors relating to acceptability in further depth. We compare our findings with studies undertaken elsewhere where abortion is legal and delivered as part of a national healthcare system.

A comparison with research findings in settings where abortion is illegal is beyond the scope of this paper.

The overall aims of the study were to examine: (1) what constitutes a 'good' self-managed abortion; and (2) what might improve the experience in instances of lower acceptability.

Materials and methods

This qualitative study utilised a storytelling approach to interviewing people with direct experience of self-managed abortion *via* one-to-one telephone interviews. Incorporating a storytelling element was appropriate for an in-depth exploration of subjective experiences where our interest was in personal stories of lived experiences (McCall et al. 2019) We asked participants to tell us their 'abortion story' from the moment of learning they were pregnant to the time of the interview. We asked them to do this in as much detail as they could remember and to include their feelings and emotional responses. Follow-up questions sought clarifications and key information relating to the study research questions if this was not included in the initial story. Specific questions included: the content of telephone consultations; gestation at abortion; pain relief; contact with abortion providers; and other sources of support.

Participants were recruited *via* the My Body My Life project website, related social media accounts, and an online classified advertisement website (Gumtree) between late 2020 to early 2021. We selected these recruitment methods, rather than working with abortion providers for two reasons both connected with the COVID-19 pandemic: abortion providers were under considerable strain to change service provision whilst continuing to provide a timely service; and more formal processes would have entailed a lengthy approval process within the formal health service. The study was approved by the Open University's Ethics Committee (HREC/3560/Newton). The names used in this paper are pseudonyms. The method of recruitment did limit the sample to people who were active online. We did not seek a representative sample, and we were therefore concerned to ensure that we continued recruitment until we were able to identify similar themes and experiences (sometimes referred to as data saturation).

Eligible participants were people who had undergone an abortion during the COVID-19 pandemic who could provide informed consent. No one who contacted us was excluded from participating. The final sample all identified as cisgender women, ranged in age between 22–43, and comprised mothers and non-mothers. There was a combination of working, non-working and students; and also of different ethnicities, though most identified as white British. Participants were offered a GBP20 voucher as compensation for their time. A total of 20 interviews were conducted by LH, CP and FB. Of these, three were excluded from analysis for this paper: one related to a woman having had a surgical abortion, and two women had been admitted to hospital as 'day cases'. One participant who experienced a non-formal healthcare pathway has been included: 'Laura' was supported by community activists in Northern Ireland with medication supplied by Women Help Women. This paper is thus based on analysis of 17 interviews that included accounts of supported self-managed medication abortion.

Analysis comprised two components, the first being thematic (Spencer, Ritchie and O'Connor 2003). Two transcripts were read by VN and LH and preliminary themes were

identified. Transcripts were then coded by AO who further developed a data-driven initial coding frame in consultation with VN. Since a key element of a storytelling approach is maintaining the distinctiveness, coherence and complexity in individual cases, case profiles for all the participants were developed by a research assistant. Repeated re-readings of the original transcripts was undertaken by LH. These measures supported the development of cross-cutting thematic groupings and the quality and reliability of the subsequent interpretation. NVivo 12 was used to support data management.

In this paper, we focus on the overarching theme of 'support', including ways in which support was described and experienced. While existing literature on self-managed abortion stresses the importance of practical and emotional support (Endler et al. 2019; Moseson et al. 2022), we constructed the analytical theme of 'social connectedness' to interrogate the component parts of social connectedness in the specific context of telemedicine self-managed abortion. Through this analysis, we developed the following sub-themes: feeling cared for—trust and connection with health professionals; connectedness at home; connectedness challenges—isolation and fear of the unknown; and disrupted connectedness—expectations and reality. The themes and categories developed are not mutually exclusive. This conceptualisation of 'social connectedness' goes beyond notions of support to capture more specifically what elements of support participants sought, particularly when at a distance from their abortion provider.

Findings

Feeling cared for: trust and connection with health professionals

A sense of feeling cared for by the abortion provider was a major theme in our data. It incorporated a sense of feeling (a) accepted and (b) supported. For most participants, the telephone consultation was their only direct contact with a health professional. It was clear that this initial contact between the person seeking abortion and a health professional (most commonly a nurse) was of great significance. Participants were overwhelmingly positive about their experiences of this telephone consultation, and many compared it favourably with other healthcare experiences:

> In all my time accessing health services I usually feel …like I'm a bit of a burden or I that I don't want to be a burden. And I've never felt less like that when accessing a service than I have with this one. I think they were just amazing, really sympathetic, really kind… they came across with such compassion. I felt genuinely cared for. (Judi)

Here, Judi emphasised the emotional aspects of the connection established during the consultation, drawing on positive emotions of kindness and sympathy. This was a common theme, as was the associated feeling of being 'genuinely cared for'.

This sense of connection could be particularly important in a context where there is no physical co-presence. Participants described reacting positively to health professionals' efforts to establish emotional connection and support in the telephone consultation, as well as being informed about the abortion process:

> She seemed very sympathetic as she was reading out the procedure, and she was telling me not to be scared, and that she was there for me for anything. (Rosa)

This excerpt highlights several key components of connection which contributed to a positive telephone consultation: acknowledgement of and empathy with fear; expressions of commitment and care; and reassurance about a continuing connection. These were similar to accounts provided by women accessing abortion through a clinic pathway (Purcell et al. 2017). Anxiety was eased in the telephone consultation and these elements of connection—not feeling like a burden, having fears validated or assuaged, and not feeling judged—contributed to an overall sense of feeling accepted, rather than potentially stigmatised, by the health professionals with whom participants interacted.

On receiving their self-managed abortion treatment pack (whether by post or collection), most participants described the instructions as informative and straightforward. The instructions emphasised a continued connection with the abortion provider, which fostered trust and confidence.

> There was a package. In there was a […] big leaflet-type thing, on exactly how to take the tablets and what to expect when you take each tablet and then when you should call the hospital if something's gone wrong and what 'going wrong' looks like… And there was a small section on mental health as well in the booklet, actually. There was, I think, one page of going 'this is normal and if you need to talk to us afterwards, we're here for you' type thing, which was good because that's how I found out about their counselling. (Immy)

When asked about what had helped them manage their own abortion, many participants reflected on the initial phone consultation, and the perception that a health professional was 'there for them', whether or not that support was ultimately drawn on. Several made use of the offer and called the telephone support line. Some had also arranged subsequent counselling, following through on that sense of connection:

> I called them [provider] and they were amazing, they were absolutely amazing. I think they said from the very get go you can have some counselling sessions, so I booked in a counselling session. And every time I called them, they said you can have as many counselling sessions as you need, you can call us 24 hours a day, we're here for you. And it genuinely felt like they really were and every person I spoke to I was just like, they just were really kind. (Steph)

Trust, emotional connection, and a sense of ongoing support were elements of connectedness that reinforced a sense of feeling cared for. This was also the case for Laura who experienced the acceptance and support of an activist organisation (Alliance for Choice) in Northern Ireland:

> The support that they gave me, even just emotionally, you can't put a price on that… And it was just a safe space for me to be able to talk, and to just, and they never got bored even though it was the same thing over and over again. Just listened, and they just repeated their information, and they continued to listen. (Laura)

There were indications that, for most participants, the feeling of being cared for established early in their abortion pathway began an ongoing process of feeling comfortable with the self-managed abortion process overall. An important part of this comfort—and connectedness—was associated with being at home.

Connectedness at home

The theme of connectedness at home comprised both the valuing of connection in the form of existing relationships with friends and family, but also spatial connectedness with home and the associated home-comforts. A strong theme for many participants was the sense of safety and belonging associated with the home environment:

> The fact that I didn't have to feel like I needed to do my hair and makeup to get in my car, to drive somewhere, to see people, to have an appointment and get what I needed. The fact that I could just stay in bed in a comfy hoody and all I had to do was open the door to the postman, meant so much to me. It really meant that I could just really take care of myself at home. (Ayda)

This sense of comfort was at least in part linked with COVID-19, as participants also expressed relief at not putting themselves at risk of infection. Some welcomed the perceived safety of their own environment and expressed relief that they were able to be at home given the bodily experiences associated with the medication abortion process:

> I'm really thankful that I could have it [all] at home. I can't imagine doing it somewhere else … I was a mess. At one point I was in so much pain I was peeling my jammies off my body and just throwing up but also bleeding extremely heavily and crying and I don't think I could have done that anywhere else. I needed to be at home both for my mental health and for my physical needs… I don't think I would have felt safe anywhere else. (Brid)

Participants' accounts also suggested that, for those who had the option of in-person support, connection with friends and family supported them in feeling safe in their home environment. They described valuing their social networks at the time of their abortion, with almost all having sought some form of support from friends or family:

> One of my housemates I had told … And we sort of jokingly refer to the abortion as bathroom soup day, because I was really hungry but I was in so much pain and I kept being sick. And she was like 'are you sure you want to eat?' And I was like 'yeah, I'm really hungry'. So, she went downstairs, and she brought me tomato soup in a cup, which I drank whilst I was lying on the bathroom floor. I was very lucky to have her there, she was wonderful. (Ayda)

Alongside a sense of provider support from a health professional, having supportive friends and family on hand was, for Ayda and many others, described as highly valued. Significantly, of course, this was very challenging early in the pandemic, and in these circumstances, participants often spoke of feeling isolated. Some participants spoke of a complex interplay between support, safety and fear:

> I felt safe. It's my environment. I'm not in a hospital. I'm not having to go through this emotionally on my own. I had my two housemates, one of my housemates' partners and my partner all there and they were all sitting round me and doing everything they could to make me comfortable. And I was in my home environment, and it felt a lot more comfortable; however, I think it gave a lot of way for fear. I was very scared that something was going wrong, and I was very scared by the pain, and I really would have - if I was in

> hospital, I think I would have been given the pain medication a lot sooner and that would have helped. (Immy)

Immy clearly welcomed the opportunity to be at home and valued the support she received from her friends. The above account also conveys the complexities of her experience, however, in that while Immy felt comfortable and safe in her home environment, elements of fear nonetheless were present. Our interpretation was that Immy felt safe and supported but fearful of what the abortion process itself might entail. This illustrates tensions between comfort and safety, the familiar and the unknown.

Connectedness challenges: isolation and fear of the unknown

A key question highlighted by our use of social connectedness as an analytical tool was what occurred when connectedness was difficult to achieve, as was the case for most participants who had undergone their abortions during the early days in the pandemic when there were major restrictions on social movement. Pandemic restrictions contributed to feelings of loneliness and isolation from their established social networks which some had experienced in relation to both their pregnancy and the abortion:

> I guess like it's just an exaggerated feeling of extreme loneliness that so many feel during COVID-19 and the pandemic, but it's even worse when you've got this, you've got this big secret basically, and you just feel even more alone. (Jade)

While some participants described feeling safe at home, others painted pictures of isolation and, by association, of feeling fearful:

> There's the fear of the unknown because everything can go well, but something may go bad…you don't know what can happen when you take this medication. (Hannah)

In these ways, participants' accounts highlighted the significance of connectedness as an absence. Instead, the social isolation associated with abortion as a result of stigma and secrecy, was magnified by the COVID-19 context. These feelings were also linked to a broader fear and uncertainty about what to expect of the abortion process. Hannah's fear that 'something was going wrong' was not uncommon:

> I became increasingly paranoid that I hadn't actually passed any clots, and that it was only a bit of blood. Because normally I think they give you a scan if you were to actually go in, rather than it being all done telemedicine. I became really paranoid that I still had tissue inside me and it hadn't come out. And I'd read about infections that could happen if that was the case (Jade)

Jade had also found the written information provided had not fully prepared her for the experience:

> It's confusing, because you're reading it off a sheet, and the sheet just says like oh you can either put these drugs in your mouth or you can insert them into your vagina … you're trying to make a decision when you're that anxious, alone. If I was with a healthcare professional…they would probably be able to put me in a better position to make that decision. (Jade)

Jade's worries could be interpreted as exemplifying concerns that may emerge in the absence of (ongoing) connection with a health professional. While she also described feeling extremely anxious and 'paranoid' about whether her abortion had completed, Jade did not contact the abortion provider to discuss her worries, suggesting a sense of ongoing connection in this case had not been established.

Many participants felt they had not known entirely what to expect of the physical process. Jak, for example, thought her abortion was complete on the day she took her medication, yet:

> three days after that I went to the loo and I was bleeding quite a lot and I passed the actual pregnancy, because I hadn't realised I hadn't passed at the time. Which I was completely not prepared for. (Jak)

As Jak's comment indicates, uncertainty about what to expect—and anxieties about unanticipated bodily experiences—signal when improved connection with the provider (or someone else with sufficient knowledge of the abortion process) may have helped.

Disrupted connectedness: expectations and reality

In some cases, connectedness was not enough to counter their negative experiences. These were primarily associated with intertwined issues of pain, isolation, and fear. As with Immy above, many participants described a combination of experiences of pain and fear of the unknown. There were also notable tensions between participants' expectations and subsequent experiences of pain.

> I just had no idea it was going to be that sore, I don't know if I could ever do it again to be honest it was so physically painful. And that was, looking back that's one of the things that I think about most that I'm really angry about (…) instructions everywhere saying, oh you might feel a bit of cramping, this wasn't a bit of cramping, it was excruciating (Brid)

Brid found that the information provided left her unprepared for the ensuing bodily experiences. Many other participants spoke of feeling unprepared for the pain they experienced and felt this had been underplayed in the consultation and written information they had been given.

> It was also quite a lot more painful than the literature had implied. I mean it was incredibly painful and no painkillers of any kind made the slightest dent in it. So within, it got steadily worse, but within I would say two hours I was completely bent double on the toilet, in incredible pain. (Claire)

In terms of a broader sense of connectedness, this disjuncture between what participants felt they had been led to expect and what actually happened, disrupted the connection between health professional and patient.

After an unpleasant experience of medication abortion, a minority of participants noted that their preference in future would be for a surgical procedure. Ginny, who had experienced a surgical abortion before the self-managed medical abortion observed:

> … even though I thought the surgical would be more traumatic, it was actually the easier of the two. I found it a much more relaxing experience and the fact that once you're asleep, once you wake up it's all over with. (Ginny)

It is significant however, that despite the pain, fear and other unpleasant experiences described above, most participants stated that they would prefer to undergo supported self-managed abortion *via* telemedicine at home rather than an in-hospital or surgical procedure, should they require a subsequent abortion. Moreover, regardless of whether they would choose self-managed abortion again themselves, almost all participants felt at-home self-managed abortion should continue to be an option for women in the UK.

Discussion

This paper has present an analysis of interviews with women who underwent a telemedicine self-managed abortion in the UK during the COVID-19 pandemic. This offer appears set to continue; though without full decriminalisation, approvals remain somewhat precarious. With specific reference to the UK and echoing findings from other recent studies (Boydell et al. 2022; Harden, Ancian, Cameron and Boydell 2021; Lohr et al. 2022), the primary reasons participants supported the continued provision of at-home self-managed abortion centred on the comfort and connection associated with the home setting. It is also noteworthy that those who might not choose it again for themselves nevertheless supported continued provision. Rather than simply reinforcing these findings, however, we also considered experiences that were more difficult, to understand the difficulties, and consider what could help improve future experiences of self-managed abortion.[1]

Building on theory developed in the context of mental health (Haslam et al. 2015; Hare-Duke et al. 2019), we applied the conceptual lens of 'social connectedness' as a means of interpreting participants' experiences, identifying good practice and areas for further support. Whilst recognising the challenges of applying a concept that has, to date, been applied primarily elsewhere, we agreed that it supported our theorisation. The analysis examined specific elements of connectedness in the context of reproductive health and abortion: feeling cared for (trust and connection with health professionals); and connectedness at home (including connection with friends and family, home comforts and a sense of belonging). Our analysis also foregrounded concerns and difficulties that can emerge in relation to self-managed abortion—primarily isolation, pain and fear of the unknown. Framing these difficulties as challenges to, and disruption of, social connectedness has allowed us to identify how current care might be improved. Additionally, although our analysis did not aim to elucidate mechanisms of connectedness (Haslam et al. 2015), we were nevertheless able to identify issues key to effectively support self-managed abortion, within the broader landscape of abortion provision.

Similar to Harden and colleagues (2021), our analysis foregrounded fear and anxiety, particularly concerning the 'unknown', and what might be understood as 'normal'. This finding points to the importance of the initial telephone consultation and to the need for a 24/7 helpline, as recognised elsewhere (Fix et al. 2020). What participants valued

about the telephone consultation was not only being given the information needed, but also a sense of connection which enabled them to proceed with confidence—knowing that a health professional was 'there for' them at any time. It is important to emphasise that, in most cases, this sense of connectedness with health professionals endured, despite later negative experiences. Although not many participants used the helplines, their awareness of their existence offered important reassurance.

Technical information was also important—particularly regarding pain—and women were left dissatisfied when this was not felt to be sufficiently accurate. This is similar to recent findings from a Norwegian study, a similar context to the UK, where some participants described being unprepared for the intensity of the pain experienced due to the downplaying of pain in the abortion leaflets (Røseth et al. 2023). High pain intensity following medical abortion has also been documented in a number of quantitative studies (see for example, Reynolds-Wright et al. 2021). Clearer information on pain expectations, realistic discussions about what constitutes a normal level of pain, and the provision of more options for better pain management are important. This could include providing materials for those who might be supporting the person having an abortion and encouraging them to make use of the support line.

It was clear from our analysis that the emotional labour engaged in by health professionals in order to facilitate self-management was also important. Being non-judgemental, promising continuing support, and simply being kind made a lasting impression. It was also clear that much of what was valued was largely intangible (a 'sense' or 'feeling' of) and is therefore potentially difficult to codify into care standards.

Some researchers have discussed fears concerning the quality or efficacy of abortion medication (Stillman et al. 2020). Such fears are more evident in legally restrictive settings due to often inaccurate information and uncertain means of procurement (i.e. black-market) (Ferguson and Scott 2020; Stillman et al. 2020). While our participants did not express fears about the quality of the medication, they had anxieties regarding the completeness of their abortion, the management of potential complications, and the effectiveness of the medication. The fact that these concerns could all have been evident in a pre-COVID-19 pandemic regime (mifepristone in clinic and misoprostol at home) does not obviate the need to pay attention to this finding. 'Fear of the unknown'—particularly evident in the absence of connectedness—highlights the importance of ongoing connection with abortion providers.

These UK-based findings also echo those found in two recent reviews (Baraitser et al. 2022; Wainwright et al. 2016), both of which highlight the importance of personalised care, and a sense of feeling safe and cared for. While we did not necessarily find evidence of self-managed abortion as offering space for the different (re)interpretations of abortion identified by Wainwright and colleagues (2016), the value placed by participants on connectedness with friends, family and home comforts does resonate with their findings concerning the opportunity for support, the relative convenience of the model, and with an overall sense of acceptability.

The minority negative experiences highlighted in this paper should constitute a warning that high quality abortion care cannot exist without a choice of methods. In our analysis, some of the negative experiences primarily related to the medication abortion experience more broadly, and not to self-management specifically. The

proportion of medication abortions has increased significantly in recent years.[2] A key benefit of self-managed abortion may be its cost-effectiveness as a model of provision, as well as the benefits it may offer in terms of timeliness of treatment (Aiken et al. 2021). Although current guidelines (Royal College of Obstetricians and Gynaecologists 2022) emphasise the importance of a choice of procedure, choice of abortion method has been identified as an area of care that requires improvement in the UK (Heath, Mitchell and Fletcher 2019; Blaylock et al. 2022). It is clear that surgical abortion needs to remain available to those who prefer not to undergo medication abortion, self-managed or otherwise.

Tensions between, and overlaps with, a feminist-informed drive for reproductive control as well as the neoliberal imperative toward self-management of health—and the implications thereof for those seeking abortion—are relevant to framings of self-managed abortion. No generalisations about the impact of the UK as the cultural context framing this study can be made from the data, largely down to the cultural diversity within and between the UK's four nations. However, there was no sense of objection to the offer of self-management of abortion in our data and, if anything, it was seen as a benefit. While beyond the immediate scope of this study, this may be linked to an acceptance of the notion of self-management in health more generally. In this respect, the need to consider cultural norms, social support, and engagement between health professionals and patients when proposing self-management (Greenhalgh 2009) has as much relevance to an acute procedure such as an abortion as it does to chronic illness.

Conclusion

This study has shown that supported self-management has significant potential as a means of providing early medication abortion in the UK. It has also highlighted the importance of social connectedness and how this has a number of dimensions. The analysis we have presented demonstrates that people receive and seek support from a range of different sources to meet differing needs and experiences, and thereby reinforces the international literature that suggests that the support can be provided by non-healthcare professionals, including doulas. Participants in this study described seeking and experiencing connectedness with health professionals as well as with those in their existing social networks. These connections supported the confident self-management of abortion outside of a clinical setting. However, we also saw that a sense of safety at home could easily give way to anxiety and fear. A significant challenge for health professionals and abortion services is to be able to anticipate and respond consistently and in a tailored way. A key form of support to emerge from our analysis is sense of connectedness, including the ability to validate feelings and offer reassurance of what is 'normal', and to maintain an ongoing sense of connection. Our findings highlight a need for appropriate individualised support to be provided as part of the future offer of self-managed abortion in the UK.

Notes

1. The ongoing absence in Northern Ireland of NHS provision of telemedicine SSM continues to mark a significant inequity in UK healthcare provision.

2. In 2021, 87% of abortions in England and Wales were medically induced, which increased from 85% in 2020. The figure has increased by 40 percentage points since 2011. Accessed February 2, 2023. https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021/abortion-statistics-england-and-wales-2021

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