



Centre for Reproductive
Research & Communication

Experiences and Expectations of Pain with Early Medical Abortion

Report on a Research Panel and Workshop

Organised by the Centre for Reproductive Research &
Communication at British Pregnancy Advisory Service

18 April 2024

Conway Hall
London, England

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Acknowledgements

Thank you to Adhishree Sunilkumar, Aliyu Sokomba, Claudia Hobbs, and Julia Kelly from the London School of Hygiene and Tropical Medicine for their support in notetaking and helping to ensure the event ran smoothly. Additional thanks to Chantel Briggs for supporting with event preparation and administrative details.

Cite this report

Centre for Reproductive Research & Communication (2024). Experiences and Expectations of Pain with Medical Abortion: Report on a Research Panel and Workshop. Centre for Reproductive Research & Communication, British Pregnancy Advisory Service. London, United Kingdom.

List of Acronyms

AI: Artificial intelligence

NHS: National Health Service

BPAS: British Pregnancy Advisory Service

NSAID: Non-steroidal anti-inflammatory drug

EMA: Early medical abortion

SRH: Sexual and reproductive health

IUD: Intrauterine device

WHO: World Health Organization

Note on terminology

Although most abortion care is provided to women, adolescents and minor adolescents, other people whose gender identity does not align with the sex they were assigned at birth can also experience pregnancy and abortion. For simplicity of language this document uses the term women, but this should be taken to also include people who do not identify as women but who are pregnant [1]. The term 'people' or 'patient' has also been used to describe those who have had an abortion, particularly where this language reflects the original study. (Adapted from the National Service Specification for NHS Abortion Care)

Executive Summary

Pain is a common feature of medical abortion. However, research evidence is lacking on the best ways of preparing people for the pain they may experience, or for preventing or managing pain when it occurs. Lack of robust evidence has implications for informed consent and abortion method choice and for ensuring an optimal abortion experience.

On 18 April 2024, the Centre for Reproductive Research & Communication (CRRC) at the British Pregnancy Advisory Service (BPAS) hosted a research panel and workshop on "Experiences and Expectations of Pain with Early Medical Abortion." The event brought together abortion providers, researchers, public health professionals, health service managers, and representatives from NHS England to discuss challenges and opportunities in abortion pain research, clinical practice, and policy. Attendees also worked on developing proposals for future research and clinical priorities.

Presentations were given by Dr John Reynolds-Wright (University of Edinburgh), Dr Carrie Purcell (Open University), and Ms Hannah McCulloch (CRRC, BPAS), who shared recent research on pain associated with Early Medical Abortion (EMA). This was followed by a question-and-answer session with panellists and delegates, as well as breakout discussions focused on identifying key research priorities and clinical recommendations in this field.

The priorities identified for research and clinical innovation were:

- Conduct high quality original research on interventions to manage pain during EMA
- Understand patients views on pain control versus elimination with EMA
- Design a UK-specific decision-making tool on the relative risks and benefits of medical versus surgical abortion including information on pain
- Standardise post-abortion patient satisfaction data, including about experiences of pain, for use by UK abortion providers
- Develop a validated measure of pain during EMA, and effective methods for communicating about pain and expectation management
- Explore use of digital technologies for pain management

Future work on EMA should focus on both making the pain experience more manageable and prioritising the lived experiences of those who have undergone the procedure.

Exploring how language and metaphors used to describe and prepare patients for pain may unintentionally affect their experience was identified as a key area for improving care. Effective communication about pain is also essential for ensuring valid consent, as patients may consider such information crucial to their decision-making.

We hope the research priorities and clinical development areas identified at this event will support healthcare providers, academics, and third-sector organisations. By fostering collaboration and innovation, our goal is to improve the EMA experience and empower patients to make informed, evidence-based decisions about their care.

Background

Pain in reproductive healthcare is poorly understood and underestimated in clinical settings. Despite being a common feature of many chronic reproductive health conditions and procedures [2,3], it is often normalised and, as a result, inadequately considered, believed, or managed.

Abortion is one of the most common reproductive health interventions in Britain, with one in three women having an abortion before age 45. Nearly 90% of abortions in Britain are early medical abortion (EMA), which involves using two medications to end the pregnancy within the first 12 weeks [4]. Pain is often described as one of the worst features of EMA and is nearly universal [5-7]. In recent years, pain related to reproductive health experiences has attracted significant attention in news media and popular culture, particularly for conditions like endometriosis or procedures like an IUD insertion. However, pain with abortion receives far less attention likely due to abortion stigma [8].

The World Health Organization (WHO) recommends routinely offering pain medication to those having medical abortion and providing it to individuals for use when needed [9]. Non-steroidal anti-inflammatory drugs (NSAIDs) are recommended, although acetaminophen/paracetamol can be taken if NSAIDs are not available. While a somewhat wider range of pain management solutions, such as epidural anaesthesia, may be offered to those having a medical abortion over 12 weeks of pregnancy, there is limited evidence for pain management options earlier in pregnancy. A recent Cochrane review supported the use of

the NSAID ibuprofen although optimal dosing was unclear [10]. The review concluded that more research was needed due to the low certainty of evidence for most outcomes.

Communicating pain and its management during EMA raises important concerns about informed consent and method choice. Informed consent has become a central focus in healthcare over the past two decades, with policies emphasising patient involvement in treatment decisions [11, 12]. The landmark case *Montgomery v Lanarkshire Health Board* (2015) [13] established that doctors must disclose information patients would consider significant. Some argue that without better counselling on pain, valid consent for EMA cannot be guaranteed.

Given the high proportion of EMAs, it is crucial to examine whether patients' method choices are fully addressed. Providers often face constraints such as cost, staffing, and infrastructure, reflecting systemic under-investment in abortion services and limiting the availability of options [1, 14]. Stigma further restricts patient-led advocacy on these issues. While patients cannot demand treatments that are unavailable, their ability to make informed choices depends on receiving comprehensive information, including about pain.

The need for robust research to improve the quality of pain counselling, support choices, and manage medical abortion pain was highlighted in a 2023 paper by the Centre for Reproductive Research & Communication (CRRC) at British Pregnancy Advisory Service (BPAS) [15]. This study explored the impact of changing from routine to opt-in codeine provision for medical abortion up to 10 weeks' gestation. It found that when patients opt-in to receive codeine they had greater satisfaction with pain management but that pain levels were still high. Participants also contributed qualitative data to support the development of client-centred pain counselling but left several unanswered questions about how to optimise the medical abortion experience.

Event Overview

To further explore this topic, the CRRC held a research panel and workshop on **Experiences and Expectations of Pain with Early Medical Abortion** on 18 April 2024 in London.

Objectives

- Bring together a multidisciplinary group of stakeholders including researchers, abortion providers, health care professionals, policy makers, to discuss current challenges in abortion pain research, clinical management, and policies
- Highlight and discuss latest research from the UK on pain with medical abortion.
- Provide clinicians and managers working in abortion care with an opportunity to participate in a research event and contribute to a sector-wide conversation.
- Establish research and clinical priorities around pain with EMA.

Panel

Dr John Reynolds-Wright

John is an NHS Education for Scotland/ Chief Scientist's Office Clinical Lecturer in Sexual and Reproductive Health at the Centre for Reproductive Health, Institute for Regeneration & Repair, University of Edinburgh. His research interests include telemedicine provision of abortion care, post-abortion contraception, and management of pain during abortion. John presented: **“Developing a tool for measuring pain during medical abortion”**. Read more [here](#).



Dr Carrie Purcell

Carrie is a Research Fellow in the Faculty of Wellbeing, Education and Language Studies at the Open University, and leads the Reproduction, Sexualities and Sexual Health Research Group. Her main research interests are around sexual and reproductive health (SRH), stigma, embodiment, self-management, reproductive justice, and access to healthcare, and her current work primarily focuses on SRH-related pain. Carrie presented: **“Medical abortion-related pain through a lens of reproductive justice.”** Read more [here](#).



Hannah McCulloch

Hannah is an Evaluation Researcher within the CRRC at BPAS.

Collaborating internally with BPAS colleagues, and sometimes externally with other independent providers or academic institutions, Hannah conducts evaluations of BPAS' clinical services and changes made to care pathways and clinical policies. Hannah presented: **“Managing expectations of pain for medical abortion up to 10 week’s gestation: BPAS evaluation and service development.”** Read more [here](#).



Breakout Sessions

Following the presentations and a Question-and-Answer session, four breakout group discussions (summarised below) took a deeper dive into:

- Current conceptualisations of pain with EMA
- Patient information provision and language
- Clinical interventions, policies and best practice
- Next steps in research on pain with EMA.

Current conceptualisation of pain in early medical abortion

Session Lead: Carrie Purcell

This session looked at ways in which pain is currently understood in relation to abortion. The group explored questions around language and attitudes, whether understandings of abortion pain differ to other sexual and reproductive health contexts and, if so, in what ways.

The group raised that abortion may be seen as a morally ‘bad’ thing unlike, for example, having an IUD fitted or undergoing fertility treatment. It was suggested that those seeking abortion (and potentially some providers) may therefore see abortion pain as serving a punitive function in that they want or deserve to feel pain for having an unintended conception and/or seeking abortion.

Differences were noted in the sources of pain and what training might involve for different procedures. Pain resulting from IUD fitting or cervical smear tests, for example, could be a result of inadequate training or an absence of 'state-of-the-art' equipment. Pain with EMA, on the other hand, is a direct result of the medications used. There were mixed views in the group on the extent that it would be possible to eliminate EMA-related pain entirely, but there was agreement that better pain management options could and should be pursued.

The role of gender norms was also discussed. Group members suggested that, in the course of routine sexual and reproductive health (SRH) care, women tend not to complain, but to 'grin and bear it'. As a result, health professionals may not always appreciate the intensity or impact of the pain experienced, nor give sufficient attention to pain management. An increasing level of public interest in gender and pain was noted, including a proliferation of discussion on social media, and high-profile personalities talking about their SRH pain experiences.

There was a view across the group that the stigma around abortion may play a part in exacerbating pain, through complex interactions between physiological and psychosocial factors. Abortion is often marked out as distinct from other areas of SRH care. Addressing the stigma surrounding abortion could support services and health professionals in reducing the pain experienced during EMA.

Learn more:

- Purcell, C., Newton, V.L., Bloomer, F., Hoggart, L. (2024). **Foregrounding pain in self-managed early medication abortion: A qualitative study**. *BMJ Sexual & Reproductive Health* (Early Access). DOI: <https://doi.org/10.1136/bmjshr-2023-202198> Open access version is available [here](#).
- **The Gender Pain Gap in Sexual and Reproductive Health Across the Life Course:** information available [here](#).

Patient information provision and language

Session Lead: Hannah McCulloch

This session considered how information provision and language may affect how patients experience pain with EMA. The session began with a discussion on the creation of user-

centred patient information, both to prepare patients for pain they might experience, and to support and advise on pain management during medical abortion. There was agreement that a diverse range of tools (across different mediums and channels) needed to be developed to suit patient needs. This might include creating information to meet accessibility requirements (for example for those with a learning disability, or in other languages) or tailoring the level of detail to reflect patients' preferences (for example by using accounts of lived experiences). Further, it was agreed information should include visual aids, have lay-friendly formatting, and be easy to read. Innovative tools, such as accompaniment apps, could be explored to support patients and advise about pain relief during medical abortion.

The group also reflected on whether there were insights on pain from other areas of healthcare that could provide learning. The example of Black, Brown and other racially minoritised women's experiences of pain during childbirth, where many reported their pain was dismissed or ignored, or they were denied pain relief was discussed [16]. The group also discussed racist beliefs about pain tolerance in Black women and how in other parts of health care recent studies have identified racial disparities in information provision around pain. The discussion extended to asking whether this had also happened in abortion care. This led the group to ask: What research is there into disparities between expected and experienced pain with medical abortion, compared by ethnicity?

Learn more:

- Luigi-Bravo, G., Maria Ramirez, A., Gerdts, C., & Gill, R. (2023). **Lessons learned from developing and implementing digital health tools for self-managed abortion and sexual and reproductive healthcare in Canada, the United States, and Venezuela.** *Sexual and Reproductive Health Matters*, 31(4), 2266305.
<https://doi.org/10.1080/26410397.2023.2266305>
- Furgalska, M., de Londras, F. (2024). **Towards a rights-based approach for disabled women's access to abortion.** *Medical Law Review*, fwae026.
<https://doi.org/10.1093/medlaw/fwae026>

- Birthrights. (2022). **Systemic racism, not broken bodies: An inquiry into racial injustice and human rights in UK maternity care**. Find more information and download the report [here](#).

Clinical interventions, policies and best practice

Session Lead: John Reynolds-Wright

This session addressed clinical policies and practice around pain management during abortion care. It also touched on policies for abortion care in general and telemedicine abortion care as an area where clinicians are most in need of guidance for assessment and management of pain.

For telemedicine abortion care it was noted that training quality is variable and dependent on the trainer. Although this apprenticeship-style model can have positives, there is likely value in developing standardised training resources (including how to enquire about pain, measure pain, and provide advice on treatment of pain). It was felt that further research on patient self-assessment/management of pain, including during asynchronous consultation, and abortion care in general was needed. This research should extend to exploring the phenomenon of some patients choosing to not use analgesia when it is provided and the possibility that this may represent an internalised form of stigma.

Interfacing with this was a discussion about whether a policy approach should be to prepare all patients for the 'worst case scenario' regarding pain or to provide a spectrum of pain experiences that they may fall on. This must be considered within known phenomena surrounding pain such as fear and the 'nocebo effect' heightening pain experiences.

There was acknowledgement that cultural expectations around pain may lead to insufficient pain management – this is not restricted to people born outside of the UK and will include regionalism and classism in the approach to pain tolerance, expression, and management. It was recognised that these nuances are difficult to capture within clinical guidelines designed with a broad remit.

There was discussion about the balance between sufficient access to in-person care (which might be beneficial for pain communication) and telemedical care (which might be more accessible and offer flexibility to some) – and to investigate and evaluate models where

there are different balances of these types of care. Some clinicians may think they are better able to assess pain in-person but there is a dearth of evidence to support one model over another. Along similar lines, the potential for disparity in pain management options based on the setting of abortion (i.e., hospital versus home) should be considered by clinical guidance. However, this needs to be tempered by the comfort afforded by one's own home environment and the reality of ward-based care, where there are often staff shortages and associated difficulty in responding to requests for analgesia in a timely manner.

The group recognised the lack of research on adequate pain management (in abortion, but also across gynaecological conditions). This includes who is most at risk of severe pain (risk prediction models) and the characteristics of those needing additional advice or support, that would be critical for development of clinical guidance and protocols.

Finally, there was acknowledgement of the concerns around capacity to offer surgical (and in-patient medical) abortion care for patients who were most concerned about pain during counselling. Adequate capacity to provide a greater proportion of surgical care may increase the candour and clarity with which clinicians provide information on pain during medical abortion.

Learn more:

- Royal College of Obstetricians & Gynaecologists. (2022). **Best practice in abortion care.** *Making Abortion Safe: RCOG's global initiative to advocate for women's health.* Read the paper [here](#).
- Reynolds-Wright, J.J., Woldetsadik, M.A., Morroni, C., Cameron, S. (2022) **Pain management for medical abortion before 14 weeks' gestation: A systematic review.** *Contraception*, 116. <https://doi.org/10.1016/j.contraception.2022.08.005>

Next steps in research on pain with early medical abortion

Session Lead: [Rebecca Blaylock](#)

This session focused on next steps for research on pain and early medical abortion. Initial conversation reflected on whether research should be aiming to eliminate pain associated with medical abortion, and if this was even possible with current treatments.

In recognition of the significant variation in pain that people experience with medical abortion, the group agreed that research in this area should focus on a personalised and individualised approach to pain management. The group discussed the importance of paying particular attention to the experiences of marginalised and minoritised patients. Research has shown that their experiences of pain have historically been dismissed or underestimated in other areas of healthcare, including in maternity services. Discussion identified adopting a culturally competent approach to research in this area as a priority. Research on pain and medical abortion should include diverse study populations but should also be undertaken with specific groups on their unique experiences. A focus on the most equity-deserving groups will help improve services and outcomes for everyone. The group also discussed the importance of learning from other areas of healthcare, including but not limited to gynaecology and obstetrics.

Learn more:

- Free, M.M. (2002) **Cross-Cultural Conceptions of Pain and Pain Control.** *Baylor University Medical Centre Proceedings.* 15(2)
<https://doi.org/10.1080/08998280.2002.11927832>
- Woodland, L., Blignault, I., O’Callaghan, C. Harris-Roxas, B. (2021) **A framework for preferred practices in conducting culturally competent health research in a multicultural society.** *Health Research Policy and Systems.* 19(24)
<https://doi.org/10.1186/s12961-020-00657-y>

Research & Clinical Priorities

The question-and-answer session and breakout group discussions identified key research priorities and clinical focus areas related to pain with EMA, summarised in the table below.

Priorities		Rationale
1.	Pursue high quality original research on interventions to reduce or eliminate pain during EMA (including the extent to which patients want complete pain elimination), drawing	Five heterogeneous studies on pain management in abortion is an insufficient evidence base for the millions of women having EMA, world-wide each year. Additionally, across a range of studies on

Priorities	Rationale
<p>on biopsychosocial perspectives and lived experience.</p>	<p>home/self-managed EMA, there are a subset of patients who do not take analgesia or do not take the recommended regimen. However, for others, there is a strong desire for their pain to be sufficiently managed during the process. There is a need to balance realistic medicine and patient preferences and expectations around EMA.</p>
<p>2. Achieve a better understanding of how patients manage pain at home, including whether they use alternative medication or herbal supplements, such as cannabidiol for pain management.</p>	<p>In addition to research on diverse pain management options, it is important to understand what patients currently employ to manage pain at home and, if possible, conduct studies into their clinical effectiveness.</p>
<p>3. Further develop decision-making aids for the UK context which outlines the relative risks and benefits of EMA versus surgical abortion, including specific information on pain.</p>	<p>In addition to the decision-making aid on abortion method, published by NICE, further developments could be made to ensure patients are supported when making decisions about their care. Particular consideration must be given to groups who are digitally excluded or may encounter barriers to accessing decision aides.</p>
<p>4. Standardisation of patient satisfaction data collected post-abortion across all abortion providers in the UK, including data specifically on pain management and expectation setting.</p>	<p>While indicators of patient satisfaction with care are routinely collected in the UK, content is not standardised or easily available for analysis or comparison. The lack of available data, particularly on expectation of pain and its subsequent</p>

Priorities		Rationale
		management, makes it challenging to understand the impact of language on the abortion experience. Standardising patient satisfaction feedback can inform changes to language used in patient-facing materials. Any resulting materials should be co-produced with patients to reflect the language they find most relevant and relatable.
5.	Develop and evaluate educational modules about pain in EMA (including the importance of cultural competency) for abortion providers.	Communication around pain is complex and, in healthcare, it is often based on gendered assumptions and rarely grounded in lived experience. Healthcare providers should be supported in how best to communicate pain and manage expectations of EMA experience in a way that accounts for variations in attitudes, values, beliefs and backgrounds.
6.	Identify methods or technologies from other gynaecological experiences that can be adapted for EMA to improve the abortion experience.	Research into other gynaecological procedures or conditions may shed light on technological advancements that could be adapted for or adopted within abortion services in the UK. Collaboration could lead to more timely innovation within abortion services.
7.	Explore different dosages for existing pain medication, and potential non-pharmacological methods of pain management; including an escalation protocol for pain in a clinical setting	Currently there is no consensus on the ideal pain dosage regimen that reduces pain to an acceptable degree. Robust clinical trials are needed to explore different doses and combinations of

Priorities		Rationale
		<p>treatments in the context of abortion-related pain.</p> <p>Complementary non-pharmacological options for pain management should also be explored to provide a more robust evidence-based offering for pain management to patients undergoing an EMA and wishing to explore non-pharmacological options.</p>
8.	Explore the use of digital technologies for pain management (i.e., AI, wearables, hardware).	<p>In countries like Venezuela and the United States, there have already been technological advancements for women having an EMA, which include digital offerings, such as a digital companion to seek clarification on steps in the EMA pathway, to a more robust digital end-end offering. However, such technologies have not yet been widely adopted in the UK, nor have studies been done to understand their acceptability in this context, including how they could support better pain management.</p>

Key Takeaways & Conclusions

At the end of the event, attendees were asked what their ‘key takeaways’ were from the day. Some attendees shared their view that **preference-sensitive care**, from method of treatment, to pain management, is vital within the abortion care pathway, and that more can be done to enable this. Other attendees argued that with **sufficient investment in abortion services**, we might be able to offer more **personalised abortion care** in the UK.

There was agreement that abortion providers have a responsibility to support **informed decision-making around pain**.

Some attendees maintained that addressing the **needs of the most marginalised** in research efforts will improve quality of care for everyone. There was also agreement that currently, there is no perfect answer for how to manage pain. Additionally, other attendees noted tensions between wanting to inform patients of pain expectations and not wanting to this information to unduly dissuade patients from considering this method. It was noted that there are many possible workable solutions to improve experiences of EMA, and **technology** is one solution worth exploring for how to improve pain management options for those having an EMA. Finally, attendees felt **pain with abortion should be more visible** in society outside of research and clinical spheres to help aid progress in some of the issues and barriers addressed throughout the event.

In conclusion, this event highlighted the critical need for patient-centred approaches in abortion care, with a focus on informed choice, personalised treatment, and equitable research efforts. By encouraging open dialogue, exploring innovative solutions, and increasing societal awareness of abortion-related pain, we can work collaboratively to improve the experiences and outcomes for individuals accessing EMA.

The clinical recommendations and research priorities identified during the event provide a strong foundation for advancing the field. We hope the insights shared and the collaborations initiated here will drive progress in addressing these pressing challenges and enhancing standards of abortion care across the UK.

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