Young women's experiences of unintended pregnancy and abortion

Key findings

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The study

This document reports on the key findings of a mixed methods study to investigate different aspects of young women's (aged 16-24) pregnancy experiences of one or more unintended pregnancies ending in abortion. Following an abortion at one of Marie Stopes' main centres, a total of 430 women completed a quantitative telephone survey between June 2012 and May 2013. In addition, thirty six young women were interviewed qualitatively following their abortion. These interviews took place between February 2013 and April 2014. Seventeen of these participants were then interviewed for a second time approximately five to eight months later. Women were asked about their contraceptive use at the time of pregnancy, their experience of the abortion consultation and service, their post abortion contraception decision making, their attitudes towards pregnancy and abortion, and their perception of contraceptive risk taking. The women who had experienced a previous abortion were also asked about their contraceptive use between their two most recent abortions.

Key findings

The study has provided new findings to help understand why some young women experience one or more unintended pregnancy. It also provides new insights into the contraceptive behaviours of young women following an abortion. This new evidence has the potential to help policy makers and service providers improve services in order to help women exercise more effective reproductive control and decrease unintended pregnancies.[1]

Becoming pregnant

The majority of all abortions follow contraceptive failures. More than half of the women (57%) who had an abortion reported using contraception at the time they became pregnant. The most common reasons cited for why contraception had not worked were not using the method consistently (26%); or correctly (20%); and (29%) did not know why it had failed. The qualitative strand interviewed some women who were shocked to find themselves pregnant because they did not fully understand why their contraceptive had failed. Their own explanations: *I think I must have missed a pill* (Carrie); *I got really ill one night and I think I obviously like threw it up* (Roxanne) indicate uncertainty and poor understanding of what went wrong for them. Common themes in the qualitative research were: **unimaginable pregnancy** due to fertility misperceptions; **unpredictable pregnancy** because they had been using contraception and/or emergency contraception; and **predictable, but not predicted, pregnancy** due to inconsistent contraceptive use. Overall, our findings on becoming pregnant have shown a range of different situations, different behaviours, and different beliefs that can contribute towards experiencing an unintended pregnancy.

Most women, who had an unintended pregnancy that resulted in an abortion, had not used emergency contraception. The main reasons for not using emergency contraception (EC) were not being aware that their contraception had failed (66%), or not knowing they were at risk of pregnancy (31%). Of the women surveyed, 12% of all women had used emergency contraception, but it had failed. Most women surveyed had therefore not used EC. The main reasons for not using EC were not being aware that their contraception had failed (66%), or not knowing they were at risk of pregnancy (31%). In the qualitative study, many of the young women who recalled being aware that their contraception had failed, or who had not used contraception (often due to unanticipated sex) had not accessed EC. Reasons they gave for not using EC were clustered around poor knowledge, accessibility and concerns about cost. Some, though, had sought out Emergency Hormonal Contraception (EHC), but it had not worked. Both types of EHC are likely to be ineffective immediately following ovulation. After this point, a copper intrauterine device (IUD) is a more effective form of EC. We found very poor knowledge of the IUD as emergency contraception.

Abortion experience

The young women reported high satisfaction with their service experience, though there were also areas for improvement identified. Satisfaction levels were consistently high with, for example, 78% of women saying that they were 'very satisfied' with their treatment at the clinic. This was echoed in the qualitative research when participants spoke favourably of not being judged and were often shocked that clinic staff were kind and 'nice'. In limited cases participants recalled what they saw as insensitive treatment at the clinic: *I looked to the nurse for comfort and I didn't get it from her* (Alex). When asked how their experiences might have been improved, participants mentioned lack of privacy, overcrowded

[1] Full reports are available on the Open University website: www.open.ac.uk/health-and-social-care/main/research/research-themes/reproduction-sexualities-and-health. Full reports can also be obtained by contacting lesley.hoggart@open.ac.uk

waiting rooms, and having to leave their companion for the actual abortion: *I felt on my own. I know the nurse and that were there, but it's not like having say my mum sitting behind me or sitting next to me or even just behind a screen talking to me, so then I'd know that someone was there* (Fern).

Abortion-related stigma was a feature in all of the women's recollections of their abortion journey. Additionally, some women recalled instances of encountering abortion negativity that sometimes caused referral delays. The extent to which women internalised abortion stigma differed between participants. There was evidence that popular discourses about abortion had influenced how the young women felt about their decision: *I just felt like a bit of a wrong 'un, you know* (Natasha). Participants also discussed the moral framework around abortion and defended their choice for doing it for the 'right' reasons: *how could I have looked after that baby? I wouldn't have been able to do what I'm doing, like going to uni, I don't want to end up having a loan from uni which I haven't finished and having a baby that I can't afford, when I want to give it everything* (Danika). Many participants also noted that the presence of protesters outside clinics made them feel upset and angry.

Participants reported being unprepared for the side-effects of a medical abortion. Young women commented on how 'ill' the medical abortion made them feel and they were largely unprepared for this: *I was bleeding so much, and then I started to feel in a lot of pain, like stomach cramps ... I had diarrhoea and I was being sick at the same time for about five or ten minutes, and it was just awful. ... I just couldn't wait for it to be over. It felt like a long, long time* (Dee). Those undergoing a surgical abortion generally reported a more positive experience.

Post-abortion contraception

The use of contraception at four weeks following abortion was high for all women (86%) and there was no difference between women who had more than one abortion and those who had one for the first time with respect to their decision to start using contraception. In the survey, the majority of women (79%, n=339) were given their method from Marie Stopes at the time of their abortion and most women were still using this method at the time of the survey. Although there was no difference between women who had a previous abortion and those who had one for the first time and their uptake of contraception, there was a significant difference regarding their choice of method. Women who had a previous abortion were more likely to start using long acting reversible intrauterine contraception (LARC), such as the implant, IUD/intrauterine system (IUS) or injection, compared to women who had an abortion for the first time (74% & 59% respectively, p=0.009).

A significant minority of women were not using contraception at four weeks after their abortion. At four weeks, 14% of women (62 out of 430) were not using contraception and half of these women reported to be in a relationship at the time of the interview, and therefore likely to be sexually active. The qualitative longitudinal research enabled us to see how women can choose to change or discontinue their contraception in a short time frame if they are not happy with it, or simply discontinue, their contraception if they are not happy with it for any reason. The most likely reason to change or discontinue with LARC was due to undesirable side effects: *you put on weight and [it]gives you spots* (Maddie).

Although all women were provided with contraceptive advice during their consultation and at the time of their abortion, 21% (n=89) were discharged after abortion without a method of contraception. These women either did not want to start using a method immediately after their abortion, their preferred method was not available, they were undecided what method to start, or they preferred to see a different service provider for contraception. Out of the women who did not accept a method of contraception from Marie Stopes immediately following their abortion (21%), almost two thirds (61%) did not go on to see another service provider for contraception. Some women in the qualitative strand noted finding it difficult to decide on contraception at the time of their abortion: *They wanted to put an implant in my arm right after it but I just thought that I didn't want to do it that same day* (Saskia).

There is a significant difference between the method of abortion women choose and the uptake of contraception immediately following their abortion. Women who had a surgical abortion were more likely to be using contraception at four weeks compared to women who had a medical abortion (88% vs. 80%; p=0.026), and furthermore, were more likely to be using a LARC method (70% vs.50%; p=0.000). The administration of implants on the same day as medical abortion is possible, and this study did find an equal proportion of women having a surgical or medical abortion adopting implants as well as the injection. After the second abortion pill in a medical abortion, however, it is not possible for intrauterine contraception (IUC) to be inserted; women's choice of contraception methods at the time of a medical abortion is thereby limited. The qualitative research found that some women welcomed the opportunity to have IUC fitted whilst undergoing a surgical abortion.

More than one abortion

There were no significant differences between the characteristics of women who have had a previous abortion and those having one for the first time. This makes it difficult to target services to a particular group of 'at risk' women. One important conclusion that has emerged from this study is that there are no specific groups of women who appear to be more likely to have more than one abortion, with the unsurprising exception of age. The study has found a majority of young women who had a previous abortion (82%) were motivated to protect themselves from another unintended pregnancy. In the qualitative study we found a diverse range of situational and behavioural scenarios in which women experienced more than one unintended pregnancy. Difficulties with hormonal contraception and unanticipated sex were major themes for the sub-group of young women who experienced more than one unintended pregnancy: *I had one sort of reconciliation with my ex, and that was how that happened* (Natasha).

The majority of subsequent abortions also follow contraceptive failures. This study has provided detailed information about contraceptive use during the interval between women's previous abortion and their most recent abortion. Among the 121 women who had a previous abortion, 82% started to use contraception following their last abortion, and the majority did so immediately (66%) or within one month following their last abortion (24%). Most women started to use the pill (54%) and 22% had chosen a LARC method. More than half the women (60%, n=59) stopped using their method of contraception, with 27% of these women stopping within less than 3 months and 71% not using this method for more than one year. Women who stopped after three months were largely women who were experiencing side effects or who had run out of their supply of pills. In the qualitative strand, women had changed their contraceptive and sexual behaviour but described something else going wrong for them, sometimes referring to themselves as unlucky. The diversity of their situations, and their accounts, was such that we were not able to develop a typology of these women beyond the obvious observation that contraception was not being used effectively. The stories changed for each pregnancy, so that we did not find evidence for a continuation of previous behaviour. It is important to recognise this complexity because it indicates that there is no 'silver bullet' that could be proposed to help women improve their reproductive control.

Recommendations

This study indicates that most young women who have an abortion are motivated users of contraception before and after abortion, but that some face difficulties in selecting and/or maintaining an effective contraceptive regime in the immediate post abortion period. It has also shown how a diverse range of behavioural and situational scenarios requires multi-faceted policy and practice responses. It is clearly not just an issue of encouraging women to select an effective contraception, with a focus on LARCs but, more importantly, also providing ongoing support to women to manage side effects; or adjust their choice of methods if they wish. Arising out of this research, the following issues have been identified as areas for action to help women exercise reproductive control more effectively:

Contraception – access and support

1. **Implement different ways to remind young women about renewing contraception**
   Providers could draw on available and popular technologies, such as automated text messaging, email or social media (with women's consent) to communicate reminders to resupply pill and other contraceptive prescriptions.

2. **Offer young women greater support in their use of the pill if it is their method of choice**
   More could be done to improve communication about the circumstances when the pill may fail to work, what women can do in regards to emergency contraception and where women can go if they have questions about the pill. Mobile phones were used by some women in the study population to remind them to take their pill. Therefore, an App which reminds users to take their pill, and also contains information about what to do if a pill is missed, and where to go for additional support, would be a useful resource for many women.

3. **Consider new ways to help young women retain LARC**
   Contraceptive advice and counselling should include more advice on how to manage negative side effects, for women who wish to retain LARC. Some women may require more support and could benefit from follow up telephone calls or texts to address questions regarding their chosen method. Such reminders would be a cost effective way to enhance continuation. It could also serve as an efficient way to identify women who may be willing to try another long term method. This approach could also be applied to women not using LARCs, but less effective user-dependent methods such as the pill and condom.

Emergency contraception

4. **Improve awareness among all EHC suppliers of when EHC might fail, and improve provision of the copper IUD as a method of EC**
   EHC had failed for a number of our participants and that was very distressing for them. There was little awareness among the study group of the IUD as EC. A greater awareness among practitioners of when EHC may fail and how, where and when the IUD can be accessed as EC would be beneficial in order to sign-post women towards appropriate services. The message that EHC is not fail safe close to ovulation needs to be communicated more effectively.

5. **Improve availability of, and information about, all forms of emergency contraception**
   It is important that young women's knowledge of, and understanding about, EC is also improved, including the use of the emergency IUD. It is evident that most participants had absorbed the message about efficacy and hours post-sex, but not about efficacy at different points in the cycle. Women need to know exactly when to use both types of EC (especially when the pill may not work effectively, or when the condom has failed), the time period during which EHC can work, when EHC might fail, and where and how women can access the IUD as emergency contraception.

6. **Provide an advance supply of EHC for women using user-dependent methods of contraception**
   For women who choose to use a user-dependent method of contraception, it would be beneficial to offer them an advance supply of EHC. This includes women who are prescribed the pill or condoms from GP/sexual health services, as well as those who opt for a user dependent method post abortion. An advance supply of EHC would enable women to take it as soon as needed, thus utilising it at its most effective.

Fertility knowledge

7. **Improve fertility awareness among young women**
   Young women would benefit from an improved understanding about how their body and cycle work in reproduction, as well as about when EHC might fail (in addition to time limited factors). In particular, service providers as well as other sexual health education sources need to highlight the quick return to fertility immediately after abortion.

Abortion experience

8. **Develop improved pathways between abortion providers, and local contraception services including General Practice, both pre and post abortion**
   There is a need to improve communication between abortion providers and locally based sexual health services. This would not only make it easier for women to be followed-up after their abortion, but could help to de-stigmatise abortion. Young women should not experience unnecessary delays in their referral, and self referral should be as broadly publicised as possible. Young women also need to be informed of where to go for follow-up services after their abortion, bearing in mind that some young women may not wish to discuss contraceptive options at the time of their abortion.

9. **Recognise the important role of informal support networks**
   Participants valued knowing the experiences of others, and also having the support of family and friends. Thought might be given to allowing companions to stay with women for longer, and the role of partners/family could be considered in the context of the clinic and client flow. Additionally, a resource which tells the stories of real women's abortion experiences might help women undergoing an abortion to feel supported.

10. **Abortion providers should ensure that women are adequately prepared for side effects following a medical abortion**
    Many women described being in a great deal of pain, and of becoming very unwell following taking the second medical abortion pill. Providers need to ensure that women are fully informed of possible side effects, of both methods of abortion, at the first consultation when most women select their method. They should then be sensitive to women's individual needs for pain relief and other support at the time of their abortion.

11. **Abortion providers need to remain aware of the importance of sensitive, compassionate and non-judgemental care**
    Whilst women overwhelmingly described positive experiences at the clinic, it is clear that any negative experiences can cause unnecessary distress.

Post-abortion contraception

12. **Systematic and adequate commissioning of contraceptive consultation and provision at the abortion provider**
    Commissioners and providers need to give greater acknowledgement to the importance of this crucial aspect of the abortion service in order to enable time to ensure women's contraceptive counselling needs are met, to ascertain whether they feel confident to use contraception effectively, and/or understand where they can go for further contraception services if they prefer an alternative provider. If a woman's chosen method of contraception is not available (e.g. IUC following a medical abortion), or she is unwilling to discuss contraceptive advice, then providers need to supply a suitable bridging contraceptive method, provide a supply of EHC, and encourage women to access their local services to access their preferred method.

13. **Ensure adequate commissioning of specialist training for all providers of contraception**
    Commissioners need to ensure adequacy of competency-based training for provision and counselling about contraception, including emergency contraception, and sexual health among all non-specialist providers in primary care.

14. **Improve competency of all providers of contraception through specialist training**
    There is a need for improved competency-based training on contraception and sexual health among all non specialist providers in primary care, particularly as General Practices provide and counsel the majority of contraceptive care and young women may prefer to access these services for their contraception. In particular, as the contraceptive pill is still the method of choice for many women[2] – and this is widely provided in General Practices – more needs to be done to improve communication about the circumstances when the pill may fail to work, what women can do in regards to emergency contraception and where women can go if they have questions about the pill. It is important that all who provide contraception to women are familiar with the most recent Faculty of Sexual and Reproductive Healthcare (FSRH) guidance on all available methods.

Stigma reduction

15. **Reduce the stigmatisation of women who access abortion(s)**
    In the qualitative strand, the women's stories were characterised by abortion stigma, which was felt to varying degrees. A positive step would be for providers and policy-makers to talk about 'improving reproductive control' rather than 'preventing abortion'. Others could help establish the ordinariness of abortion, so that women who experience an abortion do not feel they have transgressed, or that they are alone. Ways to ensure that women are able to enter clinics without harassment need to be investigated. Sex and Relationships Education (SRE) also needs to include non-judgemental, non-moralistic, discussion of abortion within its remit.

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[2] www.hscic.gov.uk/catalogue/PUB15746/nhs-cont-serv-comm-cont-clin-eng-13-14-rep.pdf

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