Women’s experiences of having an early medical abortion at home

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Abstract

Objectives
The aim of this study was to assess women’s experiences of having an early medical abortion at home and to investigate how they perceive the information they were given before the abortion. The study also aimed at investigating possible differences between younger/older women, women with a partner/without a partner, women with different educational levels, women with a previous pregnancy/first-time gravidae and different gestational age.

Study design
The study is quantitative and cross-sectional with a descriptive and comparative design. Qualitative content analysis was used to analyze the open-ended questions. Semi-structured telephone interviews were conducted with 119 women who had gone through a medical abortion at home.

Results
One fifth of the women rated the analgesia provided from the clinic as bad or very bad. Older women, women who had gone through an earlier abortion and women who had previously given birth experienced the abortion as less painful than first-time gravidae did. Almost half of the women experienced the bleeding as more than expected and one quarter of the participants bled for more than four weeks. Many women found the information about the abortion procedure given by healthcare providers as good. However, some stated a lack of information especially about bleeding and pain.

Conclusions
The finding that women experience information about pain and bleeding insufficient suggests that information in those areas can be improved. Since one fifth of the women did not find the analgesia sufficient, routines of pain relief may need to be reviewed. A dose of extra oral analgesia to take in case of need could be an option for women having a medical abortion at home. The result that younger women, without previous experience of abortion or childbirth stated the pain worse, suggests that special attention should be given to those women.

Keywords:
Medical abortion; Home abortion; Information; Pain; Bleeding; Women’s experiences
Abbreviations

TOP = termination of pregnancy
EMA = early medical abortion
POC = products of conception
VAS = visual analogue scale
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INTRODUCTION

During 2011, 37 750 induced abortions were performed in Sweden, equivalent to 20.9 abortions per 1000 women of fertile age. In early pregnancy (up to nine weeks amenorrhea) the woman can choose between a medical or surgical abortion. The number of medical abortions is increasing and according to the statistics from the National Board of Health and Welfare, 89% of all abortions performed before nine gestational weeks are medical [1].

Medical abortion has been available in Sweden since 1992 and is a method that can be used up to a gestational length of 63 days/nine weeks [2]. According to Swedish national guidelines, a medical abortion starts with the ingestion of mifepristone and within two days after the administration of mifepristone, misoprostol is taken vaginally [3]. Since 2004 Swedish women have the possibility to choose whether they want to take the misoprostol in a clinic or at home, but the abortion is always initiated at the clinic [4].

The combined regimen of mifepristone followed by misoprostol has been shown to be a safe and effective method for medical abortion in early pregnancy [5-8]. Studies have shown that the rate of complete abortions varied between 93 and 98% [6, 9-18]. In 0.5-1.1% of the medical abortions the pregnancy continues [4, 6, 12, 14].

Serious complications with medical abortion are rare [9, 16, 19]. A review of 65 studies from 2004 described a frequency of diagnosed and/or treated infection after medical abortion in less than 1% [20]. In rare cases, the need of a blood transfusion has been reported [6, 17]. Side effects described are pelvic pain, nausea, fever, shivering, vomiting, headache, diarrhoea and dizziness. The symptoms were mostly mild to moderate [21].

One of the most common side effects is pain [21]. Earlier research has shown that women with a gestational age of 50-63 days, younger women and lower or null parity needed more or stronger analgesia [12, 22, 23]. Good pain relief is of great importance [3] and need for extra analgesia had a significantly negative influence on the women’s experience [10].

The bleeding after a medical abortion is usually similar to a rich and prolonged menstrual period [4]. Duration of the bleeding is very individual and varies between 8-30 days according to Wang, Huang & Li [24].

The combined treatment of mifepristone and misoprostol is as effective and safe during early pregnancy as the alternative vacuum aspiration, and is equally acceptable if the woman is
allowed to choose the method she prefers [25]. Earlier research have shown that most women are satisfied with choosing a home abortion and would opt for the same method again if needed, and also recommend it to a friend [10, 15, 26-30]. In one study having an abortion at home was described as a comfortable experience [31].

Since the number of home abortions has consistently increased since introduced in 2004, and probably will continue to rise, there is a need of more research on women’s experiences of home abortions. According to The National Institute of Public Health [32] there are no national guidelines for how information, medical care and follow up should be provided in relation to medical abortions at home. Previous research has mostly been focusing on women’s experiences of completing a medical abortion at home, in terms of satisfaction with the method. In earlier research it is hard to distinguish what information the women have received by the care-givers and how they assess it and if there are areas in which the information can be improved. When comparing different groups of women, it might be possible to distinguish group-differences and thereby enable care-givers to adjust the information better to each individual woman. Research has shown that women who are well informed and supported in their choices experienced good psychosocial outcomes from their induced abortion [33].

An abortion must, according to the Swedish law, be performed by a physician in a public clinic. However, the head of the clinic can since some years back delegate the medical procedure to specially trained midwives, leading to increased responsibilities of midwives. The midwife needs to know how women experience home abortions and how she perceives the information given. This study might put some new light on how the midwife best can prepare the individual woman and help her feel safe during the abortion at home.

AIM

The aim of this study was to assess women’s experiences of having an early medical abortion at home and to investigate how they perceive the information they were given before the abortion. The study also aimed at investigating possible differences between younger/older women, women with a partner/without a partner, women with different educational levels, women with a previous pregnancy/first-time gravidae and different gestational age.
MATERIALS AND METHODS

This study is a quantitative cross-sectional study with a descriptive and comparative design. The participants were recruited at the outpatient family planning clinic at a university hospital in Sweden, between November 2012 and February 2013. The sample size of 100 participants would be sufficient to respond to the aim of the study. All Swedish- and English-speaking women going through an early medical abortion at home were asked to participate in the study. The recruitment of participants was performed by one assistant nurse and during the days she was present at work 169 women opted for an early medical abortion at home. Language barriers excluded 12 women. Of 157 women who met the inclusion criteria 10 women choose not to participate for undocumented reasons. Three women who accepted to participate in the study were away during the interview period and 25 women could not be reached by telephone or chose not to participate via text message. This resulted in a response rate of 76%.

All women seeking an abortion saw a physician who determined gestational length by clinical examinations and vaginal ultrasound scans. The physician decided about abortion method in cooperation with the individual woman. The women who would go through an EMA at home then saw a midwife who gave additional information about the method and what the woman could expect at home, focusing on bleeding, pain, and side-effects. The midwife also handed out an information brochure about the procedure and telephone numbers to the clinic 24/7. After counseling, the women received mifepristone to take orally under supervision at the clinic. They were given misoprostol to take at home 36 to 48 hours later and instructions how to insert it vaginally. The patients received oral analgesics; paracetamol and ibuprofen, and rectal diklofenak to take in case of vomiting. Information about other ways to relieve the pain, such as heat and massage were given. The women were recommended not to be alone at home during the abortion. The midwife also informed the women about what signs should lead to contact with medical care, and that they should take a home pregnancy test four to six weeks after the abortion. Patients were given contraceptive counseling by the physician or the midwife.

After seeing the physician and the midwife, an assistant nurse informed the women about the study, both orally and by an information letter (appendix 1). She also informed them that the study was voluntary, that they could withdraw from the study at any time, and that participating in the study would not affect their medical care. The assistant nurse documented
all the women she asked to participate, so that the response rate could be calculated. The women who accepted to participate provided their phone number and their preference for the timing of the interview.

The time of the telephone interviews was set to approximately six weeks post-abortion to be able to investigate if the women had taken a home-pregnancy test four to six weeks after the abortion as recommended by the clinic. The day before the interview, the women were contacted via a text message with a suggested time for the interview. Women who did not answer the first telephone call were telephoned again after 15 minutes. If they still did not answer a new text message was sent with a suggestion for a new time for an interview. The authors then called twice with 15 minutes interval. Women still not answering were excluded. Since there were no English-speaking participants, all interviews were conducted in Swedish.

The questionnaire (appendix 2) was designed for a master thesis previous year, and re-worked by the authors and supervisor to optimally suit this study. It contained 31 questions, mainly structured, but some were open-ended. Four questions were socio-demographic (about age, language, partner and education) and three were about the woman’s reproductive history. One question asked for gestational length and one asked if the woman had taken a home pregnancy test after the abortion. Six questions were about information given from the clinic and two were about support at home. Two questions related to bleeding and five questions to pain/pain relief. A visual analogue scale (VAS) ranging from 0 to 10 was used for rating the intensity of pain. Contact with medical care was explored in three questions. One question asked if the woman would opt for the same method again if a future termination was required and if the answer was “no”, the woman had the opportunity to explain why not. The last open-ended question gave the participant the opportunity to comment freely on her experiences of the abortion.

The interviews were conducted five to eight weeks after the abortion due to logistical circumstances. Each interview started with information about the aim of the study and the respondents were assured that participation was voluntary and that they had the right to discontinue at any time. The telephone interviews lasted between 5 and 31 minutes with an average time of 12 minutes. The responses were documented during each telephone interview.

The data were analysed using the statistics program SPSS (Statistical Package for the Social Science, version 20). Comparisons between groups were made using Fisher’s Exact Test as
appropriate for nominal data. The Mann-Whitney U-test was used for ordinal variables. Differences were regarded as statistically significant if \( p < 0.05 \). Groups that were compared were younger/older women (divided by the median age of 26), women with a partner/without a partner, having children/not having children, previous abortion/no previous abortion, gestational age 4-7 weeks/gestational age 8-9 weeks and different educational levels. Women with an educational level up to senior high school were considered as a lower educational group and women who had continued to study at a postsecondary level or university were in the higher educational group.

The open-ended questions were categorised and analysed using quantitative content analysis, as described by Graneheim and Lundman [34]. The entire text was read by the authors separately to identify units of meaning which then were compared before they were coded and sorted into a number of categories.

The questionnaires were coded and kept separate from the name and telephone list. The results are reported at group level. The study was approved by the Regional Medical Ethics Committee in Uppsala, Sweden (No 2012-350).

RESULTS

Demographic characteristics of the participants

The mean age of the 119 women who participated in the study was 27.5 years and the median age was 26 years, ranging from 15 to 49 years. Most women (87%, n=104) spoke Swedish at home, 5% (n=6) spoke another language and 8% (n=9) spoke both Swedish and another language at home. Almost three quarters of the participants (74%, n=88) had a partner.

Three of the participants were only 15 years old and were therefore still in elementary school and a total of 67 women (56%) had elementary school or senior high school as their highest educational level. The rest of the participants (n=52, 44%) had a postsecondary or university education. Demographic characteristics are shown in Table 1.
Reproductive characteristics

A total of 66% (n=78) of the women had previously been pregnant. Almost half of the participants (45%, n=53) had one or more children and 44% (n=52) had had at least one previous abortion (Table 2).

Both the median and mean gestational length at the time of current abortion was seven weeks, ranging from four to nine (n=118). One participant did not remember how far pregnant she was.

Table 1. Demographic characteristics of the participants (N=119)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Per cent of all women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median (years)</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Mean (years)</td>
<td>27.5</td>
<td></td>
</tr>
<tr>
<td>Range (years)</td>
<td>15–49</td>
<td></td>
</tr>
<tr>
<td>Younger women (15-26 years)</td>
<td>67</td>
<td>56</td>
</tr>
<tr>
<td>Older women (27-49 years)</td>
<td>52</td>
<td>44</td>
</tr>
<tr>
<td><strong>Partner</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>88</td>
<td>74</td>
</tr>
<tr>
<td>No</td>
<td>31</td>
<td>26</td>
</tr>
<tr>
<td><strong>Language at home</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swedish</td>
<td>104</td>
<td>87</td>
</tr>
<tr>
<td>Swedish and another language</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Another language</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td><strong>Educational level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elementary school</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>Senior high school</td>
<td>51</td>
<td>43</td>
</tr>
<tr>
<td>Postsecondary school</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>University up to 3 years</td>
<td>24</td>
<td>20</td>
</tr>
<tr>
<td>University &gt;3 years</td>
<td>24</td>
<td>20</td>
</tr>
</tbody>
</table>
Table 2. Reproductive characteristics of the participants (N=119)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Per cent of all women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>41</td>
<td>34</td>
</tr>
<tr>
<td>Yes</td>
<td>78</td>
<td>66</td>
</tr>
<tr>
<td>Prior birth</td>
<td>53</td>
<td>45</td>
</tr>
<tr>
<td>Miscarriage</td>
<td>26</td>
<td>22</td>
</tr>
<tr>
<td>Extra uterine pregnancy</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Previous abortion</td>
<td>52</td>
<td>44</td>
</tr>
<tr>
<td>EMA at a clinic</td>
<td>25</td>
<td>21</td>
</tr>
<tr>
<td>EMA at home</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>Vacuum aspiration</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>Late medical abortion</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Experiences of pain

The participants rated their worst experienced pain during the abortion process on a Visual Analogue Scale from 0 = no pain to 10 = worst imaginable pain, shown in figure 1. The median was 6.

![Figure 1](image)

Figure 1. How the participants rated their pain on a VAS (N=119)

All except three women took the analgesia provided by the hospital. The majority stated the treatment was good or very good, 11% rated it as bad and 8% as very bad.

About one quarter of the participants (27%, n=32) took extra analgesia at home during the abortion or the days/week after. Analgetics used by the women’s own choice were paracetamol, ibuprofen, paracetamol/codein, diklofenak, naproxen, tramadol, acetylsalicylic
acid, and codein/coffein. Some women (n=22) commented that they needed analgesia for longer than the first day. When asked if they had done anything else to relieve the pain, 65% of the women (n=77) answered that they had. Five categories of non-medical pain relief were used as shown in table 3.

**Table 3.** Non-pharmacological pain relief used by the women (N=77)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heat</td>
<td>56</td>
<td>47</td>
</tr>
<tr>
<td>Rest</td>
<td>26</td>
<td>22</td>
</tr>
<tr>
<td>Shower</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Movements</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Massage</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Experiences of pain differed between the age groups. The older women rated their pain as less intense than the younger women did (p = 0.012). Differences in pain were found when comparing women who previously had been pregnant (p =0.006), had children (p = 0.000), and/or an earlier abortion (p = 0.030). They all rated less intensive pain than first-time pregnant women did. The participants who had someone present during the abortion rated the pain as worse than women who were alone did (p = 0.036). No differences were found regarding educational level, having a partner, or gestational length. Women who had children tended to more frequently rate the pain relief as good/very good compared to the group who did not have children (p= 0.02).

**Table 4.** Comparisons of rating pain on VAS between various groups of women

<table>
<thead>
<tr>
<th></th>
<th>Rated pain on VAS (median)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger women (n=67)</td>
<td>7</td>
</tr>
<tr>
<td>Older women (n=52)</td>
<td>5</td>
</tr>
<tr>
<td>Previous pregnant (n=78)</td>
<td>5</td>
</tr>
<tr>
<td>First time gravidae (n=41)</td>
<td>7</td>
</tr>
<tr>
<td>Prior birth (n=53)</td>
<td>5</td>
</tr>
<tr>
<td>No prior birth (n=66)</td>
<td>7</td>
</tr>
<tr>
<td>Previous abortion (n=52)</td>
<td>5</td>
</tr>
<tr>
<td>No previous abortion (n=67)</td>
<td>7</td>
</tr>
<tr>
<td>Someone present at home (n=105)</td>
<td>6</td>
</tr>
<tr>
<td>Alone at home (n=14)</td>
<td>4.5</td>
</tr>
</tbody>
</table>
Experiences of bleeding

One quarter of the participants (26%, n=31) stated the bleeding had been as expected, 43% (n=51) experienced it as more than expected and 28% (n=33) as less than expected (Figure 2). A majority (87%, n=103) of the women stated that they had received information about bleeding. Two women did not remember whether they were given any information about bleeding or not, and 14 women (12%) stated that they had not received any information. No differences were found between the groups regarding experiences of bleeding.

![Figure 2. How the women experienced the bleeding (N=119)](image)

One quarter of the participants (n=31) bled for more than four weeks and of these, 16 women bled for more than five weeks (Table 5).

**Table 5. How the women stated the duration of bleeding (N=119)**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 days</td>
<td>13</td>
</tr>
<tr>
<td>6-10 days</td>
<td>25</td>
</tr>
<tr>
<td>11-14 days</td>
<td>27</td>
</tr>
<tr>
<td>15-21 days</td>
<td>15</td>
</tr>
<tr>
<td>22-28 days</td>
<td>8</td>
</tr>
<tr>
<td>More than 28 days</td>
<td>31</td>
</tr>
</tbody>
</table>
Taking a home pregnancy test

Three quarters of the participants had not taken a home pregnancy test four to six weeks after the abortion as instructed by the midwife at the clinic. Of those, one third planned to take the test within a week and this was the most common reason for not having taken a test. Other reasons are shown in table 6. Among the 29 women who had taken a pregnancy test after the abortion, three showed a positive result. They had all taken the test less than four weeks after the abortion. One of those women planned to take a new test and one had got her menstruation back and she was therefore not planning to take another test. The last woman had had an ultrasound scan at the clinic showing remaining POC. Expectant management was however decided.

Table 6. Reasons for not having taken a pregnancy test (n=89)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy symptoms disappeared</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>Period back</td>
<td>17</td>
<td>19</td>
</tr>
<tr>
<td>Forgotten</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Confirmed with ultrasound scan</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Plan to take within a week</td>
<td>28</td>
<td>32</td>
</tr>
<tr>
<td>Going to take at the follow-up</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Could not afford a test</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Did not know you’re supposed to</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Still bleeding</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other reasons</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Contact with the clinic

All women had received telephone numbers in case they needed to contact the hospital. One quarter (n=30) of the women contacted the clinic and/or the medical guidance for different reasons. The reasons for contact were coded into six categories; lower grade of consciousness (n=1), doctor’s certificate (n=2), concern about still being pregnant (n=3), the abortion process (n=5), bleeding (n=9), pain/analgesia (n=13). Two of the women contacted medical care for both bleeding and pain.

Of the women who had contact with the medical care 11 visited the clinic and/or other medical personnel. Five of these booked an appointment and five went to the emergency room. One woman called an ambulance but did not need to go to the hospital. The reasons for visiting medical care were coded into four different categories; lower grade of consciousness
concern about still being pregnant \( (n=3) \), bleeding \( (n=4) \), pain/analgesia \( (n=5) \). In four of the women products of conception could still be verified by ultrasound scan. Two of these women needed curettage, one was treated with Mifepristone for three days and one was recommended to wait for her next menstruation. One of the women with an incomplete abortion needed a blood transfusion.

**Experiences of support and other information**

Of the participants 79\% stated that they had received good or very good information about different abortion methods and 16 women (13\%) considered the information to be neither good nor bad. Of all women, 80\% experienced that they completely or to a great extent had a choice to take the misoprostol at home or at the clinic.

The majority of the women 83\% \( (n=99) \) stated they had been offered to see a counselor in conjunction with the abortion, but 16 women had not had that offer. A few women \( (n=4) \) did not know or did not remember if they had been offered to see a counselor. Of all women nine had seen a counselor.

The majority of the participants (88\%) had someone close (partner, parent, friend, other) present as support at home during the abortion. Almost all (97\%) rated that support as good or very good. Most women (88\%) answered that they felt completely or very safe completing the abortion at home. It was completely clear how to administer the vaginal misoprostol for almost all women (96\%) but five women (4\%) were unsure.

**Opt for the same method again**

The majority of all women (83\%, \( n=99 \)) would opt for the same abortion method again if a future termination was required. Thirteen percent \( (n=15) \) would not opt for it again and 4\% \( (n=5) \) did not know. Women who would not choose an EMA at home again were asked for the reason why not. The reasons were coded into five categories; incomplete abortion and curettage \( (n=1) \), physical sensations such as pain, bleeding and nausea \( (n=9) \), seeing the embryo \( (n=2) \), feeling more safe in a clinic \( (n=6) \), would rather do a surgical abortion \( (n=5) \). No differences were found between the groups regarding preference for the same method again.
Other objections/Qualitative aspects regarding the abortion

A majority of the women chose to comment freely about their experiences of the abortion procedure. Their responses were coded and categorised into five main themes; **satisfied with the method, experiences of information, the way they had been treated, availability and follow-up** and **pain/analgesia**.

**Satisfied with the method**

Several participants said they felt satisfied with the method. They described it as good, very good or smooth and that it felt good to be at home.

**Experiences of information**

Many participants mentioned information in some way. Some were very satisfied with the information while others stated that they lacked information in different areas like bleeding, pain, the abortion process, expulsion of the fetus and the opportunity to see a counselor. Lack of or insufficient information about bleeding was most frequently mentioned.

*It would have been good to get information that one can bleed for more than four weeks.*

*Bled more after the abortion than when giving birth, would have liked information about that.*

Three women said that they had wanted information about the expulsion of the fetus.

*It was very hard when a big lump came out when I was in the shower. I had not understood that it would be so obvious when the embryo came, had a shock. Felt like pushing. Did not know what to do with the lump, had wanted information before about how it can be and what to do with the embryo. The pain you can take, the hard part was to see the embryo.*

Some participants made comments that the pain was worse than they had expected and that they had wanted information about this and what to do when the pain relief supplied from the clinic was insufficient.

Four women made comments about the lack of information about different abortion methods. Some women stated they did not receive much information about other methods, but that they had read about it themselves before seeing the doctor or midwife. Some participants also said they had wanted the offer to have the abortion at the clinic, even though they had decided to complete it at home.
How the women were treated

Most of the women mentioning the care givers approach rated it as positive. They described it in words like respectful, calm and professional, all which made them feel well cared for and safe. Women who were not satisfied with the approach often described a specific situation.

Two women said that they had been shown the embryo during the ultrasound scan which was something they had wanted to avoid. Three participants described that a student was present during the examination which they felt they had not have the opportunity to decline.

During the ultrasound scan at the clinic a student was present without anyone asking me if it was okay. It did not feel good at all but I did not dare to say anything about it.

Availability and follow-up

Some women stated that they had to wait too long before they got an appointment at the clinic but other women commented the opposite view. More flexible telephone availability was requested by some women. One woman who called the clinic during the abortion experienced that the thirty minutes waiting time before she was called back was too long when she was in pain.

It felt good that I got an appointment so fast, eight days from calling.

I felt that two weeks was too long to wait before we got an appointment for the abortion

Some women did not experience that they had been offered a follow-up visit at the clinic. Five women mentioned that it felt good to know that somebody was going to call them after the abortion (meaning this study).

Really good with a telephone call after, good to know that a follow-up is done.

Pain and analgesia

Many women commented about pain and pain relief in more ways than just lacking information about it. Several women mentioned they had pain for days or weeks after the abortion and that they needed to take analgesia during this time. Some of them described the pain as worse after the abortion day and that they had wished for more analgesia. Some participants had wished for something stronger to take in case of need.
Took ibuprofen for some days after the abortion since the pain was worse then than during the abortion.

Had wished for stronger pain relief to take in case I needed to.

DISCUSSION

Information in relation to a medical abortion completed at home can be seen as the main theme that connects all parts of this study. The results mainly focus on information about bleeding and pain and whether this information was perceived as good or bad, sufficient or not.

The participants rated their pain on a VAS, resulting in a median value of 6. Most women found the analgesia provided by the clinic to be good or very good but a fifth of the women rated it as bad or very bad. Differences in pain were found in relation to age, experiences of previous abortions, having children and having a support person at home. Almost half of the women experienced the bleeding as more profuse than they had expected. One quarter of the participants bled for more than four weeks. Almost all of the women experienced that they had received information about bleeding. The free comments, among other things, concerned information in different ways. Some women said that they had received “good information” in general whereas some women lacked information about various subjects. Insufficient information about bleeding was the most frequent comment.

Almost half of the participants in this study had previously had an abortion and the result shows that they experienced their pain as less intense compared to women who had not gone through an abortion earlier. Similar results were obtained in women who had previously given birth. Reasons could be that they knew what to expect or that they had experienced the same, or worse, pain before. Younger women in the study rated their pain as worse than older women did, which could have a similar explanation with previous experiences of abortions and/or births. Another reason could be that older women have learned to cope with pain better than younger women have. The result that older women and women who have previously given birth, experienced the abortion as less painful is supported by earlier research [23, 35]. Another study showed that the relative risk of using narcotic analgesics decreased in women with previous births and with increasing age of the woman [22]. Those studies did however not support our result regarding less pain in case of previous abortion experience. The finding
that younger women without experiences of earlier abortion and/or births, experience pain as more intense, suggests that the regimen of analgesia could be differentiated to optimize pain relieve for the individual woman.

Several studies [12, 22, 23] have shown that gestational length affects the experience of pain. This was not supported by our study. A reason for this could be that the gestational length was stated by the woman herself in our study, and therefore not entirely reliable. Although our result did not support this, it might still mean that when giving information and providing analgesics, consideration should be taken to the woman’s gestational length together with all other factors that might affect her experiences of pain.

An unexpected result was that women who had someone with them as support at home during the abortion rated their pain as worse than women without support did. Could it be that women, who feel safe and comfortable, in both themselves and the situation, do not deem it necessary to have someone with them, and therefore experience their pain as less intensive? Being uncomfortable and insecure may contribute to more pain. Unfortunately, our study sample was too small to draw such conclusions or to establish any association between pain and feeling safe during the abortion. One study [15] showed that being alone at home during the abortion did not make any difference regarding satisfaction with the method.

One fifth of the women in our study rated the pain relief provided from the clinic as bad or very bad, and about one quarter of the participants took extra analgesia during the abortion. This can be compared to another Swedish study [36] where more than half of the women required additional oral analgesia. The question in our questionnaire could not separate the women who took extra analgesia during the abortion day, from the women who took it the days/week to follow. This would have been interesting to know in order to better evaluate the women’s need for analgesia. Some women stated that they had taken more analgesia than recommended and that they had taken the same generic substance but under different names. This suggests that the information about what analgesia to take should be more precise, and that some women need more or stronger analgesia. One study showed that sufficient pain relief was associated with an overall high satisfaction of the abortion [37]. A dose of extra oral analgesics to take in case of need could be an option for women having an abortion at home. It would also have been interesting to know for how long the women were in pain since some women stated that they needed analgesics for an extended period of time.
Our result showed that almost half of the participants experienced the bleeding as more profuse than expected. This contradicts another study in which less than one fifth of the women stated the bleeding as “worse than expected” [38]. Earlier research has shown that the duration of bleeding differs between 7-33 days [24]. The current information provided at the family planning clinic is that the bleeding may last up to four weeks. Our study shows that several women bled for more than five to six weeks, although it was difficult to distinguish what was bleeding after the abortion and what was caused by newly provided contraceptives and/or that the women’s menstruation had returned.

Insufficient information about bleeding was frequently mentioned in the free comments, but at the same time our result showed that a majority of the participants experienced they had received information about bleeding. A study from 2006 showed that as much as 67% of telephone calls from women after a medical abortion were considered preventable and that giving sufficient information about bleeding might reduce the number of telephone calls [39]. This suggests that the information about bleeding can be improved. This is however a challenge since the experience of bleeding seems to be very individual and no specific group of women may be more at risk than others.

About half of the participants had not taken a pregnancy test or was not planning to take a test, even though instructed by the midwife at the clinic to do so. A common reason for not taking the test was that the symptoms of pregnancy had disappeared. According to a study by Jackson et al, one third of the women with incomplete abortions may not be identified if determined only by symptoms and abortion history [40]. Even though the prevalence of continued pregnancy after a medical abortion is rare, this risk could be included in the information to motivate women to take a pregnancy test. Another option would be to provide the women with a pregnancy test to take home for later use.

Even though the general recommendation for women is to have someone present during the abortion, 12% of the women stated they were alone. This can be compared to another study, were 8% reported that they had no adult at home [38]. Since there are risks with an abortion and difficulties to identify on beforehand which women will need support, this part of the counselling may need to be clarified.

We had not included any question about the expulsion of the fetus. However, four women spontaneously talked about their feelings about that part of the abortion and three of them said
that they had wanted information about the expulsion. In a previous study most women did not find it especially dramatic to see and handle the POC, although some felt uncomfortable at the sight [26]. Two women in that study stated that they were not prepared to see the embryo and that they considered all patients should receive information about what the POC would look like. This confirms what some of the women in our study said and it may therefore be important to stress the significance of informing women about the POC.

The participants in this study were recruited at the family planning clinic by one assistant nurse. The recruitment process was thus conducted in the same way for all women. On the other hand, using one person for recruiting has its limitations because when that person is unavailable no women could be recruited. However, these non-recruited women were random and not systematic, which strengthens the study’s reliability.

Interviews conducted over telephone can provide a greater sense of anonymity than personal interviews, which may give more honest answers to questions of a sensitive nature. On the other hand, this method can pose a risk in that it is difficult for some women to talk undisturbed, leading them to be more cautious with their responses. To make it easier for women to talk privately, they were able to choose a time for the interview. They were also contacted by a text message the day before to confirm the time of the interview.

The drop-out analysis showed that the external non-response was quite low, the study had a response rate of 76%. Since the questions have been answered through telephone interviews the internal response rate was almost 100%. This implies both a good reliability and validity. We do not know anything about the women who chose not to participate but it can be presumed that they might differ from our study subjects and therefore not making our result generalizable for all women. Another reason for not making our result generalizable for all women is that non Swedish- and English-speaking women were excluded. It is also a limitation that the participants were recruited at only one clinic in a university city, although the catchment area includes both rural and urban areas.

The questionnaire had some limitations. The terms “during the abortion” and “in conjunction with the abortion” were unclear since the participants could refer both to the abortion day and to the days/week to follow. The question about how the women were treated by the caregivers concerned only if the women had contacted medical care due to complications. It would have been more interesting to investigate how the women felt about the care-givers’
approach during the whole abortion process. The question about information about bleeding could have been more detailed to clarify whether the women had received sufficient information. It would also have been interesting to investigate the participants’ expectations of pain and to compare those expectations to what they later had experienced.

The women stated gestational length themselves. We realized that women express gestational length in different ways and it would therefore have been better if the recruiting assistant nurse at the clinic had documented the gestational length on the recruitment list.

CONCLUSION

Many women found the information about the abortion procedure given by healthcare providers as good. However, some experienced the information to be insufficient. The finding that women experienced information about pain, pain relief and bleeding insufficient suggests that information in those areas can be improved. Differences could be seen in experiences of pain between compared groups of women, implying that the midwife needs to be perceptive of the individual woman and adjust the information to each woman. Special attention should be given to younger women without previous experience of abortion or childbirth, which could contribute to higher satisfaction with care and an improved feeling of safety and well-being during the home abortion process. Since one fifth of the women did not find the analgesia sufficient, routines of pain relief may need to be reviewed. A dose of extra oral analgesia to take in case of need could be an option for women having a medical abortion at home.

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ADDITIONAL BACKGROUND

The abortion law
Sweden’s first abortion law is from 1938 and allowed abortion only on very limited indications after being tried by the Board of Medical Health. In 1946 the law was liberalised, but approval from the Board of Medical Health was still mandatory. The current abortion law was enforced/implemented in 1975 [1]. According to that law the woman can decide herself about TOP until 18 gestational weeks. After that an abortion can be approved by the National Board of Health and Welfare, if there are very specific reasons for the abortion, for example if there is a risk for the woman’s life or health. When the fetus is capable of life outside the uterus, an abortion may no longer be performed [41]. This practically means that abortion is no longer possible after 22 weeks of pregnancy [2].

Statistics in Sweden
During 2011, 37,750 abortions were performed in Sweden, equivalent to 20.9 abortions per 1000 women of fertile age. Of all abortions during 2011, 79% were performed before the ninth gestational week. In early pregnancy (up to nine weeks amenorrhea) the woman can choose between a medical or surgical abortion. The proportion of medical abortions is increasing and according to the statistics from the National Board of Health and Welfare, 89% of all abortions performed before nine gestational weeks are medical [1].

Medical abortion
Medical abortion has been available in Sweden since 1992 and is a method that can be used up to a gestational length of 63 days [2]. A medical abortion begins with the ingestion of mifepristone, which is anti-progesterone that induces a miscarriage by a local progesterone deficiency. Mifepristone affects the endometrium, myometrium and cervix. Complications after this part of the treatment are few. Within two days after the administration of mifepristone, misoprostol is taken vaginally, a prostaglandin which induces uterine contractions and has an effect on the cervical ripening [3]. Since 2004 Swedish women have the possibility to choose whether they take the misoprostol in a clinic or at home, but the abortion is always initiated at the clinic [4].
Safety, complications and side-effects

The combined regimen of mifepristone followed by a prostaglandin analogue has been shown to be a safe and effective method for medical abortion in early pregnancy [5 – 8]. Studies have shown that the rate of complete abortions varied between 93 and 98 % [6, 9-18]. In 0, 5-1.1% of the medical abortions the pregnancy continues [4, 6, 12, 14]. Some studies have shown that women with longer gestational age needed surgical intervention more often [42].

Serious complications with medical abortion are rare [9, 16, 19]. A review of 65 studies from 2004 described a frequency of diagnosed and/or treated infection after medical abortion in less than 1% [20]. In rare cases, the need of a blood transfusion has been reported [6, 17]. Side effects described are pelvic pain, nausea, fever, shivering, vomiting, headache, diarrhoea and dizziness. The symptoms were mostly mild to moderate [21].

Pain and bleeding

One of the most common side effects is pain [21]. Earlier research has shown that women with a gestational age of 50-63 days, younger women and lower or null parity needed more or stronger analgesia [12, 22, 23]. Good pain relief is of great importance [3] and need for extra analgesia significantly influenced women’s experiences [10]. In one study it was found that ibuprofen was more effective than paracetamol for pain reduction during medical abortion [43].

The bleeding after a medical abortion is usually similar to a rich and prolonged menstruation [4]. Duration of the bleeding is very individual and can vary between 8-30 days according to Wang, Huang & Li [24].

Experiences of a medical abortion at home

The combined treatment of mifepristone and misoprostol is as effective and safe during early pregnancy as the alternative vacuum aspiration and is also equally acceptable if the woman is allowed to choose the method she prefers [25]. Earlier research have shown that most women were satisfied with their choice of home abortion and would opt for the same method again if needed, and also recommend it to a friend [10, 15, 26-30]. In one study the majority of the women preferred to complete an EMA at home rather than in a clinic. The majority found home management very or somewhat acceptable [45]. In a study from 2009 the majority of the women included considered their home-abortion to be ‘as expected’ or ‘easier than expected’ and rated their physical symptoms as ‘expected’ or ‘easier than expected’ [26].
Kopp Kallner et al showed that the safety and experience of taking misoprostol at home did not differ between women with a gestational age up to 49 days compared to a gestational age of 50-63 days [10]. Studies have shown that women chose a medical abortion at home because it felt more natural and private and allowed the presence and support of a partner/friend who could care for them [15, 26, 44]. In one study having an abortion at home was described as a comfortable experience [31].

The importance of information
Since the number of home abortions has consistently increased since introduction in 2004, and probably will continue to rise, there is a need of more research on women’s experiences of home abortions. According to The National Institute of Public Health [32] there are no national guidelines for how information, medical care and follow up should be provided in relation to medical abortions at home. Previous research has mostly been focusing on women’s experiences of completing a medical abortion at home, in terms of satisfaction with the method. In earlier research it is hard to distinguish what information the women have received by the care-givers and how they assess it and if there are areas in which the information can be improved. When comparing different groups of women, it might be possible to distinguish group-differences and thereby enable care-givers to adjust the information better to each individual woman. Research has shown that women who are well informed and supported in their choices experienced good psychosocial outcomes from their induced abortion [33].

An abortion must, according to the Swedish law, be performed by a physician in a public clinic. However, the head of the clinic can since some years back delegate the medical procedure to specially trained midwives, leading to increased responsibilities of midwives. The midwife needs to know how women experience home abortions and how she perceives the information given. This study might put some new light on how the midwife best can prepare the individual woman and help her feel safe during the abortion at home.
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