Early Telemedical Abortion, Safeguarding, and Under 18s: a qualitative study with Care Providers in England and Wales

Running title: Telemedicine Abortion, Safeguarding, and Under 18s

Dr Elizabeth Chloe Romanis[1,2,3] and Jordan A Parsons[4]

1. Edmond and Lily Safra Center for Ethics, Harvard University, US
2. Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics at Harvard Law School, Harvard University, US
3. Centre for Ethics and Law in the Life Sciences, Durham Law School, Durham University, UK
4. Keele Law School, Keele University UK

Corresponding author:

Elizabeth Chloe Romanis

elizabeth.c.romanis@durham.ac.uk

E&J Safra Center for Ethics

124 Mount Auburn Street

Suite 520N

Cambridge, MA 02138

Jordan A Parsons

j.parsons@keele.ac.uk

School of Law

Keele University

Staffordshire

ST5 5BG

Background: Telemedical early medical abortion (TEMA) was introduced in England and Wales as a temporary measure in 2020 and made permanent in 2022. While there are considerable data showing the safety, efficacy, and acceptability of TEMA for patients, there have been objections raised to TEMA based on safeguarding – particularly for people under 18. Little is known about abortion care providers' views and experiences of carrying out their safeguarding duties with people aged under 18 in the shift to TEMA.

Methods: Qualitative study involving online semi-structured interviews and reflexive thematic analysis. Audio-recorded, semi-structured interviews with abortion providers in England and Wales (n=20) generated data about their views and experiences of safeguarding in telemedical abortion care. Recordings were transcribed verbatim and then subject to reflexive thematic analysis to construct themes.

Results: While the study was designed with adult safeguarding in mind, the safeguarding of under 18s became a key area of discussion. Three major themes were constructed in relation to under 18s: (1) age as a risk factor in safeguarding; (2) telemedicine as improving access to care; and (3) telemedicine as enhancing communication.

Conclusion: Care providers believe TEMA has benefitted U18s. There was a strong feeling both that TEMA had improved access (which, in turn, improved safeguarding) and that U18s were comfortable communicating using remote means. Providers believe safeguarding proformas must account for the different nature of risks where service users are U18, but that it is disproportionate to assume that TEMA is unsuitable for all U18s or groups of U18s.

Keywords: abortion, adolescent, Patient Safety, Physician-Patient Relations, qualitative research

WHAT IS ALREADY KNOWN ABOUT THIS TOPIC

- Following the introduction of telemedical early medical abortion in England and Wales, objections were raised by some clinicians and anti-abortion campaign groups on the grounds that providers may not be able to adequately safeguard abortion-seekers under the age of 18.

WHAT THIS STUDY ADDS

- This study reports abortion care providers' (ACPs) experiences of carrying out safeguarding with abortion-seekers under 18. ACPs suggested that telemedicine improved access to abortion for under 18s, that under 18s communicated well by remote means (e.g., messenger, telephone, or videocall), and that face-to-face safeguarding in abortion care may not necessarily be better than remote safeguarding for under 18s.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE, OR POLICY

- These findings illustrate that it is inappropriate to place blanket limitations on under 18s'/groups of under 18s' access to telemedical abortion, in favour of in-clinic consultation, on the grounds of safeguarding.

1.0 INTRODUCTION

Telemedical early medical abortion (TEMA) – encompassing both remote consultation and at-home administration of both abortion medications – was temporarily lawful in England and Wales in 2020-2022.[1,2] In 2022, TEMA was made permanently lawful.[3] Data have clearly established that TEMA is safe, effective, and acceptable to service users.[4,5,6] It also improved individuals' (experiences of) access to care.[2,5,6,7] Importantly, all providers have multiple points in their TEMA care pathway where there can be a change to in-person care (e.g., for consultation or to collect the medication) if the service-user requests it or it is deemed necessary.[7] Despite the benefits, there is opposition to TEMA on the grounds that it prevents abortion care providers (ACPs) from adequately safeguarding abortion seekers.[8,9]

Where an under-18 (U18) seeks abortion care without a person with parental responsibility to consent on their behalf, ACPs must ensure that the young person is competent to make decisions about their medical treatment,[10] and that the Fraser guidelines[10] (**Box 1**) suggest that abortion provision without parental consent is indicated.

Box 1. Fraser Guidelines

- The young person has sufficient maturity and intelligence to understand the nature and implications of the proposed treatment
- The young person cannot be persuaded to inform their parents/relevant persons with parental responsibility, nor will they permit the healthcare professional to inform on their behalf
- The young person is likely to continue having or begin having sex with or without contraceptive treatment
- The young person's physical and/or mental health is likely to suffer without advice and/or treatment
- The best interests of the young person require them to receive advice and/or treatment regardless of whether there is parental consent

Furthermore, within healthcare settings, the duty to safeguard children goes beyond the consultation, encompassing wider issues of protection and wellbeing. For example, identifying and responding appropriately to instances of abuse. In England, the Children Act 2004 requires that healthcare providers (amongst various other bodies) ensure that 'their functions are discharged having regard to the need to safeguard and promote the welfare of children'. This might entail a referral to the local authority or the involvement of police. A similar duty applies in Wales under the Social Services and Well-being (Wales) Act 2014.

This qualitative study explores ACPs' views and experiences concerning safeguarding in the shift to TEMA in England and Wales. While there has been some academic exploration of this matter,[7, 11-13] this study is the first to provide pertinent qualitative data. Our study intended to

focus on adult safeguarding. However, when asked to compare, participants discussed their experiences of U18s at length. This paper reports findings related specifically to U18s. Such data are timely. The Royal College of Paediatrics and Child Health (RCPCH) recently published guidance on safeguarding young people in abortion care. The guidance indicated that providers 'should aim for all [children and young people] to be given an appointment for an in-person consultation at some point in the early medical abortion care pathway unless there is a compelling indication to do otherwise' (**Table 1**).[14]

Table 1: Specific RCPCH Recommendations for young people in abortion care pathways

Age of Child/Young Person	RCPCH Recommendation
Under 13 years old	An in-person appointment must be arranged as soon as possible, 'preferably on the same day' they contact the service.
Between 13 and 15 years old	They should complete their consultation in person unless there is a compelling reason otherwise.
16 and 17 years old	In-person consultation must be offered and they 'should be actively encouraged to attend'.

2.0 METHODS

2.1 Design

'Qualitative research describes in words rather than numbers'[15] to generate detailed, rich, and valid data. We conducted semi-structured interviews, which strike a useful balance between producing a detailed account of a participant's views and experiences while ensuring the research question is addressed.

2.2 Recruitment

Our inclusion criteria required that participants be:

- A qualified healthcare professional involved in the provision of abortion care in England and Wales

  or

- In a management role overseeing abortion care in England and Wales

All participants also had to be able and willing to consent and able to communicate in English. We conducted purposive sampling to focus on representing a range of professional perspectives. Participants were recruited through several organisations: MSI Reproductive Choices, the British Pregnancy Advisory Service, and the British Society of Abortion Care Providers (which includes some NHS providers).

Following ethical approvals, participant information was provided to our study collaborators for distribution amongst staff/members. Potential participants then contacted the study team to express interest and were then provided with a detailed participant information sheet. Interviews were scheduled with those willing to participate. Informed consent was obtained verbally at the beginning of the interview and a recording stored separately to the interview recording. Participants were informed of their right to withdraw during the interview and up to one week after without providing a reason. On completion of the interview, participants were provided with a £20 shopping voucher to thank them for their time.

2.3 Data generation

Interviews took place on Zoom between April and June 2022 (interviews at BPAS began in May 2022). Interviews lasted a mean of 53 minutes (range: 46-60) and were guided by a topic guide. The topic guide was amended throughout the data generation period in response to each interview. For example, more specific questions about safeguarding proformas were asked after early participants discussed them in detail.

2.4 Analysis

Our approach was based on Braun and Clarke's account of reflexive thematic analysis.[16-18] This entailed data familiarisation, inductive coding, constructing themes, reviewing themes, naming themes, and writing up.[18]

Interviews were audio-recorded and transcribed by a transcription service. All transcripts were then checked against the recording by the study team. We undertook a data-driven approach to coding using NVivo software, with transcripts coded by the researcher who did not conduct that interview. Codes were discussed and themes generated collaboratively.

3.0 RESULTS

We recruited 20 participants across study collaborators. The majority (n=13) of participants (whether doctors or nurse-midwives) were currently seeing patients, and many (n=9) had a designated safeguarding role. The mean age of participants was 45 (range: 28-57). Due to ease of identification, we have not provided a breakdown of participant demographics here.

Following analysis of interview transcripts, three key themes were constructed: age as a risk factor in safeguarding; telemedicine as improving access to care; and telemedicine as enhancing communication. In the following, supporting quotations are provided within boxes and signposted (e.g., "Q1" for Quote 1).

3.1 Age as a risk factor in safeguarding

There was a sense amongst participants that age *itself* should not always be treated as a determinative risk factor of safeguarding concerns (Q1). This was not a unanimous view, with some expressing a preference for additional, in-person contact with young people just because of their age (Q2). For most, however, the suggestion was that it is individual risk factors that matter.

Participants reflected on how the *nature* of risk factors for U18s is likely to be different to those for adults. They believed it was important that screening questions for U18s were adapted to recognise differences, with a focus on creating an environment where disclosure of any concerns was possible (Q3).

Participants explained that U18s need to be recognised as a heterogenous group, such that a blanket approach to (not) recognising capacity to consent would not be fit for purpose. For example, the concerns about safeguarding when a younger child presents pregnant are very different to those approaching 18 (Q4).

Some participants described how, since the easing of initial COVID-19 restrictions in England and Wales, their employer changed telemedicine policies for some U18s. This was sometimes discussed as the result of external pressure rather than being based on available evidence (Q5).

Box 2. Age as a risk factor in safeguarding

Q1: *"[Y]ou could have somebody that is over 18 that has far more risks than somebody that is under 16, for example, who is well supported, have got their parents involved. It is just a teenage pregnancy with somebody of the same age. There are no other risk factors. But you could have someone that is 28 years old that is at risk of honour-based violence, have got their parents threatening to kill them. You know, they might be in receipt of services. They might require a MARAC [Multi-Agency Risk Assessment Conference] intervention. Age doesn't really come into it as much. It is the actual risk that that person faces"* (P06)

Q2: *"[T]hey'll be brought in because we need to see them. […] I think you need to safety net these children. It might be the only time you get to actually have that conversation with them"* (P04)

Q3: *"[F]or everyone, it's [the safeguarding proforma] quite a lengthy thing. The under-18 one is obviously slightly more so. We go a lot more into detail in terms of their sexual partners, where they're having sex in terms of- There's a lot more to do with child sexual exploitation and things"* (P09)

Q4: *"[I]s this a 16-year-old, who's just about to go into her A-levels, has had sex with her first boyfriend, and something's happened. She says she's got the support of her mum. Or compared to, you know, we've got an 11-year-old who has just rung, and her stepdad keeps ringing for her. The spectrum is huge. But what I think we need not to do is - and this is what I put into training and supervision at [previous employer] - is we need not to treat all under-18-year-olds as children who can't consent"* (P01)

Q5: *"We did change our policy, now we do bring all under-16s in for a face-to-face. That was because of some pressure that we got from CCG [Clinical Commissioning Group] around the service that we're providing - they weren't confident in the safeguarding"* (P20)

3.2 Telemedicine as improving access to care

Participants described telemedicine as having improved treatment access for U18s, because it addressed some of the biggest barriers to abortion care for younger people. Some participants

connected the issue of ensuring access to care to safeguarding – the idea of access itself being a safeguarding matter (Q6).

Before the introduction of telemedicine, having to come to a clinic (several times) was described as hindering access for young people (Q7). Many participants reflected on the difficulties in getting to a clinic, such as with travelling, affording travel, and making arrangements to be absent from school/college (Q8). One participant, who provides care across a rural area, highlighted the greater travel difficulties for U18s relative to adults (Q9).

Participants noted that these barriers are more pressing for vulnerable younger people. For example, those in precarious living situations or from an under-privileged background (Q10). Indeed, there was recognition that these potential delays could prove harmful to young people in removing certain (safer) treatment options (Q11). As data show, the risks of different abortion methods vary, generally increasing over time.[7,19]

Overall, there was an overwhelming sense that telemedicine had improved U18s access to care and that to remove this option for them would be a step backwards (Q12).

Box 3. Telemedicine as improving access to care

Q6: *"If we are saying that our under-18s are Fraser competent, and so long as they have got the capacity to consent, then they should be treated like an adult, and they should be afforded exactly the same service. And I think it is a lifeline for them, because we shouldn't make it more difficult for them to attend services. We should make it easier"* (P06)

Q7: *"[O]ur safeguarding policies are barriers to some people who, you know, because they have to have a scan and they have to have this and they have to have that. […] they've got*

to have an over-18 support person, which I've found a real barrier because some people, they don't have an over-18 person and they don't want anyone to know, and they're not going to tell their parents. You know, I've found that a real barrier. The policies are a barrier to somebody getting treatment, which is difficult" (P14)

Q8: *"I've had under-18s say that it's been easier because they've been able to take the call and not have to miss a day of school or college to be able to have their telemedicine appointment. And, also, not having to travel to a centre if they don't drive or don't have to then go and ask someone for money for public transport. I think it depends. I think it's helpful for the under 18 who doesn't feel comfortable informing a parent because they- there are just less barriers for them being able to access care. Although we would always encourage them to do so, as long as it's safe to do so"* (P03)

Q9: *"Because they can't drive themselves- Sitting on a bus for hours to get here, [interviewer's name]. So, I think why they would feel so at ease with telemed […] What's there not to like [especially for someone] who lives four hours away"* (P08)

Q10: *"Trying to get teenagers to an 8 o'clock appointment, where they've got to travel to, it isn't an easy thing to do, particularly if they're a really vulnerable young person. They might be living in a hostel, they might not be having any parental support at home. They might have no money. If they miss school it might get them into a huge amount of trouble"* (P01)

Q11: *"[D]elaying treatment, for example, would mean that the person would be treated by an alternative method. So that could then impact on the safety of the procedure that they received"* (P16)

Q12: *"I believe that it would be really sad not to have this now, because when I think of a 16- or 17-year-old having to make their way across London from somewhere else and catch trains, and all that kind of thing, would I want that to happen now? No, I wouldn't, not when it can be posted, and it can be posted safely"* (P18)

3.3 Telemedicine as enhancing communication

Participants described how U18s engaged well with remote communication methods in telemedicine, perhaps finding it more natural or even easier. Some suggested this might be because young people are used to communicating via technology (Q13).

Some participants described this specifically as it being a matter of the young person feeling safer speaking in their own environment, as opposed to a clinical one. One noted that for some young people, perhaps with less experience of healthcare interactions, unknown adult professionals can seem intimidating (Q14). The creation of a comfortable remote environment for care provision was felt by participants to afford some U18s confidence to disclose safeguarding matters should they wish (Q15).

In addition to phone and videocall, participants mentioned webchat services as useful for building positive relationships with young people at first contact. One participant described how the medium offered a different form of communication – the use of emojis and text speak – to help build trust with a young person (Q16). Participants further highlighted the utility of webchat for urgent situations because they provided a location of the person potentially in danger (Q17).

Some participants described feeling they had identified a vulnerable young person and their associated needs in a situation where they may not have through a face-to-face consultation. Videocalls were discussed as sometimes providing more information about an individual's living situation, information that a face-to-face consultation may not identify (Q18).

One participant reflected on the audit systems in place for teleconsultation that were able to identify concerning patterns that could be investigated, such as in responses from young people to safeguarding questions (Q19).

Participants felt strongly that through telemedicine they can perform their safeguarding duties towards U18s, and that remote communication options had at times enhanced their ability to do so. One participant expressed their disappointment that face-to-face was being returned to as the default approach with the lifting of pandemic restrictions, despite the benefits of remote safeguarding in some cases (Q20).

Box 4. Telemedicine as enhancing communication

Q13: *"I think also generationally with young people they are just so much more in tune with doing things digitally than actually face-to-face"* (P06)

Q14: *"[I]n general, it is much easier to build a quick rapport, because you can be just a little bit more open and just immediately friendly. Again, everyone's always walking into an abortion clinic expecting the worst and expecting to be judged […] I think that's especially the case for young people. You know, at least older adults will already have had experience of a GP's surgery and know that people aren't monsters and so on. But for a teenager, it's much, much harder. And she may well be fearing what any adult will bring, let alone one who has power over her"* (P11)

Q15: *"[I] have had under 18s make disclosures during telemedicine or tell me that they've already got a social worker and going through that information with them"* (P03)

Q16: *"[W]e had a 14-year-old who came through on webchat. She was just beside herself. She was communicating with us, which just was really interesting, through emojis […] She was just showing us how upset she was about the pregnancy, using a tear face. Then, towards the end, as we were managing to get things sorted out for her, because she was saying she just couldn't leave the house, but she'd got this window when she was going to be in school. We were working with her and really supporting her. The feedback from her, using webchat, just like, "OMG, thank you so, so much". Then praying hands and, "I can't believe you're helping me". So, that kind of feedback you would get often"* (P01)

Q17: *"[W]e had a young person, actually, who was messaging us saying that, and if I remember rightly, they were about 15 years old, messaging saying that they weren't safe. They were being held in this house with other people. The person was trying to stay online to them to get more information, and they dropped off. So, we got the URL and reported it to the police"* (P02)

Q18: *"[H]er body language, I can read from what I can see in the image. You've got your image blurred but most of my patients [do not do that] […] I can see what's in their background"* (P08)

Q19: *"And one of the things that we picked up, for example, was in the North of England in the back end of last year. We felt we were seeing much more young people coming to our services, and almost they had these coached answers to some of our questions. Which made us think that there was something more orchestrated going on"* (P06)

Q20: *"I think that is one of the disappointments, having come out of it now, is there is still a hard core in the paediatric community and the professional child protection community who just don't recognise the validity of non-face-to-face contact. I think it must just be a cultural thing"* (P11)

4.0 DISCUSSION

Since TEMA became temporarily lawful in England and Wales and services were introduced, there has been opposition on the grounds that an absence of face-to-face interaction prevents adequate safeguarding.[7] There has been a particular focus on U18s. Since TEMA has been made permanently lawful, RCPCH guidance has been released that treats face-to-face consultations as the gold standard for safeguarding.[14]

In contrast, our findings indicate that ACPs, with their relevant experience, believe that face-to-face safeguarding may not necessarily be better than remote for U18s. Participants described a feeling of safeguarding U18s effectively through telemedicine, highlighting instances where they felt this had been particularly successful. In some instances, remote consultation was described as having enhanced communication with young people. In addition, some participants observed the value of interacting with abortion seekers in their own environment, enabling the provider to understand more of that person's circumstances both because of

improved communication and, where video is used, possible visual observations of their living environment. The reflections of participants align with suggestions in the normative literature about younger people being more comfortable in their own environment,[7, 11] and how this can create enable young people to choose the space where they feel safe discussing safeguarding issues.

From the perspective of individual ACPs, it appears that young people are satisfied discussing their care remotely and may be more inclined to disclose. Importantly, there was not an accompanying suggestion that U18s should not be offered in-person care. Offering a choice of care pathways enables individuals to access care in the way that works for them,[7] and some U18s may feel more comfortable attending a clinic. Nonetheless, our findings indicate that TEMA should not be wholly unavailable to U18s and that in-person care should not be assumed as the default based on safeguarding concerns.

Our findings highlight various benefits telemedicine has had for U18s in addressing the barriers to access they face trying to access abortion care. Incidentally, these barriers are likely to be more pronounced for young people with safeguarding needs. Consequently, offering remote options for these young people might mean the difference between them having contact with an ACP or choosing to explore other (unlawful) channels – such as buying medications online. Where U18s are required to access abortion care in person, our findings indicate that this could be more stressful, and potentially distressing, experience because of the difficulties in travelling and arranging that travel.

Given these findings, guidance indicating that face-to-face consultation is necessary might be deemed disproportionate because it does not give due consideration to the benefits of remote care – both generally and in terms of safeguarding – instead centring the risk of missing a safeguarding issue that, it is assumed, could have been identified in person.[11] Our findings indicate that ACPs believe an approach that assumes individuals are vulnerable based on age alone is unnecessarily precautionary. Screening questions asked of U18s are different to those asked of adults because the types of risks to safety and wellbeing can be different, which participants found to be an appropriate – and sufficient – divergence in approach which can be incorporated into a TEMA care pathway.

5.0 LIMITATIONS

With many of our participants having designated safeguarding roles, our sample may be considered as lacking representation across the care pathway. Our focus has been on independent ACPs, recruiting directly from two of the three main abortion providers in England and Wales, because they provide the majority of abortions.[20] Some participants also work within the NHS, but we did not recruit directly through NHS sites where there may be a different experience of care provision. Our study objective justified using a carefully constructed purposive sample of experts. While qualitative research does not seek to make generalisations about the study population, our sample does allow us to glean significant insight into the English and Welsh context.

6.0 CONCLUSION

To our knowledge, this is the first qualitative study examining ACPs' experiences of safeguarding by telemedicine in England and Wales. Our study interviewed a range of

professionals in different roles facilitating TEMA across different organisations. Our findings suggest that ACPs believe that TEMA has benefitted U18s. There was a strong feeling both that TEMA had improved access (which, in turn, improved safeguarding) and that U18s were comfortable communicating using remote means. In some instances, this meant a better environment for disclosure from younger people was facilitated by telemedicine. ACPs believe it is important that safeguarding proformas account for the difference in the nature of the risks where service users are U18, but that it is disproportionate to assume that TEMA is unsuitable for all U18s or certain groups of U18s. Safeguarding should be focused on the individual and what is best for them. Our findings are consistent with a qualitative study from Scotland about ACPs' experiences of TEMA during COVID-19 in which safeguarding was a theme constructed in the data.[21]

This study provides detailed insight into the views and experiences of ACPs around safeguarding U18s in the move to telemedicine. Such perspectives are vital to our understanding of this evolving area of healthcare provision and should guide policy developments.

Contribution to authorship

JAP and ECR designed the content of the research. JAP led recruitment. ECR conducted eight interviews and JAP conducted twelve interviews. Both authors carried out the primary analysis. ECR led the analysis and writing on this paper.

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Disclosure of interests

None declared. Completed disclosure of interests form available to view online as supporting information.

Details of ethics approval

Ethical approval was granted by Durham Law School Ethics Committee on 4 March 2020 (Reference: LAW-2022-03-03T15_00_18-fdgn34). Ethical approval was also granted by the British Pregnancy Advisory Service Research and Ethics Committee on 10 May 2020 (Reference: 2022/05/ROM).

Patient and Public Involvement

Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Data Availability Statement

No data are available.

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