Multiple Abortions: The women who request them and the staff who provide them

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Abstract

Purpose

There has been little qualitative research on abortion care in the UK, which explores the voices of women who have undergone this procedure. Previous research has focussed on clinical research into the safety and efficacy of abortion, the characteristics of those requesting abortions, whether abortion has a detrimental impact on women emotionally or physically and how to utilise contraception methods especially long acting reversible contraception (LARC) within this group. The aim of this research is to investigate women's experiences of multiple abortions and the experiences of staff who provide those abortions and from those experiences what would work to help reduce multiple requests for abortions.

Methods

Ten women who had requested multiple abortions and twelve staff members who worked in an abortion service, were interviewed about their experiences of multiple abortions. Their interviews were transcribed verbatim. Thematic analysis was performed on the interviews which generated themes.

Results

Three main themes were identified within the data. The first theme the psycho-social-political impact of stigma presented evidence that stigma is pervasive in abortion work and impacts on all levels from the interpersonal to public policy. The second theme was the experience and expectation of avoidant style coping,

presented evidence that women within this study utilised an avoidant style of coping, which is maladaptive. The final theme imperfect contraception examined how the side effects of contraception impact on women's view and use of contraception. This theme also explored the 'feminisation of contraception' and the lack of male involvement.

Conclusions

Abortion is a gendered health care provision in which the burden is on women however, due to the stigmatised nature of this the power does not lie with the individual women themselves.

Introduction

"They don't get pregnant twice unless they're hopeless" (Doctor cited in (Allen, 1981, p. 71))

Historically, abortions have been carried out for millennia and can be traced back to ancient times (Devereux, 1971; Potts et al., 1977). They were first mentioned in British law in the 13th century, occurring before the 'quickening', as in Christian teaching this is when the soul entered the foetus (Abortion Rights, 2014). Suggesting that abortion was legal however, it is likely that midwives who carried out abortions were routinely persecuted as witches (Joffe, 2009). In the 19th and early 20th centuries the law began to change which made it illegal for women to obtain abortions before or after the quickening. However, women continued to use pills, tonics and douches for 'female ailments' as well as homemade abortifacients such as, penny-royal tea (Lewis, 1984). If these methods did not have the desired effect women would seek out abortionists, this would increase the likelihood of death or injury due to risk of infection (Beaumont, 2007).

During the 19th and early 20th century there was a shift from the traditional female knowledge regarding pregnancy, to the male dominated medical expertise (Fyfe, 1991). Also, at this time the onus of abortion legislation shifted from criminalising doctors to criminalising women themselves; therefore, legitimising medical abortions carried out by male medical experts (Amery, 2015). Criminalising abortions that were performed outside the clinic and usually carried out by women (Fyfe, 1991)

increasing the risk of mortality and morbidity due to infections (Beaumont, 2007). These changes medicalised pregnancy and also criminalised women's bodies; positioning power to men over this arena of women's lives.

During the 1930's a number of women's groups began campaigning for legal and safe abortion in an effort to reduce the number of maternal deaths that were attributed to illegal abortions. The incidence of abortion and thus maternal deaths increased in the interwar period (Beaumont, 2007) in 1930, 10.5% of all maternal deaths were attributed to illegal abortions and this rose to 20.0% by 1934 (Brookes, 1988). In 1938, the Birkett Committee Inquiry into abortion found that "many mothers seemed not to understand that self-induced abortion was illegal" (Lewis, 1984, p. 18). In fact, abortion was often considered more respectable than internal contraceptives, which were fitted at birth control clinics (Brookes, 1988). In 1934 there was a landmark case where a doctor had performed an abortion on a young girl aged 14 years who had been raped, he argued that this was the right course of action and was acquitted. Cementing the importance of doctors' decision making in abortion. In 1934 it was estimated that 64,000 illegal abortions took place (Brookes, 1988), while estimates for the years prior to legalisation in 1967 suggest that over 100,000 illegal abortions took place each year (Callahan, 1970; Diggory, 1970). In 1944 George Orwell commented that abortion is theoretically illegal but was "looked upon as a peccadillo" (Brookes, 1988, p. 22). Suggesting that although abortion was technically illegal it did have some social acceptability.

There is no right to abort in British law, at least if a right is understood as implying the freedom to exercise a choice for any or no reason (Scott, 2016). Abortion is still a crime, the lawful grounds for which are instantiated in the Abortion Act 1967 (as amended by the Human Fertilisation and Embryology Act 1990). The Abortion Act 1967 brought an end to the serious medical and social problems of 'backstreet abortions' (Potts et al., 1977). Although it did not replace the Offences Against the Person Act 1861 only supplemented it. The Offences Against the Person Act 1861 refers to the unlawful administration of any poison or other noxious thing or use of an instrument or other means with intent to procure a miscarriage. Section 58 refers to the woman herself and any other person intending to procure an abortion; Section 59 covers supply or procurement of the means (Rowlands, 2012).

However, abortion is not criminalised under section 1 of the amended Abortion Act 1967 if two doctors judge in 'good faith':

1. That the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family
2. That the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman
3. That the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated
4. That there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Medical practitioners use seven grounds to justify an abortion set out on the HSA4 form to report to the Department of Health, these are:

A. The continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated (Abortion Act, 1967 as amended, section 1(1)(c))
B. The termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman (section 1(1)(b))
C. The pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman (section 1(1)(a))
D. The pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of any existing children of the family of the pregnant woman (section 1(1)(a))
E. There is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped (section 1(1)(d))

or, in an emergency, certified by the operating practitioner as immediately necessary:

F. To save the life of the pregnant woman (section 1(4))
G. To prevent grave permanent injury to the physical or mental health of the pregnant woman (section 1(4))

The majority of abortions are carried out under section 1 (1)(a) of the Abortion Act and in 2018, 97.7% of all abortions carried out were under Ground C (Department of Health, 2019). Where there is solid evidence on which a doctor may reach a good faith determination that an early termination is indicated having an abortion is considerably safer than carrying a pregnancy to term. Whilst this 'statistical argument' (as it is referred to) has been known for some decades, it has gained more force as the medical evidence base has developed over the lifetime of the Act (Sheldon, 2016). Women's access to abortion is still, 50 years on, dependent on the agreement of two doctors. Meaning that although abortion is a safe medical procedure, women are still not trusted to take full responsibility for their own decisions regarding whether or not to have an abortion.

In Britain, where abortion is safe women can be assured that major complications and mortality are rare at all gestations (Lohr et al., 2014). With an overall complication rate of less than 1%, obtaining repeat procedures does not present significant health risks (Prager et al., 2007). The abortion mortality rate is 0.6 deaths per 100,000 which is far lower than that associated with childbirth, which is 8.76 per 100,000 (Knight et al., 2017). Major complications occur in 0.7 per 1000 first trimester surgical abortions and hospital admission or blood transfusions are needed in four of every 1000 women undergoing early medical abortion. No associations between induced abortion and ectopic pregnancy, infertility, placenta previa, or miscarriage have been proven (Lohr et al., 2014). Medical abortion does not differ from surgical abortion with respect to these risks. A link between surgical, but not medical abortion, and a subsequent preterm birth has been reported but a causal

association has not been established (Lohr et al., 2014). Even though abortion is a safe procedure from the inception of the Abortion Act 1967 there have been many attempts to restrict access to abortion via Parliament (Boyle, 1997).

More recently, there has been a political shift to improve access to abortion. Diane Johnson, MP for Hull North, introduced her Reproductive Health (Access to Terminations) Bill under the 10-minute rule the House of Commons on Monday 13th March 2017. The bill calls for the scrapping of sections 58 and 59 of the Offences Against the Person Act 1861, which makes abortion a criminal offence. The bill has cross party support and was passed with a vote of 172 to 142; however, it has not been able to progress any further (*Reproductive Health (Access to Terminations)*, 2017). Although this bill could not progress further in decriminalising abortion, areas of the UK have improved access to abortion with the reduction of restrictions about provision of 'abortion pills'; where women are allowed to take misoprostol at home. These changes are enhancing and improving access to services with the knowledge that abortion is a common gynaecological procedure. Being able to take the tablets at home increases women's control over their own abortion and also reduces time in clinic appointments. Increasing women's choices with offering self-management of abortion can also improve patient knowledge, understanding, confidence and coping ability (Foot et al., 2014).

As can be seen from the beginning of this introduction, historically abortion has been viewed through the prism of the legal system. Seeing abortion as a legal issue has excluded any dialogue regarding either the human medical interaction that takes

place or regarding the experiential views of women, which are both topics for health psychologists.

Epidemiology

Nearly 50% of pregnancies in the UK are unplanned (Bury & Ngo, 2009; Kishen & Belfield, 2006; Kost et al., 2008) and approximately one-fifth of conceptions end in legal abortion. This is despite over 70% of women, aged 16-49, using some form of contraception (Kishen & Belfield, 2006). One in three women will have an abortion before the age of 45 in Britain (Regan & Glasier, 2017) and one in three of those women will go on to have a subsequent abortion (Department of Health, 2018).

In 2018 a total of 200, 608 abortions were performed for residents of England and Wales (Department of Health, 2019). This equates to a rate of 17.4 abortions per 1000 women aged 15-44 years. With 78, 998 classified as repeat abortions, which is an increase of 1% since 2017. An increase of 6% in the proportion of women requesting a repeat abortion from 33% in 2008 to 39% in 2018 (Department of Health, 2019). Repeat abortions are more common in women over 30 (Department of Health, 2017, 2018, 2019; Prager et al., 2007).

What are repeat abortions?

The Department of Health counts any subsequent abortion from an index abortion as a repeat abortion (Department of Health, 2019). The Department of Health brought this indicator in to measure how well abortion services were providing contraception (L. Massey, personal communication 2nd May 2016) as in healthcare

policy, abortion is used as a proxy indicator of a problem with contraception (Beynon-Jones, 2013). However, having one abortion aged 16 then a subsequent abortion at aged 42 is quite different to have several abortions in a shortened timeframe. Women's contraception needs change throughout the life course and having two abortions with a vast timescale in between are not indicative of a problem with adherence to contraception. Whereas, having multiple abortions in a shortened time could be indicative of an issue with uptake and adherence to contraception.

Researchers use different time frames to assess whether a subsequent abortion is a repeat. Some of these timeframes are based on inter pregnancy intervals (IPI). IPI's have come to the fore, as we understand that having well-spaced pregnancies are beneficial for both mother and child (Conde-Agudelo et al., 2006; Hegelund et al., 2018; Shachar et al., 2016; Shachar & Lyell, 2012; Wendt et al., 2012; Zhu, 2005). Some researchers have used a twelve month inter abortion interval (Alouini et al., 2002) whereas, other have used a twenty-four-month interval (Crittenden et al., 2009; Das et al., 2009; Gispert et al., 1984). Researching women who have a shorter inter abortion interval focuses on those women who may be having a 'crisis with contraception' (Meyrick, 2001). However, having no consensus on what constitutes a problematic repeat abortion makes it difficult to compare studies that have researched the phenomenon.

Rose et al. (2015) in their retrospective cohort study of 6767 women found that 11% returned for a second abortion in twenty-four months and this rose to 20% at forty-eight months. Kilander et al. (2016) found that 24% of their participants returned for

repeat abortion within thirty-six and forty-eight months. This is in line with the conclusions of Stone & Ingham (2011) finding that the median time lapse between abortions is forty-one months, with a third of abortions taking place within twenty-four months. St. John et al. (2005) performed a retrospective case note review of 358 women having an abortion in which 26% had had a previous abortion. The median time interval between requests was thirty-six months (range of 4–186 months). Only 10% of women had inter-abortion intervals of fifteen years or more (Stone & Ingham, 2011). The main issue for researchers is timeframes that are imposed on them with a longitudinal analysis being of importance. These studies are all based on timeframe analysis and do not take in the individual differences of women who present for abortions and repeat abortions. Rapid repeat abortions could be indicative of a women's relationship, or lack thereof, with contraception. Although it could be much more indicative of what is going on for that woman personally rather than just her contraception use/non-use.

Health Psychology and Contraception

Post abortion ovulation can resume within eight to twenty-one days, with no differences between medical or surgical abortions (Cameron et al., 2012; Curtis et al., 2010; Goodman et al., 2008; Hognert et al., 2016; Lohr et al., 2014; Marrs et al., 1979; Sääv et al., 2012; Schreiber et al., 2011). Likewise, the initiation of sexual intercourse takes place quickly post abortion with 15% of women resuming sex in the week following a medical abortion and more than 50% resuming within two weeks (Boesen et al., 2004; Hognert et al., 2016; Sääv et al., 2012). Therefore, women who wish to use a contraceptive method should start as soon as possible after the

procedure. Provision of long acting reversible contraception immediately after abortion as it is highly effective and has the potential to prevent subsequent unintended pregnancy and abortion (Cameron et al., 2012; Heikinheimo et al., 2008; Hognert et al., 2016, 2016; Lohr et al., 2014; Rose & Lawton, 2012; Winner et al., 2012). Women's motivation to use effective contraception at time of abortion may be high (Bulut, 1984; Cameron et al., 2012). Although effectiveness of contraception is important from the view of reducing repeat abortions other non-contraceptive effects may be more important to women. Leading them to be happier with less effective methods of contraception because that method fits into their lifestyle (Wigginton et al., 2015).

When a woman is requesting an abortion, she is directly/indirectly saying something about contraception either 'didn't use it', 'didn't use it effectively' or 'used it effectively and it failed' (Boyle, 1997). However, abortion and contraception are not simply alternatives they comprise of a network of interrelated attitudes and decisions which may even be interdependent (Petchesky, 1990). Medicalisation of contraception has placed the priority on technical efficacy in evaluating contraceptive methods in a way that sometimes minimises or denies women's concerns about their health or personal needs.

Health psychology research has mainly focussed on preventing either unwanted pregnancies or sexually transmitted infections. This has been done through targeting of high-risk groups such as adolescents or by researching ways to reduce high risk behaviours such as non-condom use. Health psychology has utilised social cognitive

models which have been used to help understand, predict and change health related behaviours (Conner & Norman, 1998). These approaches provide insight into some of the factors underlying individuals' decisions and intentions, specifically, whether to use or not use contraception. There are over 80 social cognitive models used in health psychology but not all have been used in the contraception field. There are several models which have been used to explain contraception use/non-use. The main 2 used in this field include the Theory of Planned behaviour (TPB) and The Health Belief Model (HBM). Newer models such as the behaviour change wheel have been well utilised in smoking cessation behaviour but have yet to be seen in contraceptive use behaviour. Although both the TPB and HBM are older models and have some issues (Mielewczyk & Willig, 2007) they will be examined here to explore what they can tell us about contraceptive use behaviour.

Some have argued that social cognitive models were designed to predict and explain illness behaviours to remedy a disease or preventative health behaviours to avoid disease (Fisher, 1977; Hall, 2012). Contraception use/non-use is a unique health behaviour as pregnancy is not a disease that a woman always wishes to avoid (Hall, 2012). For this reason, some have argued that social cognitive models may not be appropriate in contraception use for pregnancy prevention (Fisher, 1977). Although others deem social cognitive models as appropriate (Hall, 2012; Herold, 1983; Hester & Macrina, 1985; Roderique-Davies et al., 2016). It could be argued that social cognitive models are both rational and epidemiologic (Schensul, 1998). Rational models may not be the most useful in trying to change behaviour related to sexual health (Bailey et al., 2015). The motivation to prevent disease may differ from that

to prevent pregnancy and consequently the types of theories and models used could also differ.

Roderique-Davies et al. (2016) in their cross-sectional study of 128 women attending a community sexual health clinic found that the TPB and the HBM accounted for 75% of the variance in intention to use long acting reversible contraception. Within the linear regression the constructs with the greatest predictive power were perceived benefits (HBM), subjective norms (TPB) and cues to action (HBM). However, within the logistical regression model there was a negative relationship between perceived behavioural control (TPB), perceived barriers (HBM) and health motivation (HBM). Indicating that these variables predicted non-LARC use. Suggesting that the relationship between constructs of the HBM, the TPB and intention to use LARC are complex and not straightforward. DeMaria et al. (2017) in their cross-sectional study of 547 women found that attitude and subjective norm significantly predicted intention of LARC uptake among reproductive-aged women. In a further study (DeMaria et al., 2019) of 186 college women they found that all the constructs of the TPB influenced intention to move from an oral contraceptive pill to LARC. These three studies show that both the HBM and TPB have good predictive power when researching contraception use, but they also show that there is a lack of universality in findings. These studies have only looked at routine contraception and not at emergency or post-coital contraception.

It has been suggested that emergency contraception also has a role to play in reducing abortions (T. Turnbull, personal communication 13th March 2020). Again,

the most utilised health psychology theories have been the HBM and TPB. Researching emergency contraception from a health psychological perspective has its own problems as it is only used after either non-use or a failure of regular contraception. Griggs et al. (2013) used the TPB to test the intention to use emergency contraception with 420 utilising a web-based survey. They found that attitude and subjective norm predicted intention to use emergency contraception, but perceived behavioural control did not. The model accounted for 49.2% variance in intention to use emergency contraception. In line with the above studies on regular contraception. Kelsey (2016) specifically examined offering and uptake of the intrauterine copper device (IUCD) as both an emergency contraception and to be continued as a LARC within an HBM framework. Kelsey (2016) developed a flow chart for staff offering the 3 different methods of emergency contraception to aid in discussion. As well a training session for staff and other promotional and information leaflets. The uptake of the IUCD as an emergency contraception method was 3% before the intervention which increased to 11% post intervention. Suggesting that materials that have been produced within an HBM framework are acceptable. Although, individual studies provide us with some evidence of the usefulness of these modes systematic review can help consolidate that.

In their Cochrane review examining theory-based interventions for contraception Lopez et al. (2016) found that researchers utilised 9 models either independently or utilising several components, including TBP and HBM. The review noted that the quality of evidence was moderate and most of the included studies focussed on adolescents' mums with the point of reducing subsequent pregnancies. There was

some evidence that those in the intervention groups used more effective contraception post intervention and/or use condoms consistently and were less likely to have second births. However, they reported that research could be clearer about how the theory was used to design and implement the interventions. Especially as some trials only used parts of the theories or models. They also found that trials combined models and thus they were unable to determine what parts were used and what may have worked. They also suggested that a model or theory was chosen to complement the intervention rather than drive the intervention development. The information was not sufficient in many cases to assess theory implementation, thus suggesting that more work is needed in the mapping between theory and intervention.

Mielewczyk & Willig (2007) have noted that even with continued efforts to increase the explanatory and predictive power of these models, the variance in behavioural outcomes left unaccounted can be as high as 50% to 80%. Suggesting that they only have limited capacity to explain or predict sexual behaviours such as contraception use. However, social cognitive models are poor at predicting behaviour (Stainton-Rogers & Stainton-Rogers, 2001). Most social cognitive models use the intention to perform a behaviour rather than the behaviour itself. This has led to the intention behaviour gap (Abraham et al., 1999). Which suggests that there is a discrepancy between measured intention and actual behaviour.

Some have argued for the need to employ behavioural change theory in contraceptive counselling (Akinola et al., 2019). Although, contraception is a

preference-sensitive choice, raising the question of how to think of a behaviour change model in the contraceptive counselling setting. Theoretically, specialised contraception counselling should increase uptake of effective contraception methods thus reducing the rates of unintended pregnancies. This should also be the position at time of abortion to reduce repeat abortion rates (Matulich et al., 2014). Some researchers have reported that specialised contraception counselling increases uptake (Gibbs et al., 2016; Yassin & Cordwell, 2005) whereas, others have reported no significant differences (Petersen et al., 2007). Two previous systematic reviews (Carneiro Gomes Ferreira et al., 2009; Stewart et al., 2016) both concluded that there was no evidence to support effective contraception counselling on uptake of contraception (Carneiro Gomes Ferreira et al., 2009) and more specifically LARC (Stewart et al., 2016). Stewart et al. (2016) also concluded that enhanced contraception counselling had no impact on repeat abortion rates. In response to this a systematic review was completed on research that investigated social, psychological or educational interventions to reduce repeat abortions rather than the narrow definition of contraception counselling (see next section for full review). This review concluded that women who have abortions are at risk of further unintended conceptions and their attendance at a service is an ideal time for interventions to reduce repeat abortions. The review found moderate evidence of effectiveness of interventions in this higher risk group. The stronger evidence favoured utilising enhanced contraceptive counselling (theoretically based approaches) and mobile phone based 'prompt' technology to increase contraception use. However, there was no strong evidence of longer-term effectiveness or effect

on repeat abortion itself. Further development of targeted approaches for women that could be delivered alongside existing services is needed.

Health Psychology and Abortion

Reviewed within this section is the literature on abortion that examines the sociopsychological nature of repeat abortions. Researchers have taken different views as to why repeat abortion is either problematic or explainable or both. Some researchers propose that abortion is associated with co-occurring risk factors examining both systemic and personal characteristics. Whereas others suggest abortion should be understood within the stress and coping perspective (Lazarus & Folkman, 1984). Thus, the cognitive appraisal of abortion can be a way of resolving stress associated with an unwanted pregnancy and hence can lead to relief; or abortion can engender additional stress of its own (Major et al., 1998). Others place abortion within the sociocultural context examining the effects of stigma (Major & O'Brien, 2005). All these perspectives are important and may help to provide an explanation of repeat abortions.

It has been well documented that there are social factors that influence unintended pregnancies especially those that occur in adolescence (Raneri & Wiemann, 2007; Rowlands, 2010). These include the father being three or more years older than their partner, having less family support, low educational attainment and lower socio-economic status (Raneri & Wiemann, 2007; Rowlands, 2010). More recently some studies have started to investigate whether the same applies for those requesting repeat abortions. Makenzius et al. (2012) found that there is a similar pattern for

those requesting repeat abortions as in adolescent unintended/unplanned pregnancy. They found that individuals who had a lack of emotional support, unemployment or sick leave, and low educational attainment were more at risk of repeat abortion.

This association between low education attainment and repeat abortion has been shown in several countries such as the UK (Stone & Ingham, 2011), USA (Jones et al., 2011), Sweden (Makenzius et al., 2011) and Finland (Väisänen, 2016). Stone & Ingham (2011) found that relative to women who left school aged 17 years or older, women who left school aged 16 years had over twice the odds of experiencing a repeat abortion regardless of whether they had gained qualifications (OR=2.36 95% CI 1.46-3.81) or had not (OR=2.61 95% CI 1.37-4.99). This could be interpreted that school engagement rather than qualifications is the protective factor against repeat abortion. However, other social factors are also linked with risk of repeat abortion.

There is similar evidence from several countries reporting on low socioeconomic status and the association with the increased likelihood of repeat abortion from UK (Das et al., 2009; McCall et al., 2016; St. John et al., 2005), USA (Jones et al., 2006; Steinhoff et al., 1979), Sweden (Makenzius et al., 2012) and Finland (Mentula et al., 2010; Niinimäki et al., 2009; Väisänen & Jokela, 2010). St. John et al. (2005) in the UK completed a retrospective case note review of 358 women having an abortion in 2000 where 26% had had a previous abortion, relative risk for the most deprived was (RR=1.63 95% CI 1.16 –2.29). Suggesting that women from poorer communities have an increased risk of attending for repeat abortions. This could be because women

from these communities are requesting abortions on economic grounds. Whereas, if they had a higher socio-economic status, they may not request abortions as they would be able to financially support a child. However, retrospective studies cannot make these associations, only by asking women their motivations will this be able to be answered.

Some studies have focussed on the individual differences between women who request one and women who request multiple abortions. Individual factors help us look at who attends clinics to have abortion and in turn who returns for multiple abortions. Studies have shown that slightly older women, rather than adolescents, are more likely to request repeat abortions (Berger et al., 1984; Department of Health, 2017, 2018, 2019; Fisher et al., 2005; Freeman et al., 1980; Leeners et al., 2017; Westfall & Kallail, 1995). Garg et al. (2001) found that the median age of women undergoing a subsequent abortion was 26 (range: 17-42) years. There was a statistically significant difference in the ages of women requesting first and subsequent abortions ($p = 0.0006$). St. John et al. (2005) found the relative risk for returning for a repeat abortion was age 25+ (RR=1.59 95% CI 1.12 –2.27). Prager et al. (2007) found the odds ratios for women requesting a repeat abortion were (OR=2.9 95% CI 1.5-5.7) for women aged 20-29 years and (OR=6.7 95% CI 2.8-16.0) for women aged 30 years old. It makes sense for older women to request multiple abortions are they have been fertile for longer. Age is more of a confounding factor than risk factor in repeat abortion.

Repeat abortions also seem to be linked to ethnicity. The Department of Health (2019) report that 47% of Black women requesting an abortion had had a previous abortion as compared to 39% White women, 34% Chinese women and 35% Asian women. Stone & Ingham (2011) found that Black, as compared to White women, were almost four times more likely to have sought more than one abortion (OR=3.76 95% CI 1.61-8.80). The differences between the statistics from the Department of Health (2019) and Stone & Ingham (2011) can only be explained due to underreporting on the NASTAL2, which is the data that Stone & Ingham (2011) utilised, showing that abortion is still a sensitive stigmatised issue. Other countries have reported ethnic differences in women requesting repeat abortions. In the USA African American women are more likely to request repeat abortions (Bracken et al., 1972; Prager et al., 2007; Westfall & Kallail, 1995). Other researchers have found that immigrants are at higher risk for repeat abortion in Canada (Fisher et al., 2005), the Netherlands (Leeners et al., 2017) and Switzerland (Picavet et al., 2013). Within the UK those individuals from ethnic minority backgrounds are more likely to live in low-income households (Equality and Human Rights Commission, 2016). This intersection between race and poverty raises the question again of whether women are making decisions regarding abortion based on economic/financial reasons. Having looked at the sociopsychological data presented between women who request one or request multiple abortions and having alluded to women underreporting abortions. Focus can now be shifted to the stigma regarding abortions and how it impacts on women requesting them.

In his seminal work around stigma, Goffman (1963, p. 12) defined it as, “an attribute that extensively discredits an individual, reducing him or her from a whole and usual person to a tainted, discounted one”. Regardless of the exact phrasing of a definition, most definitions of stigma have two things in common. Firstly, the assumption that stigmatised people possess some attribute or characteristic that makes them different than others. Secondly, that being different from others devalues or denigrates that person in the eyes of other people in society (Major & O’Brien, 2005). Kumar et al. (2009, p. 628) propose a definition of abortion stigma “as a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood”.

Shame and guilt are the two most common manifestations of abortion stigma (Bleek, 1981; Harris, 2012; Lithur, 2004; Mojapelo-Batka & Schoeman, 2003) and there is an expectation that women will feel this way because of their sexual conduct (Furedi, 2001; Løkeland, 2004; Norris et al., 2011). Hanschmidt et al. (2016) found that the majority of studies showed that women who have had abortions experience fear of social judgment, self-judgment and a need for secrecy. Social judgement for abortion depends on the values of the culture a woman is living in. The experience of abortion may also vary as a function of a woman’s ethnicity and culture. Thus, moral and religious values intersect with identities conferred by race, class, or ethnicity.

Such as, there may be different social judgements based on religion whether you are having an abortion in England or Wales as compared to Northern Ireland, even though both are part of the UK. The religious discourse in Northern Ireland has resulted in moral conservatism which has been viewed as a primary barrier to achieving equality for women (Bloomer & Fegan, 2014). It has been argued that in countries that have high church attendance are the least supportive of abortion and thus stigmatise abortion via these ecclesiastical structures (Mojapelo-Batka & Schoeman, 2003; Scott, 1998; Shellenberg et al., 2011). Cockrill & Nack (2013) in their study to examine individual level abortion stigma found that the four factors in question, worries about judgment, isolation, self-judgment and community condemnation, were related to religiosity. Catholic and Protestant women experienced higher levels of stigma than non-religious women (coefficients, 0.23 and 0.18, respectively). On the subscales, women with the strongest religious beliefs (including Catholic, Protestant, other Christian and other) had higher levels of self-judgment and greater perception of community condemnation than only somewhat religious women. These shared social, religious and cultural meanings of abortion are embedded in social reality and are formed through social discourse. This stigmatisation leads to silence and fear of social ostracism (Bloom & Fegan, 2014) which prevents women sharing their experiences of abortion.

Abortion stigma is considered a concealable stigma as it is unknown to others unless disclosed (Quinn & Chaudoir, 2009). Thus, it is only on disclosure that the full force of stigma can be realised according to Major & O'Brien's (2005) two-level definition. Secrecy and disclosure of abortion often pertain to women who have had abortions

but may also apply to other groups including abortion providers and partners of women who have had abortions (Moore et al., 2011; Norris et al., 2011). Hanschmidt et al. (2016) in their systematic review found that between 45%-64% of women in the quantitative studies reported that they had felt the need to keep their abortion a secret or had withheld information about the abortion from someone with whom they were close. Secrecy, feelings of guilt and shame are believed to weigh heavily upon people and may ultimately lead to high stress levels as people deal with the constant threat that someone may discover their secret (Breitkopf, 2004).

Concealment of a stigma can have a negative impact on a woman's physical and mental health and the process of keeping a secret can create a cycle of thought suppression with intrusive thoughts that may lead to psychological distress (Major & Gramzow, 1999). Thus, an individual's coping style is important in reducing or enhancing a stress response.

Coping refers to efforts to master, reduce or tolerate the demands created by stress (Weiten et al., 2008). Where the abortion is the stressful event, research has focussed on how women cope with this. Foster et al. (2012) found the most common emotions that women anticipate feeling after their abortion are relief (63%) and confidence (52%). Although, a significant minority anticipate feeling a little sad (24%) and a little guilty (21%) but only 3.4% anticipate poor coping. Major et al. (1985) found that women who had high coping expectations before the abortion coped much better than those with low coping expectations. Bandura (1977, 1982) termed these expectations self-efficacy and proposed that they affect both the initiation and

persistence of coping behaviour. Other factors which indicated that women coped less well were if their pregnancy was meaningful, if the pregnancy was intended and if they were accompanied to clinic by their partner (Major et al., 1985). Women who blamed their pregnancy on their character coped less well than low self-character blamers, but self-behaviour blame was unrelated to coping (Major et al., 1985).

Other research has found that feelings of guilt, anxiety, depression and regret are associated with a reduced ability to cope (Adler et al., 1992; American Psychological Association, 2008; Foster et al., 2012) and low levels of self-esteem reduce women's ability to cope with abortion (Adler et al., 1992; Mueller & Major, 1989). If a women's culture or religion prohibits abortion women are less likely to be able to cope (Adler et al., 1992; Foster et al., 2012; Major et al., 1990). Women who perceive that they had a low level of social support also cope less well with abortion than those who perceived that they had high levels of support (Major & O'Brien, 2005). Those women who do not have high confidence in their decision (Foster et al., 2012) or women who feel that they were pushed into having an abortion and teenagers are more likely to anticipate poor coping post abortion (Foster et al., 2012).

Rationale

There has been little qualitative research on abortion care in the UK, which explores the voices of women who have undergone the procedure (Astbury-Ward et al., 2012; Bradshaw & Slade, 2003; Priaulx, 2017). Women's voices have seldom been sought in research focusing on abortion and some researchers suggest this may be due to women's reticence to talk about their own experiences (Astbury-Ward et al., 2012;

Astbury-Ward, 2008). Previous research has focussed on clinical research into the safety and efficacy of abortion, the characteristics of those requesting abortions and whether abortion has a detrimental impact on women emotionally or physically and how to utilise contraception methods especially LARC in this group. The omission of women's voices in abortion research aids in characterising abortion as a common secret (Wicklund & Kesselheim, 2008), not to be discussed.

Research Aim

The primary aim of this research is to investigate women's experiences of repeat abortions and the experiences of staff who provide them. The secondary aim is, from researching those experiences what may work to reduce multiple requests for abortion.

Systematic Review

This systematic review was conducted as part of the professional Doctor of Health Psychology. The review was conducted to specifically examine whether there was any quantitative evidence available that would help to reduce repeat abortions. This was conducted as previous reviews either examined contraceptive counselling only (Carneiro Gomes Ferreira et al., 2011; Stewart et al., 2016) or the use of contraception (Che et al., 2016; Schmidt-Hansen et al., 2020).

Title

Evidence of the effectiveness for psychosocial interventions to improve contraceptive use in women undergoing abortions: A systematic review

Abstract

Purpose

The UK has seen a 7% increase in women requesting repeat abortions between 2007-2017. Rising from 32% to 39% despite improvements in contraceptive technology. A systematic review of the evidence of effectiveness of psychosocial interventions used with women experiencing abortion was therefore carried out.

Methods

A literature search was performed on six online databases up to October 2018. Eligible research was identified that evaluated a psychological, social or educational

intervention at time of abortion. Quality of research was assessed by a modified version of the Oxford quality scoring system. Data was combined using narrative synthesis.

Results

12 studies met the inclusion criteria, 9 were rated good quality. 8 studies favoured the intervention of these 6 were rated good quality. Studies utilised a variety of interventions and outcome measures such as enhanced contraception counselling, m-health, reducing structural barriers and shared experience of IUD use. Effective studies used theory driven enhanced contraception counselling or m-health technology. 4 studies that measured repeat abortion found no differences between intervention and control groups.

Conclusions

This review found moderate evidence of effectiveness of interventions in this group. The stronger evidence favoured utilising theory driven enhanced contraceptive counselling and m-health technology to increase contraception use. However, there was no evidence of longer-term effectiveness or effect on repeat abortion itself.

Introduction

In the UK in 2017 there were a total of 189,859 abortions performed to residents of England and Wales (Department of Health, 2018). This equates to a rate of 16.5 abortions per 1000 women aged 15-44 years, a decrease of 9.1% on the 2006 rate. With 70, 526 classified as repeat abortions.

There has been an increase of 7% in the proportion of women requesting a repeat abortion from 32% in 2007 to 39% in 2017 (Department of Health, 2018). Suggesting that whilst abortion rates have been decreasing the proportion of those abortions reported as repeat abortions have been increasing despite increased effectiveness, availability and uptake of contraceptive methods such as long acting reversible contraception (LARC) (Department of Health, 2013). Complex issues mediate repeated unintended pregnancy and subsequent abortion with age being a clear factor. With increasing age, women will have been sexually active over a longer period and thus a higher exposure to unintended conception. 47% of abortions reported in the 30-34 age category are repeat abortions compared to only 7% in those aged under 18 (Department of Health, 2018).

Abortion in the UK poses few physical risks to women especially when carried out before 12 weeks' gestation (NHS Choices, 2016). To obtain an abortion is relatively safe with an overall complication rate of <1% (Prager et al., 2007). Repeat procedures do not significantly increase the physical health risk. However, unintended conceptions and subsequent abortions can be an indication of an unmet need for contraception (World Health Organisation, 2012). Several studies have

reported that between 52% and 54% of unintended conceptions were in women who were not using a method of contraception at the time of conception; 41% - 43% accounted for by using contraception either inconsistently or incorrectly; only 5% ascribed as true contraceptive method failure (Finer & Sonfield, 2013; Frost et al., 2008; Sonfield et al., 2014). Contraceptive effectiveness varies with some methods such as oral contraceptives (the pill) and barriers methods of contraception (male condom) being highly dependent on their correct and consistent use (NICE, 2005). Women not using their contraception method correctly (Finer & Henshaw, 2006; Frost & Darroch, 2008; Kost et al., 2008) is a factor in abortions, the question is what more can be done to improve use of methods beyond basic service provision. Women experiencing unintended or unwanted conception as evidenced by a previous abortion, would seem a logical group to target with psychosocial interventions on contraceptive use, which may address repeat abortion itself.

This systematic review examines the evidence of effectiveness of psychosocial interventions at the time of abortion to increase uptake and adherence to effective contraception methods that may in turn, decrease the risk of a further unintended conception. The outcomes of interest are increased uptake of use of contraception and/or reduced rates of multiple abortions.

Methodology

Eligibility Criteria

Included in this review were published studies that have evaluated a psychological, social or educational intervention at the time of abortion in women aged 15 and over, with outcomes that measure contraception use and/or repeat abortion rates. Studies were excluded when they were performed in countries where abortion is illegal, had no stated psychological, social or education intervention, where the intervention was a medical intervention, or they were service audits/evaluations. Included in this review are studies of all designs although randomised controlled trials offer the most stringent form of evidence. Inclusion of both cross-sectional and retrospective trials can offer insights into what works but also highlight interventions for future more robust research. This review has not concentrated on women who are returning for repeat abortions but who are at risk of a repeat abortion. Women at risk of repeat abortion are those who have already had one previous abortion.

Information Sources

Six online databases were searched these included MEDLINE, CINAHL Plus, PsychINFO, PsycARTICLES, ASSIA and POPLINE up to October 2018, no start date was specified. Additionally, a grey literature search was completed, reference lists of identified articles were scanned and consultation with experts in the field was done to identify relevant studies that may have been missed in the database search.

Study Selection and data extraction

Study eligibility was assessed by two researchers to ensure neutrality, see Table 1 for included studies. Once studies were included data extraction and risk of bias were assessed.

Analysis

Risk of bias (see table 2) was assessed using a modified version of the Oxford quality scoring system (Jadad et al., 1996). Narrative synthesis was selected as the most appropriate method of combining the evidence from the studies as although similar outcomes were measured the content of interventions, populations studied and settings in which they were carried out were very different. Thus, heterogeneity ruled out meta-analysis. The results are reported around key type of interventions in order maximise translation of evidence to practice. Primary outcome measure was improving uptake of the most effective methods of contraception and adherence where measured. A secondary outcome measure was repeat abortion rates, where measured.

Table 1. Characteristics of included studies

Study	Setting	Sample Size	Theoretical Framework	Intervention	Follow up	Outcomes	Baseline Differences	Quality Rating
Enhanced Contraception Counselling								
Bender & Geirsson (2004) RCT	Abortion clinic in Iceland	420 women attending for first trimester abortion. 210 in intervention group; 210 in control group	None	Women in intervention group received usual care plus enhanced contraception counselling focusing on previous, present and prospective contraception use and non-use.	4-6 months' post abortion. 65.7% followed up. 73.3% of intervention group followed up. 60.9% control group followed up	Use of contraception method post abortion.	No significant differences in contraception uptake between groups. Similar proportion of women in the intervention group (86.5%) compared to control group (85.2%) started to use contraception C^2 =0.10 df=1, p=0.752	Poor
David et al. (2007) Cross-sectional study	20 health care sites in Russia	1575 women who had undergone an abortion. 489 in 2000 baseline data 559 in 2002 and 527 in 2003	None	Providers were trained in contraceptive technologies, principles of family planning counselling, interpersonal communication skills, post abortion family planning and IUD insertion/removal	Repeat abortion within 1 calendar year	Intention to use contraception Repeat abortion within 1 calendar year	No significant differences in intention to use contraception. Intention to use contraception in 2000 was 85.3%; 2002 was 83.5%; 2003 was 83.3% p=ns Repeat abortion rate stayed constant over study period	Good
Ceylan et al. (2009) Retrospective study	Family planning clinic in Turkey	322 women who had undergone an abortion	None	Post abortion counselling utilising basic counselling skills, communication skills and active listening	12 months' post abortion. 73.6% followed up at 12 months	Uptake of contraception	Favour intervention with increased uptake of contraception OR 0.19, 95% CI 0.12-0.29	Poor
Nobili et al. (2007) RCT	Hospital clinic based in Italy	Women aged 18+ requesting an abortion	Person centred medicine	30 minutes personalised contraceptive counselling	1 month follow up and 3 months follow up. 95.34% followed up at both times	Self-reported contraception use	Favoured intervention. Significant differences between intervention and control group in uptake of effective contraception. McNemar p=0.004 for uptake of contraception between	Good

Study	Setting	Sample Size	Theoretical Framework	Intervention	Follow up	Outcomes	Baseline Differences	Quality Rating
							time 0 and time 1 and p=0.0002 between time 0 and time 2 in intervention group p=ns for both timings for control group	
Schunmann & Glasier 2006 RCT	Abortion clinic in UK	613 attending abortion clinics. 316 intervention group; 297 control group	None	Enhanced contraception counselling lasting 20 minutes on top of usual care	4 months' follow up and 2 years' case notes review 61.5% followed up at 4 months 92.9% case notes reviewed at 2 years	Contraception method uptake at post abortion and 4 months' follow up. Repeat abortion rate at 2 years	Favoured intervention for contraception uptake at time of abortion but no difference at 4 months follow up. Intervention group less likely to leave with no method p<0.001 more likely to choose implant p<0.001 No significant difference in repeat abortion rate	Good
Whitaker et al. (2016) RCT	Urban academic clinic in USA	60 women attending for abortion. 29 intervention group; 31 control group	Motivational Interviewing	Contraception counselling based on motivational interviewing techniques. Intervention lasted a median of 24 minutes (range 14-39 minutes)	1 month and 3 months follow up. 92% followed up at 1 month. 85% followed up at 3 months	LARC uptake in the 4 weeks' post abortion. LARC use at 1 month and 3 months	Favour intervention for LARC uptake and for use at 1 month and 3 months. Intervention group uptake of LARC p=0.01	Good
Zhu et al. (2009) RCT	Urban hospitals in China	2336 women under 25 seeking a first trimester abortion	None	Essential package included information and referral to family planning. Comprehensive package included essential package plus individual counselling, free contraceptives and inclusion of male partners	6 months follow up. 59% followed up	Uptake of contraception Abortion rate at follow up	Favour intervention with both packages increasing uptake of contraception. Comprehensive package increased use of effective contraception OR 2.55, 95% CI 1.00-6.46 No significant differences in repeat abortion at follow up.	Poor

Study	Setting	Sample Size	Theoretical Framework	Intervention	Follow up	Outcomes	Baseline Differences	Quality Rating
Use of Visual Aids as an Intervention								
Davidson et al. (2015) RCT	Abortion clinic in USA	191 women attending for abortion. 96 in intervention group; 95 in control group	Trans-theoretical model of behaviour change	7-minute video on LARC	No follow up	Initiation of LARC method of contraception	No significant differences in LARC uptake between groups with 59.3% of the intervention group versus 51.6% control p=0.27	Good
Langston et al. (2010) RCT	Family planning referral clinic in USA	222 attending for first trimester abortion. 114 intervention group; 108 control group	None	Women in intervention group received usual care plus the use of 2005 WHO decision making tool for family planning.	3 months with a subset followed up at 6 months. 84% followed up at 3 months. 59% followed up at 6 months	Participants choosing a very effective method of contraception. 3-month continuation rates	No significant differences in contraceptive uptake between groups OR 0.74, 95% CI 0.44-1.26 No significant differences in continuation rates at 3 months	Good
Use of Mobile Technology as an Intervention								
Smith et al. (2015) RCT	Marie Stopes clinics in Cambodia	500 women attending Marie Stopes. 249 intervention group; 251 control group	None	Usual care plus 6 automated mobile phone messages over 11 weeks' post abortion	4 months and 12 months' follow up 86.2% followed up at 4 months 65.6% followed up at 12 months	Contraception uptake and adherence at 4 and 12 months. Repeat abortion rate at 4 and 12 months	Favour intervention for contraception uptake a 4 RR 1.39, 95% CI 1.17-1.66 but not 12 months No significant differences in repeat abortion rate at 4 or 12 months	Good
Significant Others								
Benson et al. (2012)	Women's clinic in USA	415 women aged 15+ seeking an	None	Reporting a positive personal story of IUD use	Pre and post abortion questionnaire	Use of IUD post abortion	Favour intervention with positive experiences significantly predicting IUD	Good

Study	Setting	Sample Size	Theoretical Framework	Intervention	Follow up	Outcomes	Baseline Differences	Quality Rating
Cross-sectional study		abortion up to 23 weeks and 1 day		from family, friends or clinic staff	completion. 72% completed both		use. Disclosure by clinic staff OR 8.1, 95% CI 1.38-17.2	
Addressing Structural Barriers								
Rose et al. (2010) Retrospective study	Abortion clinic in New Zealand	1020 women seeking an abortion	None	Provision of LARC, clinic posters for LARC, clinic information for professionals regarding LARC	6 weeks and 6 months only those choosing a LARC method of contraception. 71.3% followed up at 6 weeks. 59.3% followed up at 6 months	Uptake and adherence to LARC	Favour intervention with a significant increase of uptake of LARC in the intervention period $p<0.05$	Good

Results

The results will be presented through an overview of study selection PRISMA diagram (see figure 1) and a summary of included studies characteristics, followed by reporting of the evidence on key types of interventions.

Study inclusion data and characteristics

A total of twelve studies were identified for inclusion in this systematic review. Table 1 sets out the study characteristics of the twelve studies included in this review, eight of the studies (Bender & Geirsson, 2004; Davidson et al., 2015; Langston et al., 2010; Nobili et al., 2007; Schunmann & Glasier, 2006; Smith et al., 2015; Whitaker et al., 2016; Zhu et al., 2009) were randomised controlled trials, two studies (Benson et al., 2012; David et al., 2007) were cross-sectional and two studies (Ceylan et al., 2009; Rose et al., 2010) were retrospective. The included studies were completed in Cambodia, China, Iceland, Italy, Russia, Turkey, United Kingdom and the USA. All studies were performed in hospitals, abortion clinics or family planning clinics. Three studies (Davidson et al., 2015; Nobili et al., 2007; Whitaker et al., 2016) presented a theoretical basis for their intervention.

Table 2. Risk of Bias

Randomised controlled trials								
Study	Appropriate Randomisation	Blinding	Allocation bias	Selection bias	Follow up <80%	Attrition bias	Score	Quality grading
Bender and Geirsson (2004)	Yes	Yes	Yes	Yes	No	No	3/6	Poor
Davidson et al. (2015)	Yes	Yes	No	Yes	N/A	N/A	5/6	Good
Langston et al., (2010)	Yes	No	No	No	Yes	No	5/6	Good
Nobili et al. (2007)	No	Yes	No	No	Yes	No	5/6	Good
Schunmann and Glasier (2006)	Yes	Yes	No	No	No	Yes	5/6	Good
Smith et al. (2015)	Yes	Yes	No	Yes	No	Not reported	4/6	Good
Whitaker et al. (2016)	Yes	Yes	Yes	Yes	Yes	No	4/6	Good
Zhu et al. (2009)	No	No	Yes	Yes	No	No	1/6	Poor
Cross-sectional studies								
Benson et al. (2012)	N/A	N/A	N/A	No	No	No	2/3	Good
David et al. (2007)	N/A	N/A	N/A	No	N/A	N/A	3/3	Good
Retrospective studies								
Ceylan et al. (2009)	N/A	N/A	N/A	Yes	No	Not reported	0/3	Poor
Rose et al., (2010)	N/A	N/A	N/A	No	No	No	2/3	Good

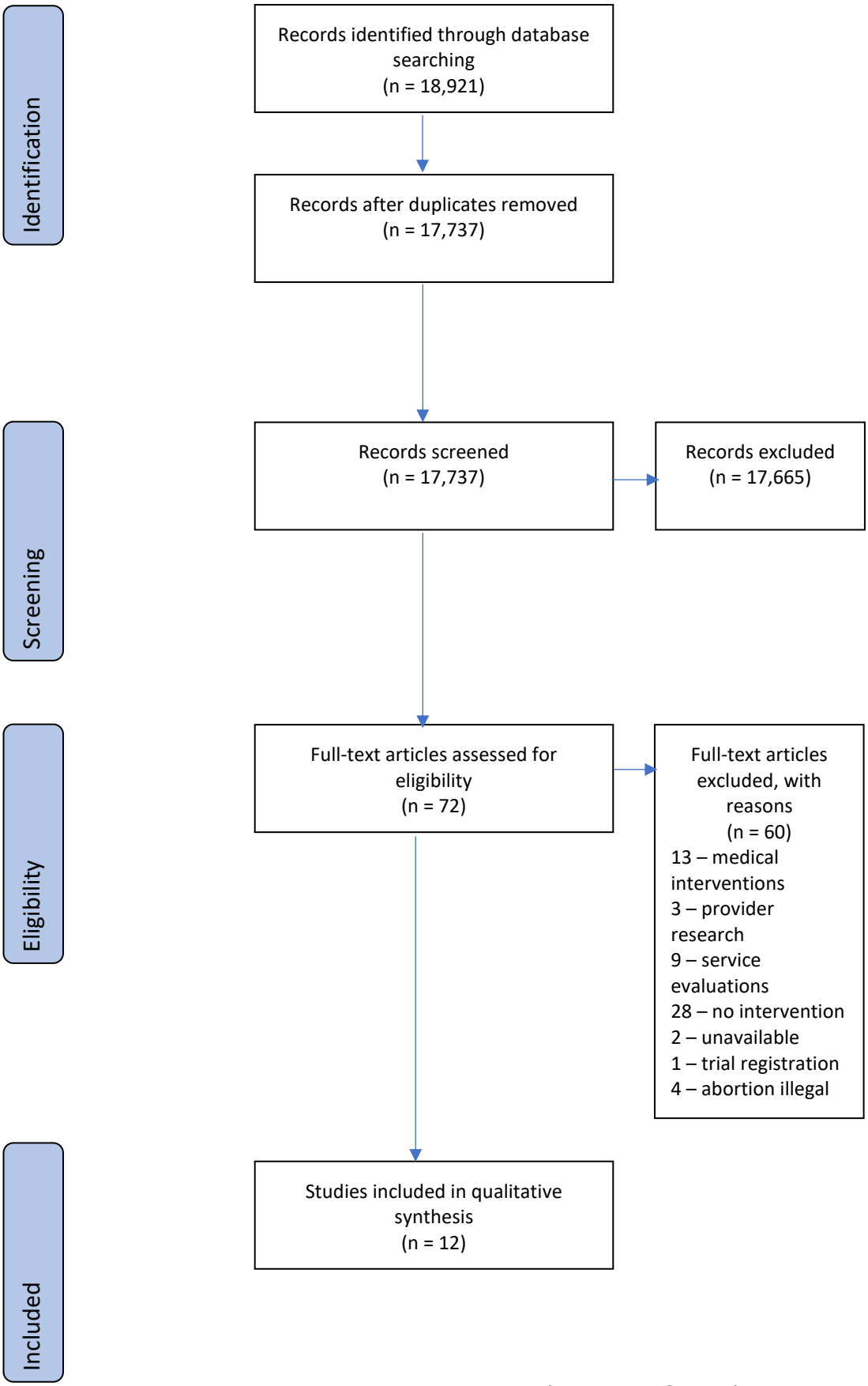

Figure 1. PRISMA Diagram

Table 2 reports the full quality assessment of included studies based on their risk of bias, of the eight randomised controlled trials, six studies (Davidson et al., 2015; Langston et al., 2010; Nobili et al., 2007; Schunmann & Glasier, 2006; Smith et al., 2015; Whitaker et al., 2016) were classified as good quality (score of <4). Both cross-sectional studies (Benson et al., 2016; David et al., 2007) and one retrospective study (Rose et al., 2010) were assessed to be of good quality (score of >2 out of 3). Studies which were assessed as poor include two randomised controlled trials (Bender & Geirsson, 2004; Zhu et al., 2009) (score >3 out of 6) and one retrospective study (Ceylan et al., 2009) (score >1 out of 3).

All interventions were multidimensional however, this review has identified five main features of the interventions under which evidence of effect is synthesised, with some studies employing several features.

Enhanced contraception counselling interventions

Although all the studies that are included in this review utilised some method of contraception counselling seven of the included studies (Bender & Geirsson, 2004; Ceylan et al., 2009; David et al., 2007; Nobili et al., 2007; Schunmann & Glasier, 2006; Whitaker et al., 2016; Zhu et al., 2009) used interventions that were based on enhanced contraception counselling with the intention of increasing contraception use post abortion. Five of these studies (Ceylan et al., 2009; Nobili et al., 2007; Schunmann & Glasier, 2006; Whitaker et al., 2016; Zhu et al., 2009) reporting increased use of contraception by the intervention group or in the intervention period. Three of these studies were judged to be of good quality (Nobili et al., 2007;

Schunmann & Glasier, 2006; Whitaker et al., 2016) and all three were randomised controlled trials assessing contraceptive counselling by trained nurses enhanced by either a theoretical approach (person centred medicine or motivational interviewing) or by increasing the time with the trained counsellor. In terms of what enhanced contraception counselling might look like, there was some 'good' evidence of effectiveness from two (Nobili et al., 2007; Whitaker et al., 2016) studies. Those studies used a theoretical base one utilised a Patient Centred approach (Nobili et al., 2007) and the other Motivational Interviewing (Whitaker et al., 2016).

Of studies reporting no significant outcome differences between the intervention and control, (Bender & Geirsson, 2004; David et al., 2007) one study (Bender & Geirsson, 2004) was deemed as poor quality. Therefore, there is some evidence that interventions providing enhance contraceptive counselling may be effective in increasing contraception use post-abortion and potentially for up to 3 months following abortion. In the longer term, in terms of contraceptive use, there is some poor quality (Ceylan et al., 2009; Zhu et al., 2009) evidence of longer-term effect up to 12 months' post abortion.

Use of visual aids interventions

Two studies (Davidson et al., 2015; Langston et al., 2010) utilised visual aids (e.g. informational video) to increase the uptake of contraception post abortion. Use of visual aids may be of benefit for several reasons in that they can reduce barriers that may arise from not being able to speak the native language or they can be time effective in that women can watch a short video clip whilst waiting to see a

professional. Both studies were randomised controlled trials and were of good quality however, neither found any significant differences in uptake of contraception post abortion between intervention and control groups suggesting that this may not be a useful area for further study.

Use of mobile technology as an intervention

One study (Smith et al., 2015) employed the use of mobile phone technology to send out automated messages as a prompt to increase uptake and adherence to contraception post abortion. This study was a randomised controlled trial and judged to be of good quality. The results showed that 4 months' post abortion there was a higher proportion of contraception use (RR 1.39, 95% CI 1.17-1.66) but no differences between groups at 12 months. Although this is a single study the sample size was large (n=500), it suggests that new technologies and new ways of using technologies may be a promising way forward. Innovation in ways to engage in m-health around contraceptive use is a promising area of research within the context of many new online sexual health services (Aicken et al., 2016; Campbell & Marsh, 2017; L'Engle et al., 2016; Minichiello et al., 2013).

Social Norms

One study (Benson et al., 2012) examined the effect of women reporting hearing a positive contraception story of an intrauterine device by either a family member, friends or clinic staff. This research found that women who had heard a positive shared experience of a more effective method (intrauterine device) were more likely to choose one. Disclosure by clinic staff had the largest effect on whether women

chose an intrauterine device (OR 8.1, 95% CI 1.38-17.2). Social norms suggest that individuals make decisions to engage in a behaviour based on the relevance and appropriateness of that behaviour among peers (K. Ball et al., 2010). It has been suggested (Reynolds et al., 2015) that they are increasingly recognised as a component of both motivation and behaviour.

Only one study (Zhu et al., 2009) involved male partners in contraceptive counselling. Men's voices are lacking in abortion research, so it was important to see research that acknowledges their connection. Although the study reported an increase in contraception use in the experimental group that included male partners (OR 2.55, 95% CI 1.00-6.46). It may also be that patients who feel able to bring in a partner are already better able to jointly negotiate contraceptive use and therefore present systematic selection bias. The Benson et al. (2012) study was cross-sectional but of good quality whereas the Zhu et al. (2009) study was a randomised controlled trial but of poor-quality cautious interpretation of these results is required. With better quality research needed around this approach.

Addressing structural barriers

One study (Rose et al., 2010) replaced the way in which the abortion clinic promoted contraception and reduced the cost of contraception for the study period. The results favoured the intervention with rates of LARC use increasing to 60.8%, p=0.05 and was categorised as good quality. Two RCT studies of good quality (Langston et al., 2010; Nobili et al., 2007) addressed cost barriers to contraception by negating the cost to all participants but with mixed results. Langston et al. (2010) observed no

differences between groups on contraception choices. Whereas Nobili et al. (2007) reported that use of an effective method of contraception increased from 20% to 80% in the experimental group (McNemar p=0.00002). There was no significant difference in uptake of effective contraception in the control group.

Two further studies offered more limited subsidised contraceptive costs. Zhu et al. (2009) a randomised controlled trial rated poor quality offered free contraception to the comprehensive package intervention group only OR 2.35 (CI 1.33-4.17). In a good quality randomised controlled trial, Schunmann and Glasier (2006) offered a full range of contraception in the intervention week only. Both studies results supported the interventions with higher uptake of contraception in the intervention groups. The uptake was mainly for the contraceptive implant as that was only available in the intervention period for surgical abortions p<0.001 (CI 2.7-13.2) and for medical abortions p<0.001 (CI 7.9-15.4).

Overall the five studies suggest mixed but promising evidence for the provision of more effective methods of contraception at time of abortion at either no cost or reduced cost improves the uptake. This also raises the issue that all methods are not equal.

Uptake of effective methods of contraception

All studies reported good uptake of all contraception methods with Bender and Geirsson (2004) recording uptake of contraception in excess of 85% for both the intervention and control group The studies that specifically measured the use of the

more effective methods of contraception presented results that were mixed, in that, some of the studies showed no effect for the intervention (Davidson et al., 2015; Langston et al., 2010). Two studies (Rose et al., 2010; Schunmann & Glasier, 2006) increased access to the most effective methods by either providing them free or providing them in the intervention period only and thus their respective interventions cannot be evaluated alone. Therefore, two good quality studies, (one RCT, one cross section survey) (Benson et al., 2012; Whitaker et al., 2016) reported increased uptake of the most effective methods of contraception (LARC) with Whitaker et al. (2016) also evidencing 3-month post abortion adherence. These six good quality studies (Benson et al., 2012; Davidson et al., 2015; Langston et al., 2010; Rose et al., 2010; Schunmann & Glasier, 2006; Whitaker et al., 2016) provide us with a mixed picture of what works to increase the uptake of the most effective forms of contraception. Understanding the integral links between contraceptive effectiveness, availability, acceptability and adherence is needed in future research as the studies examined here have considered uptake of contraception to reduce repeat abortions but have fallen short in exploring these links in the longer term.

Repeat abortion as an outcome measure

Four of the studies (David et al., 2007; Schunmann & Glasier, 2006; Smith et al., 2015; Zhu et al., 2009) measured the repeat abortion rates however these studies found no significant differences between intervention group and control group or between intervention period and control period. Three of these studies (Schunmann & Glasier, 2006; Smith et al., 2015; Zhu et al., 2009) were randomised controlled trials and all three favoured the intervention for uptake of contraception but found no

difference in repeat abortion rate. Only two of these studies (Schunmann & Glasier, 2006; Smith et al., 2015) were judged as good quality. The other study (David et al., 2007) reported no differences in intention to use contraception between baseline and intervention period. David et al., (2017) was also rated as good quality. The time over which this measure was followed up varied from 6 months to 2 years. Therefore, this systematic review found no evidence of longer-term reduction in repeat abortion rates even though three of the studies (Schunmann & Glasier, 2006; Smith et al., 2015; Zhu et al., 2009) reported increased uptake of contraception at time of abortion.

Discussion

An evidence-based approach to targeted improved use of contraception amongst this high-risk group was indicated. Of the twelve studies identified through systematic searching, two-thirds provided evidence of improved uptake of contraception post intervention, with nine of these rated as good quality. Findings suggests women undergoing abortion are receptive to targeted interventions around improved contraceptive uptake. It is thought that unintended pregnancy may be an unmet need for contraception (Frost et al., 2008; World Health Organisation, 2012) and that by meeting that need there could be a reduction in unintended conceptions and thus subsequent abortion rates. This review has found good evidence that provision of tailored interventions at the time of abortion assists in fulfilling this unmet need.

Most studies were multidimensional; it is therefore difficult to disentangle which elements were more effective. This is always problematic in devising or evaluating complex health interventions (Craig et al., 2013) and understanding the functionality of interventions. However, there are some promising areas in which some good evidence of effectiveness was found such as enhanced contraception counselling (particularly theory based) and mobile phone-based prompt technology but further study is needed on what that would specifically entail, how it would be delivered, and would it be acceptable to women. It is interesting to note that behaviour which involves two people only one study (Zhu et al., 2009) involved both and that was in the experimental group only.

Wider evidence suggests (Bartholomew & Mullen, 2011; Heath et al., 2015; Hurley et al., 2016; Susan Michie & Prestwich, 2010; Prestwich et al., 2014) that theory driven interventions may be more effective. Unfortunately, only three studies (Davidson et al., 2015; Nobili et al., 2007; Whitaker et al., 2016) in this present review identified and utilised theory providing some good evidence for theory driven interventions.

This review has presented good evidence of at least short-term uptake of contraception in women attending services for abortion. However, none of the studies evaluated provided any evidence for long-term adherence to contraception, which would in theory reduce repeat abortions. Only four of the studies (David et al., 2007; Schunmann & Glasier, 2006; Smith et al., 2015; Zhu et al., 2009) actually measured subsequent abortion rates although none of these studies were sophisticated enough to be able to track women from intervention to repeat abortion. Research therefore needs to take a longer-term view to help understand a woman's contraception journey.

This review has been unable to establish long-term adherence levels with most studies only having 4-6 months follow up. Long acting reversible contraception such as the Implant, IUS and IUD last 3, 5 and 10 years respectively which indicates longer term adherence if retained but again, data tracking women's ongoing contraceptive decisions was not found.

Further research is needed into this to understand the pathway from abortion onwards. Repeat abortion as an indicator outcome of intervention success, due to its limited frequency over a woman's lifetime, may not be a useful unless there was much longer-term follow up (limited to a maximum of 2 years in this review). Understanding women's own experiences of the pathway through multi abortions will help researchers understand what is going on for individual women. It will also help to pinpoint whether there is a teachable moment or an intervention pathway. Only qualitative research can attain this by asking women their experiences.

More research around the areas of involving male partners and mobile phone 'prompt' services is needed. Where there is clearer evidence, e.g. enhanced counselling, more work is needed on the nature of that counselling with both Person Centred and Motivational Interviewing based techniques looking promising. Within abortion research there is a lack of male involvement although there has been some move to become more inclusive (Altshuler et al., 2016; Jones et al., 2011). This research has highlighted that inclusion of men in an intervention to reduced repeat abortion was positive, more research is needed to understand how and why this may be the case. Also, as with the case of mobile phone technology this research provided some evidence that this technology may be of use. There has been a surge in reproductive technology including mobile phone apps in recent years. However, there is limited research into the effectiveness of these apps, development of the apps using health psychology theory or which components of the app work.

In general, longer term and more in-depth work with these women around why repeat abortion occurs is needed to better inform intervention choice as well as some effort to draw in the accounts of males' partners.

One methodological flaw identified in many studies was their retention rates with most studies falling below 80%. It is always of importance to reflect on the differences between women who have stayed in studies compared to those who had dropped out. Finding ways to lower attrition rates will always benefit the research process. Reporting of studies was poor around specific intervention content which would enable future researchers to disentangle the active ingredients of interventions and then begin the process of translating those interventions into clinical practice (Michie et al., 2014).

Review limitations

Within the UK, contraception and abortion are free on the NHS and it is sometimes difficult to apply research that has been carried out elsewhere with a different health service that may or may not cost a woman financially. In addition, cultural attitudes to abortion are different such as in Russia it has been quite normal for women to have multiple abortions because they have historically been unable to access good quality contraception (Joffe, 2009; Keenan et al., 2014). Thus, adapting research findings for the UK context from the culturally diverse range found in the primary research (only 1 UK based) should be done with caution. However, further research around the promising areas highlighted in this review would be a good starting point

and finding out what type of interventions are acceptable to women who are at risk of repeat abortion would be beneficial.

Only studies completed and reported in English could be included. Although a quality assessment took place which included a risk of bias in studies it did not assess for reporting bias, in which articles only report on what is significant rather than on what was found in the whole study. Also, there is always a publication bias although acknowledged there is a propensity to publish studies that have found positive results. Incomplete reporting makes the risk of bias unclear with two studies (Ceylan et al., 2009; Smith et al., 2015) not reporting on attrition.

Conclusion

Women who are having an abortion are at risk of further unintended conceptions and the abortion period is an ideal time of contact with services to deliver targeted interventions. This review provides some good evidence that women are receptive to interventions to increase post abortion contraception especially when contraception counselling is effective, involves male partners or mobile phone 'prompt' services. The efficacy of these interventions was on abortion itself or in the longer term were not evidenced. Researchers need to consider longer term or top up interventions in addition to longer term research follow up to establish the effect on repeat abortion itself. There is a need for more extensive research and better-quality evaluation work but also richer, life course work around the complex context in which repeat abortions may occur.

In conclusion, this systematic review found that there were some interesting area for future research such as the inclusion of men, mobile phones and longitudinal research. However, this review provided limited evidence of what works now. Due to this gap it would be inappropriate to continue to an intervention (quantitative) study. Although this systematic review only included quantitative research other researchers have noted a lack of qualitative research (Astbury-Ward et al., 2012; Bradshaw & Slade, 2003; Priaulx, 2017) examining how users of an abortion services feel regarding what may work to reduce multiple abortions.

Methodology

The completed systematic review found that there was some good evidence that women are receptive at time of abortion to interventions that increase uptake of contraception use. However, the views of women have seldom being sought on their personal experiences of abortion or repeat abortion (Astbury-Ward et al., 2012; Bradshaw & Slade, 2003; Priaulx, 2017).

Research Aim

The primary aim of this research is to investigate women's experiences of repeat abortions and the experiences of staff who provide them. The secondary aim is, from researching those experiences what may work to reduce multiple requests for abortion.

Research Design

The majority of research on abortion entails quantitative methodology specifically examining the safety of abortion and contraception methods following abortion. The socio-psychological literature has found differences between women requesting one and women requesting multiple abortions. There is a dearth of women's voices in research that directly affects them.

Exploratory research can also provide a basis for future research which may assist in defining certain concepts, to formulate hypotheses or to operationalise variables. This exploratory piece of research has been undertaken in order to gain information

on the enigma of repeat abortions and what may help to reduce them. The research has examined this from the perspectives of women who request multiple abortions and the staff who provide them.

Why Qualitative Research Methods

Qualitative methods, within healthcare research, can inform practice and enrich our understanding of complex human behaviours and attitudes (Astbury-Ward, 2008; Clarke, 1998). It allows the researcher to understand complex details about feelings, thought processes and emotions that are difficult to explore using other research methods (Broussard, 2006). The individual's experiences provide intense and valid narratives which is a strength of qualitative research. It also allows for context to be examined.

Thematic Analysis

Thematic analysis can be utilised within the of ontology critical realism and epistemology of contextualism (see Braun & Clarke, 2013). Within this methodological approach is it normal to generate data with themes derived from that data (Guest et al., 2012). Applying an inductive approach to qualitative data produces clusters of text with similar meaning with the aim of defining concepts that appear to capture the essence of the phenomenon under investigation (Madill & Gough, 2008). Thus, thematic analysis has been described as "a method for identifying, analysing and reporting patterns (themes) within the data" (Braun & Clarke, 2006, p. 79) which provides a rich and detailed, yet complex, account of the data (Braun & Clarke, 2006).

Braun & Clarke (2006) identify six steps firstly familiarise yourself with your data, generate initial codes, search for themes, review themes, define and name themes and finally producing the report. The first step of thematic analysis is a familiarisation with the data which entailed reading and re-reading transcripts identifying interesting parts of the data. Complete coding was used which codes 'chunks' of data which can be only one line long or several full sentences (Braun & Clarke, 2013). Once coding has taken place, they were then grouped coding into candidate themes. Once candidate themes were identified they were reviewed until a story began to emerge that reflected the data. Beginning to define themes and moving on to analysis. These steps are iterative in that the researcher moved between steps in a non-linear fashion with a constant reviewing process. Finally producing this final report.

Ontology/Epistemology

Research is not value free and is guided by a set of beliefs. Within qualitative research investigators cannot be divorced from the cultural, social or political context of their topics (Silverman, 2016). An advantage of qualitative research is that theory can be generated that is contextually sensitive, persuasive and relevant (Henwood & Pidgeon, 1994). Believing this I have situated myself within the ontology of critical realism and the epistemology of contextualism.

Critical realism suggests that there is truth, but it cannot be accurately detected. Thus, reality exists but works independently of our knowledge of it (Archer et al., 2016). Within research, critical realists do not reject either interpretivism or

positivism. Instead we are concerned with combining explanation and interpretation of facts and events that we empirically examine. This requires analysing the ways in which individuals give meaning to their experiences in relation to their socio-cultural context (Archer et al., 2016), with the aim of exploring what affects human action and interaction.

Contextualism maintains that knowledge is dependent on the setting and on interactions. Thus, all knowledge is local, provisional and situation dependent (Jaeger & Rosnow, 1988) but also contingent on the interactions we have with other people. Individuals interpret the world around them within a network of cultural meanings including researchers and their participants (Madill et al., 2000). Contextualism suggests that all behaviour must be analysed within the context with which it occurs and to interpret any act independently of context will ultimately be misleading. Thus, human activity is situated in the social, historical and cultural context; which is ever changing and shifting never static. My knowledge about the world is dependent of my view and position within that world (Brower, 1998) and within qualitative research I must be reflectively aware of the impact that will have on interpretation.

Ethics

Research ethics are in place to protect the rights, safety, dignity and wellbeing of research participants (Health Research Authority, 2014). There needs to be careful consideration before researching a sensitive subject such as abortion as "it requires disclosure of behaviours or attitudes which would normally be kept private and

personal, which might result in offence or lead to social censure or disapproval and/or which might cause the respondent discomfort to express" (Wellings et al., 2000, p. 256). Thus, a robust methodology must be in place to protect research participants as it has been suggested that vulnerable individuals have diminished autonomy due to status inequalities (Silva, 1995) and an increased susceptibility to adverse health outcomes (Flaskerud & Winslow, 1998). Not researching sensitive topics would be an abdication of duty and it is only when vulnerable groups receive the appropriate research attention will their care and quality of life be enhanced (Moore & Miller, 1999). However, giving voice to sensitive subjects may be beneficial for research participants as they have the chance to talk about a matter which they may not be comfortable talking about to anyone in everyday life (Christianson et al., 2007; Liamputtong, 2007).

Thus, when researching a sensitive subject, participant consent is imperative. The concept of consent is inferred, there is an implicit assumption that it was provided voluntary and coercion is deemed not to have occurred. Yet such an assumption ignores the potentially complex power dynamics that can operate around access and consent (Miller & Bell, 2002) especially where issues of healthcare are concerned. Participation was voluntary and reassurances were given that not taking part would not influence their health care in any way and that they did not have to give a reason for not participating. Also, research participants were told that they could withdraw their consent at any time, again no reason was required.

Another issue that must be taking into consideration when researching sensitive subjects is confidentiality and anonymity. As a researcher I am aware and conscientious of the difficulties that I have encountered in trying to safeguard the confidentiality and anonymity of research participants. Confidentiality cannot be assured, and it could be assumed that these sensitive interviews may bring up child protection issues or intimate partner violence issues which would need to be dealt with accordingly, as per the All Wales Child Protection Procedures Review Group (2008). Any disclosure of unsafe practice by staff that were research participants that contravenes the Health Board Values and Behaviours Framework would have to be disclosed to senior management and thus confidentiality could not be assured for staff either. Participants were warned up front of the circumstances under which confidentiality would need to be broken. During this research intimate partner violence was discussed by eight out of the ten women but no action was needed as it was either historic or being dealt with by the police and the crown prosecution service.

Anonymity also has to be prioritised with all research participants given a pseudonym and any details removed from the analysis and results that may reveal an individuals' identity. Anonymity for the women who took part in this research was unproblematic, as the link between actual research participant and pseudonym was broken as soon as possible. However, ensuring anonymity in a small staff team has brought up ethical dilemmas. The research included a male member of staff (the only male in the team) so promising him anonymity was not possible but thoroughly discussed with him. It was decided that any quotes used from his interviews he has

the final veto on. When presenting preliminary research findings to staff team days other staff have openly stated which quotes are theirs and thus disclosed themselves.

Sensitive researchers have raised the issues of self-disclosure of the research participants (Dickson-Swift et al., 2006; Etherington, 1996; France et al., 2000; Liamputtong, 2007; Melrose, 2002). Daly (1992, p. 10) suggests that the "informal atmosphere of qualitative research, particularly when it occurs in the home", may lead the participants to disclose more than what they had originally planned (Lupton, 1998). With the possibility of disclosure of illegal activities (Johnson & Macleod-Clarke, 2003). In some interviews staff divulged experiences they had had with women who had purchased 'abortion pills' off the internet but in one interview with a woman she disclosed that she had ordered the pills but that the pills had not turned up. Although it is illegal to procure these pills off the internet the research participant had not received them. Maintaining confidentiality is paramount in qualitative research and breaching that must be carefully thought through. I decided that breaching confidentiality about a non-violent but none the less illegal act would be unlikely to be successful. It would also end the research relationship and with it the possibly of learning more about the respondents' experiences and behaviour (Padgett, 2014).

NHS Ethics

The research gained ethical permission from the Wales Research Ethics Committee No. 6 on the 17th June 2016 reference 16/WA/0179 (see appendix 1).

Participants & Sampling

For this research I recruited two different groups of participants the first group were women who had attended the abortion service requesting a repeat abortion, the second group were staff who worked in an abortion service in South Wales. I decided to include both groups as I felt this would increase the opinions on repeat abortion. I also felt it would increase the depth of understanding as both groups would view repeat abortion from a differing perspective. I felt this would aid the analysis of repeat abortion by being able to both compare and contrast the views of women requesting repeat abortions and the staff providing them.

The inclusion criteria for the first group was that they were requesting a repeat abortion within 24 months of an index abortion or requesting a third (or more) abortion. They had to be aged 18 to 45 years, although the age for sexual consent is 16, epidemiology data shows that only 487 repeat abortions took place in those under 18 (Department of Health, 2019) in England & Wales in 2018. It was thought that due to the small numbers of repeats in this age group it was logical to omit them from the research as they are deemed children in NHS ethics and add an extra ethical burden. The final inclusion criteria for this second group is that they do not want to get pregnant at this time. It would be assumed that anyone attending an abortion service may not want to be pregnant, but life is complex as a woman may want to be pregnant by her husband but believes the baby, she is carrying may not be his. For this first group of research participants there was also exclusion criteria which were women who were requesting their first abortion or requesting an abortion for medical reasons such as foetal abnormality or requesting their second abortion but

that the gap between abortions were more than 25 months. Also, any women who would need a translator to take part in the research would be excluded.

The inclusion criteria for the second group was that they were currently working (in any position) in an abortion service. There were no exclusion criteria.

Purposive sampling method was employed as it is appropriate for the research in question as it aims to sample a group of people with a range of experiences, characteristics, that is, their proximity to provision of abortion services or using abortion services. Although results from this sampling method are not generalisable to the wider population (Silverman, 2016; Willig, 2013) it may be applicable to other abortion services who provide a similar service. Purposive sampling is a deliberate non-random method of sampling which aims to sample a group of people with a certain characteristic (Silverman, 2016; Willig, 2013). Also, purposive sampling was employed to widen the range of experiences within the target group. Within qualitative research it is the depth of experience to answer why a phenomenon takes place that is required as compared to quantitative research which uses increased numbers to test hypothesis or measure trends.

Reaching a saturation point in thematic analysis is important to validity in qualitative studies, yet the process of achieving saturation is often left ambiguous (Ando et al., 2014). This ambiguity leaves a question as to when to close recruitment. Some researchers have suggested that 12 participants are enough for research utilising thematic analysis (Guest et al., 2006 cited in Ando et al., 2014). In this research ten

women were recruited who reported between two and seven multiple abortions. Twelve members of staff were recruited these included a member of staff from each occupation within the service and thus included consultants, doctors, nurses, scan operators, counsellors and administration staff. Within this research saturation was deemed to have been reached when no new information was coming forth from new interviews with participants.

Procedure

Materials

Participant information sheets and consent forms were designed following guidelines set out by the Health Research Authority (Health Research Authority, 2014) and were approved by NHS ethics (see appendix 2). The information sheets outlined the purpose of the research and why participants had been invited to take part. It assured them that all data obtained in the interviews were completely anonymous (confidentiality could not be ensured in case of disclosure) and that in the event of publication the participants would not be identifiable. Participants were informed that their participation in the study was completely voluntary and that they could withdraw from the study at any time and for any reason. The participant information sheet set out the aims and objectives of the research, how long the interview would approximately last, contained the researchers contact details should they wish to discuss the research and made clear that they can withdraw from the study at any time.

While the semi-structured interviews use non-leading open questions, the narrative style prioritises elicitation of personal stories with minimum researcher prompting (Madill & Gough, 2008) which achieved a balance between being an interview and being a conversation. The interview schedule for women examined the women's own experiences, contexts and the prompts include partnership and family composition, most recent abortion decision, previous abortion decisions, how they are similar or different, how they coped with each abortion, the social support they received, stigma and what their ideas were regarding repeat abortions (see appendix 3). The interview schedule developed for staff included prompts about their current role within the abortion service, previous roles, have they worked in other abortion services, how they feel about repeat abortions, have there been particular cases that have stuck with them and why, how do they think the best way of working with repeat abortions and are there any ways to reduce repeat abortions (see appendix 3).

Recruitment

The abortion service is self-referral, once a woman has identified herself as having an unintended pregnancy, she phones the service (see referral pathway appendix 4) and is given an appointment within two weeks. Women fitting the inclusion criteria were identified by administration staff when they phoned to make their appointment. Administration staff were only able to identify women who have had previous abortions within the same abortion service as their details will be on Blithe (sexual health management system). Once a woman attended for her appointment, she was seen by a counsellor first. Counselling staff were informed by administration

staff women who was eligible to take part however all counsellors ask patients about previous abortions and were able to identify women who had had abortions either privately or in other health authorities. Once the counsellor finished their session, they invited the woman to take part in the research informing them that her participation in the research would not influence the clinical care she received. Counsellors went through the patient information sheet with each woman and asked if they would like to take part. Once a woman verbally agreed they were given a consent form to complete, stating her preferred means of communication and signed which gave permission for the researcher to contact her post abortion. The consent form was given back to the counsellor who then passed them back to the administration staff in clinic who kept them for the researcher to collect.

Women were given the patient information sheet to leave with and told that the researcher would contact between one- and two-weeks post abortion. It was explained that taking part would not influence patient care and that women could withdraw from the research at any point.

The researcher then contacted the participant to discuss the research and if the woman was happy to continue made an appointment to interview the participant. This initial contact was made via the participants preferred communication method set out on their consent form, these included landline, mobile, text or email. Appointments were offered to take place either at home or in a clinical setting depending on the wishes of the participant. If home visits were arranged the researcher adhered to lone working policy which employs a buddy system. Also, a

risk assessment took place asking about animals in the property and if significant others may be present.

At the allotted interview time the researcher went through the consent sheet verbally and asked women to both initial and date the form. The consent form stated that the participant had agreed to be recorded for the interview and that all the data collected will be anonymised and that each participant will be given a pseudonym (of their choosing if they so wish). However, confidentially cannot be assured as issues around safeguarding must be shared as per local protocols. The research participants were also offered another participant information sheet in case they had mislaid the one given at their clinical appointment, although no woman accepted. All information was gone through verbally to ensure understanding. Once all paperwork was completed the interview began. All interviews were audio recorded. The interviews were semi structured in that the researcher had a sheet set out with general areas for discussion but let the participant lead the conversation with only minimal interjection from the researcher.

Once interviews were completed participants were offered a chance to ask questions or add anything, they think is important or has been missed by the researcher. Once this took place the voice recorder was switched off. Once finished I thanked the participants for their time and allowing me to listen to their stories. The abortion service contact number was clearly stated on the participant information sheet and women were reminded that they can contact them for support and advice if the interview has brought out any unresolved issues.

Staff were approached individually by the researcher to take part. They were given a staff participant information sheet which they could take home and read. They did not have to decide to take part at that time but to be able to think about it all staff who took part agreed or declined on the first approach. Staff who agreed to take part had an interview organised at a convenient time for them.

At the interview the staff member was given a consent form and asked to read and sign the form. Once the consent form was completed the interview begin again staff interviews were semi-structured in nature with prompts rather than specified questions for staff.

Both groups of participants were informed that they can withdraw from the study at any point and this will not have a detrimental effect on the care they receive, if interviews had taken place, they will not be used in the data analysis, if data analysis has taken place their data would be removed from that analysis.

Staff have received feedback at team days. All women were offered the opportunity for written updates on the research all declined.

Interviews were then transcribed verbatim ready for data analysis.

Recruitment problems

There were issues in recruiting women to the study as they agreed to take part in the research whilst at the abortion appointment but used various strategies to withdraw

themselves from the study later. The strategies used to withdraw themselves from the research included the researcher being unable to contact them either via phone or email (depending on their preferred choice of contact), verbally withdrawing from the research when contacted by phone, agreeing to take part in research and agreeing an appointment to meet with researcher but not attending (researcher changed recruitment to both phone and text patient prior to appointment to act as a reminder). Previous research has also reported recruitment issues. Osler et al. (1997) found that 30% of eligible women who had 3 abortions refused to participate in their research as compared to 3% of women with 2 abortions as compared to 0% of first-time abortion patients. Research by Alex & Hammarstrom (2004) also reports on issues of recruitment of women to a qualitative study who have sought an abortion. It would seem that women are reluctant to take part in research associated with abortion this may be due to unresolved issues, fear of disclosure and the attached stigma (Astbury-Ward, 2008; Hess, 2006; Major & Gramzow, 1999). To try and alleviate these issues with recruitment I decided to attend each abortion clinic session so when a woman had agreed to take part in the research the counsellor would introduce me to the woman. I felt that this may break down the barrier of an unknown researcher contacting the women at a later date. I believe that this did improve the recruitment of women to the study.

Another issue for recruitment for this research is the notion of gatekeepers which refers to those who are in the position to permit access to potential research participants for the purpose of interviewing (Johnson & Macleod-Clarke, 2003; Miller & Bell, 2002). Within my study one of the counsellors took the role of gatekeeper

and restricted the number of referrals made, by deciding who would be 'interesting' to interview rather than the actual inclusion criteria. She wanted to recruit women who had, what she thought were problems with multiple abortions. From her interview for this research it became apparent that she holds strong moral ideas regarding women requesting multiple abortions. Thus, women with multiple abortions who did not disclose any issues to her would not be asked to take part in my research. Three other counsellors also worked in the service and did not take this stance which improved the breath of experiences that were recruited to the study. The power of gatekeepers to deny access to vulnerable people has been evidenced (Liamputtong, 2007; MacDougall & Fudge, 2001; Wigley & Fisk, 2000) and this was supported from my experience where the gatekeeper attempted to try and skew the data collected.

Data Processing

Data Management

All audio and personal data were kept on secure, password protected, NHS computer. Personal notes and any record of participant's person details were kept in a locked filing cabinet in a locked office on an NHS site whilst not in transit. All notes including personal identifying data were transported directly to an NHS site after each interview.

Data Analysis

All interviews were transcribed verbatim using ExpressScribe and Infinity USB foot pedal, once transcribed and checked audio recordings were deleted as agreed in the

ethical procedure to make sure the link between research participants was cut as soon as possible. Once transcribed all interviews were uploaded to NVivo 11 (QRS International, 2017). NVivo is a data analysis computer software programmed designed specifically for use with qualitative research data.

Data was analysed in NVivo 11 using inductive thematic analysis (Braun & Clarke, 2006) this data analysis aims to identify and report on thematic patterns across the data which allows researchers to make interpretations of the data. The research took this approach because the research is content driven, specific codes or analytical units are not predetermined, codes were derived from the data through reading and re-reading the transcripts then build up into themes. An iterative approach was taken in which the data and categories were systematically reviewed and checked back against the transcript, until the most commonly cited concepts were identified, and data saturation is achieved.

Reflexivity

As the researcher I influence the collection, selection and interpretation of the data but the research is a joint product between the participants, myself and our relationship. A different researcher will have a different relationship, respond differently, ask different questions, and prompt different replies (Finlay, 2002). Instead of nullifying this relationship between the participants and myself, by means of artificial techniques, I am seeking transparency by employing reflexivity.

To employ reflexivity, I must situate myself in the research and to acknowledge similarities and differences between myself and the research participants. As such, do I have an insider or outsider status (Le Gallais, 2008) with my research participants. A researcher with outsider status does not share particular positions with the group they are researching. Whereas, a researcher with insider status may share one or more positions with the group they are researching leading to a collective identity or shared language. Having an insider status with the research participants can blind the researcher to perceive what they expect to perceive or know; it can also bring up discordance by having a dual role in the group such as practitioner and researcher.

I am a white, middle aged, single professional with no children who has not experienced requesting multiple abortions. As such, I share some similarities with the women who were research participants and have an insider status with the staff who were research participants. Similarities with the women who took part include ethnicity (white British), gender, sexuality and similar socioeconomic status as some. I have outsider status with the group of women I have researched, as I have not experienced requesting multiple abortions. I have insider status with the staff that were research participants as I work closely with them in the abortion service and other services provided by the Directorate of Sexual and Reproductive Health. I had to fully acknowledge my professional status and understand how it may affect my research.

One of the issues that I had to circumvent was negotiating between being a researcher and not stepping into my professional role of health care practitioner. Upholding these boundaries has at times being difficult as the skills needed for researching a sensitive subject, such as, abortion and my role as a practitioner are indistinguishable. Previous research has identified this (Coyle, 1998; Dickson-Swift et al., 2006; Glesne & Peshkin, 1992; Hutchinson & Wilson, 1994; Kvale, 1996), specifically empathy and listening skills are recognised as being important for both research interviews and for therapeutic interviews (Corey et al., 2018; Dickson-Swift et al., 2006; Glesne & Peshkin, 1992; Kvale, 1996; Liamputtong & Ezzy, 1999; Renzetti & Lee, 1993). The research interview can be thought of as a quasi-therapeutic interview (Astbury-Ward, 2008; Dickson-Swift et al., 2008) which I needed to manage and not risk either giving advice or counselling participants.

To provide space between myself as researcher and myself as healthcare professional I used several different actions. The main one was employing a research diary where I reflected on each part of the research process (sample in appendix 5). This was especially important when I reflected both before and after research interviews on how I felt, what I thought went well or could have gone better. I also used the research diary to log all my decisions regarding the data I collected. To improve this all themes were discussed and reviewed by my director of studies to ensure that I was being led by the research rather than by knowledge known from my professional work.

Interestingly one issue I did come across that I do not in my professional career is the anxiety I felt in making that first contact with the women who had agreed to take part in my research. This contact anxiety has been discussed in previous research (Cowles, 1988; Johnson & Macleod-Clarke, 2003). I believe I had this anxiety for a couple of reasons the first is that I was scared of rejection. Secondly, I was worried about how the women would perceive me, my research but also the service that I work for. Finally, but most importantly I was asking women to reveal a sensitive area of their life to me and I felt that I was intruding on them in some way.

Results

Demographics of participants

Ten women agreed to take part in this research (see table 3) their ages ranged from 19 years old to 36 years old, reporting number of multiple abortions between two and seven. Half of the women taking part in this research have no children. Most were educated above school level and the majority were in current employment. All the names for the women who took part in this research that are used in the results are pseudonyms to protect their confidentiality and anonymity.

Table 3. Demographics of women participants

Pseudonym	Age	Ethnicity	Marital Status	No. Abortions	No. Children	Education	Employment Status
Andrea	28	White British	Single	2	0	School	Employed
Angela	31	White British	Single	7	2	School	Redundant
Danielle	32	White British	Single	4	2	College	Unemployed
Jennifer	24	White British	Relationship	2	0	University	Self employed
Judith	36	White British	Relationship	4	6	School	Unemployed
Mandy	33	White British	Married	2	2	University	Self employed
Naomi	32	White British	Married	3	2	University	Part time
Phillipa	19	White British	Co-habiting	2	0	College	Employed
Rebecca	22	White British	Relationship	3	0	University	Employed
Sharon	26	White British	Single	2	0	University	Employed

Twelve members of staff agreed to take part in this research (see table 4) with years of experience ranging from two years to twenty-four years. Staff were from a range of professions including administration, nursing, medical and counselling. Only three members of staff had experience of working for another abortion service/s. All the names of staff who took part in and used in this research are pseudonyms to protect their confidentiality and anonymity.

Table 4. Demographics of staff participants

Pseudonym	Designation	Years working in abortion services	Worked for another service
Abigail	Admin	19	No
Fiona	Nurse Practitioner	16	No
Hannah	Admin	9	No
Helen	Counsellor	10	No
Jessica	Nurse/Scanning	5	No
Karen	Nurse/Scanning	5	Yes - England
Lisa	Counsellor	13	No
Lucy	Doctor	4	Yes - Wales
Nicola	Counsellor	2	No
Samantha	Nurse/Scanning	8	No
Steven	Counsellor	7	No
Vanessa	Consultant	24	Yes - Worldwide

Themes

Figure 2 sets out the thematic map

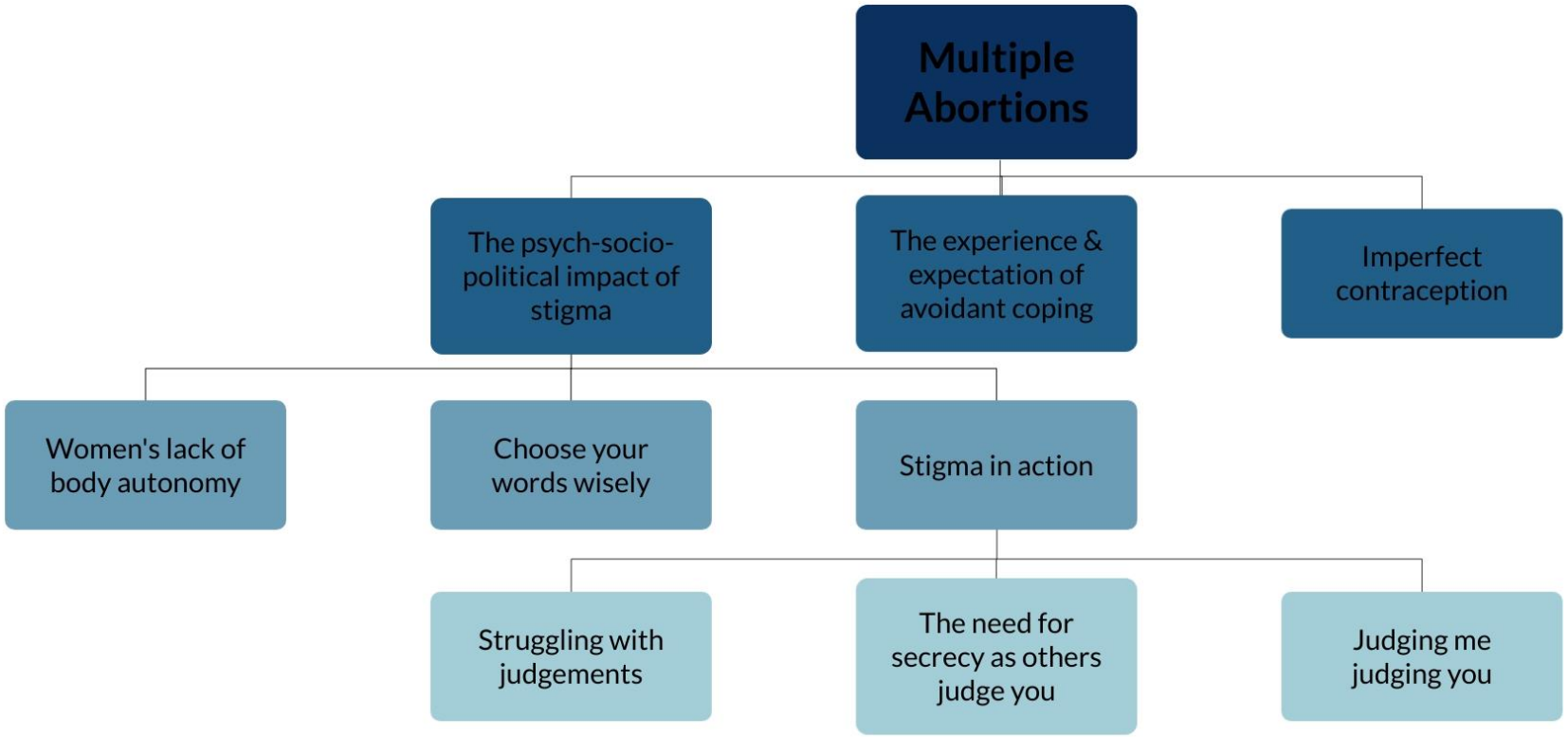

Figure 2. Thematic Map

Table 5. Thematic descriptions

Theme	Sub-theme	Description
1. The psycho-socio-political impact of stigma	1.a. Women's lack of bodily autonomy 1.b. Choose your words wisely 1.c. Stigma in action	This theme encompasses how stigma on every level impacts on women and their feelings regarding abortions.
2. The experience and expectation of avoidance style coping		This theme comprises of women explaining how they experience abortion and how staff expect women to cope with abortion.
3. Imperfect contraception		This theme covers how contraception is not the panacea of repeat abortion and the problems with contraception.

1. The psycho-socio-political impact of stigma

A stigma is defined as a mark of disgrace that sets a person or a group apart. Within this research both women and staff reported experiencing stigma from different sources. Stigma encompasses abortion by permeating all levels and aspects. These included the legal and structural framework of services that women access and staff work within. The terminology that surrounds abortion and more specifically multiple abortions. The many ways that women and staff experience this stigma, struggle with it and how they may even perpetuate multiple abortion stigma themselves.

1.a. Women's lack of bodily autonomy

Abortion is the only aspect of healthcare that legally needs two signatures of two doctors before the procedure can take place, except in emergency circumstances.

An abortion cannot take place until this legal requirement is met. Women in this research found that this requirement was an obstruction for body autonomy and questioned what right a doctor had power over the choices that she made where her own body is concerned. It is evident that women do not have full control or choice over their decisions, their body autonomy is entwined within the legal and structural framework.

Naomi: "But why if you've decided to have that procedure and it's all legal and above board then why do you need 2 people to sign it? Why? Them doctors don't even know me from Adam well I don't need your permission to do that, I don't need my husband's permission to do that. No, it shouldn't be. Cos that makes it more and more people involved and you know when you're going through it you don't want more people involved. You just want to go; you've made the decision that's why you're there. I get it that they ask you when you're there is this the right decision yes just do it basically. . . It's like a boob job you just go in and have the boob job so if you want a termination well just go in and have a termination if its legal . . ." (Naomi, 32: 3 abortions)

So, women have to get two different doctors to sign to agree to an abortion and finding doctors to agree can cause women to have to attend several places before they get a signature. Any doctor can sign the form but not all will. The impact is not just felt by women who attend the service but also by the staff.

Jessica: "So often they have encountered a GP who has refused to sign their HSA1 [legal document] form and so it's like that, this is wrong. This is wrong message before they even get here and their own emotional feelings about what they're doing their self" (Jessica Nurse)

Vanessa: "There's been so much about inspections of abortion services that I dare not proceed with the operation if I haven't got the second signature. So, I end up having to phone [the administration team] who phones round to get another one and will get something faxed over. But we've got 2 doctors sat there with us who are waiting to put the women to sleep but no no couldn't possibly do that but why couldn't you do that? (laughs) I want to say, 'tell me you've never shagged anybody you shouldn't without a condom and look me in the eye' (laughs). . ." (Vanessa Consultant)

Women who attend this service are expected to attend at least two appointments within the service. This is on top of having to get at least one copy of their HSA1 form signed by another doctor. However, as seen from the following quote this is not the only expectations that are put upon the women attending the abortion service. Staff found this exasperating, that the requests on women are difficult and seen as barriers.

Karen: "It makes it really difficult for them and if they DNA [do not attend] an appointment we're judging them for DNAing their appointment. But we're saying you can't bring your children don't bring your kids here. So not only do they have to make three separate trips, they also most of them have to arrange childcare, get time off work but if they DNA its wwhhooaa they DNA'd they're obviously not committed to this. And it's like no we're asking an awful lot of them in one week to make those 3 separate trips and to organise childcare cos they're not allowed to have children here or have children with them [in clinic]. And they have to then organise someone to look after them and take them to hospital cos they're not allowed to drive home and someone to look after them all day and all night (laughs) I couldn't do it if I had to have I couldn't organise that for myself no. . ." (Karen Nurse)

These legal and structural barriers work against women accessing abortion services. The way that the legal framework is set up impacts the stigma felt by women

accessing services. Staff in this research found that women who attend for abortions know that they have to have a justification, a valid reason, for doctors to agree to an abortion. Some find that problematic with the understanding that this causes women to experience an increased stigma.

Steven: "It's almost like 'I have to justify to him why I'm having this abortion' and I always pick that up and I always say, 'look love you do not have to justify it to me' and I wonder where that comes from. . ."

Interviewer: "Justify it?"

Steven: "It's almost like oh err he's gonna decide to let me have an abortion and I pick that up a lot and I'm like I'm not here to decide I'm here to support you in whatever decision that you want to make. And I wonder whether that comes from having to go to the doctors saying oh this is the reason I want to have an abortion . . . Yes, I've never thought about that and whether that is completely necessary I don't know . . . And does that enhance the guilt and shame cos I have to go in now to see two doctors and I have to justify to them why I want to have an abortion yeah. . . And then they come into the counselling doing it again I've got to justify every step of the way . . . mmm. . . And justify it to myself first and then I'll just justify it to everybody else I've already been through that process in my head of trying to justify it to myself and it's making me feel guilty and ashamed and now I've got to do it to other people yeah yeah I'd never thought about that" (Steven Counsellor).

1.b. Choose your words wisely

There is a mix between the preferred language that is used within an abortion service. With some women preferring termination over abortion however, that is not universal. As you can see from the following quotes there is a mix of preferred terminology. With this first quote the women is concerned with being viewed as selfish.

Jennifer: "Yeah there is stigma around the word abortion, isn't there? I think like when you say termination it could be for medical reasons but abortion, things that are associated with it like you're just been selfish" (Jennifer, 24: 2 abortions)

Whilst the following quotes are both linked to how the word sounds and thus how it is then interpreted by a wider audience. With one quote acknowledging how words are used in the media and how that then influences people.

Mandy: "Erm I think I I think it's just how the words sound don't they and how they're portrayed in the media as well. I think there's this big abortion thing at the moment and I I I've really don't mind but termination probably sounds less crass doesn't it? . . .It's quite a harsh word [abortion] isn't it, but I don't mind". (Mandy, 33: 2 abortions)

Whereas, this second quote links the use of a word with the notion of killing which impacts on the way women view themselves and their decisions. There is a need to understand and appreciate that not all women will prefer the same terminology.

Rebecca: "I think abortion is more smooth (laughs) and termination reminds me of the terminator. Like when they like it emphasises the word kill like, I think. I don't care what you put but if you're asking me what word sounds nicer yeah, it's like what they mean like the terminator kills people like it's like termination it's the same thing". (Rebecca, 22: 3 abortions)

Women use these distancing techniques to protect their sense of self-worth and find it difficult to deal with the use of language that infers criminality.

Naomi: "I don't know I honestly don't know cos it is one of those subjects that where people, unless they've been in the situation again, they see it as murder some people and they see it as killing you know". (Naomi, 32: 3 abortions)

Rebecca: "I never think I've killed a child like I've got that in my head at the end of the day it's just an embryo like. Like I never I'd never go as far as googling what they looked like at eight weeks cos that's ridiculous when I like, when I see things like it's killing your baby that really annoys me". (Rebecca, 22: 3 abortions)

Staff also acknowledge that criminalised language has an impact on the service especially with women who return for multiple abortions. This use of language has marked these women negatively.

Karen: "Yeah yeah there was a . . . someone coined a phrase a couple of years ago 'repeat offenders' and I found that really difficult I thought that was an awful thing to say . . ."
Interviewer: "offender like language"
Karen: "Yeah and it's almost as if we have to tolerate them it's that kind of attitude erm, the word tolerate is a horrible word anyway its really negative (laughs). If you tolerate someone, you're just putting up with them just putting up with the fact that they're coming back. So, we have to tolerate them to give them the abortion, so we just have to tolerate, and I think you know. . . that's if anything they need a bit more TLC, don't they?" (Karen Nurse)

Steven: "Yeah yeah, it's like probation repeat offender you're going into a high risk now and it's like it's criminalised and it's slightly discriminatory, but it is it is mmm. . ." (Steven Counsellor)

However, for some staff the use of this repeater language has fallen into common parlance.

Samantha: "We've still got failings, haven't we? Yeah whatever we do I dunno and why haven't we got something more, we've got men on the moon why haven't we got something better (laughs) for these repeat offenders? (laughs) I dunno we are so funny no I don't know what the answer is I don't know" (Samantha Nurse).

1.c. Stigma in action

Stigma is a dual process as we can feel stigmatised, but we can also stigmatise others. Stigma falls into three levels of perceived stigma, enacted stigma and internalised stigma which are not always clearly delineated as can be seen from this section.

1.c.i. Struggling with judgements

Women talked about how the service and the staff impacted on their feelings of guilt and shame from the moment they contacted the service. With one woman expressing previous positive experiences of the service but felt more judged when returning.

Rebecca: "I've been through the NHS they've always made me feel like as if I am a person and they are genuinely concerned about me. The only time I felt a bit thing was when I rang [the] clinic and she was just like completely black and white on the phone and she wasn't like sympathetic or anything towards me like. So, it was like we hear this everyday so for god sake get a grip like that's how I felt . . ." (Rebecca, 22: 3 abortions)

Judgement and the associated stigma that Angela felt from her first contact with the clinic led her to contemplate breaking the law.

Angela: "So, a lot less judgement would go a long way right from the first phone call . . . which they threatened me with the same doctor then I had 2 weeks to worry which is why I ordered the internet tablets. So, that person on the telephone could have caused me so serious issues she's only a receptionist . . ." (Angela, 31: 7 abortions)

Women also found it difficult when challenged on previous number of abortions or when they conceived.

Rebecca: "Like I said, and that woman said to me you've had 3 mind that really got stuck in my head that did where normally I can let it go over my head but that was like" (Rebecca, 22: 3 abortions)

Sharon: "She just made me feel like I was lying a little bit, but I know exactly when it was it was either then or six months ago so (laughs) it certainly wasn't 6 months ago" (Sharon, 26: 2 abortions)

Staff struggle between wanting to provide an excellent service and the way that they feel about the women who attend the service. Staff acknowledge that women experience stigma.

Steven: "Being aware of of of what we do and who we deal with, so feeling that stigmatised ourselves how does a woman feel? . . . You know and you see it all the time when they come in that guilt and that shame and and that. And if I had a pound for every time, I heard I've never believed in abortion but look where I am, sat here" (Steven Counsellor)

Samantha: "It it can't be easy it can't be an easy thing to do? Because it is, there is a stigma to it and you just think it can't be easy to do that? To ring up for that appointment surely" (Samantha Nurse)

Jessica: "Yeah definitely I just think its sexual health in general, I just think there's a stigma attached to it" (Jessica Nurse)

However, they want to point out that the stigma is not coming from them directly or the service.

Fiona: "(deep breath) I don't think the word stigma is the right word erm I think maybe erm . . . what's the right word erm . . . no erm . . . some people feel stigmatised . . . some people feel embarrassed . . . erm . . . Some ladies' older ladies feel very upset you know that this has happened, and they have to access this service erm . . . And some probably do feel stigmatised but we don't make them feel like that, that that comes from their own per . . . their own perspective you know from their background or friends" (Fiona Nurse Practitioner)

Staff do feel a sense of failure with the women that are returning as if they have not done everything that they can. This frustration can then spill out into the clinical setting.

Fiona: "I do feel frustrated personally myself, I feel that probably how did we let her down, how did the service let her down erm. What could we have done differently? How could we have supported her more? But erm. . . then again when you talk to people you find that it's not that simple, you know there's a lot you don't know what goes on behind closed doors unfortunately erm. . . so erm. It is frustrating in a way, but I have to deal with that client at that particular time and where she is in that stage of her life. Erm you know I just talk and counsel as I would do anybody else really although I still am frustrated (laughs)" (Fiona Nurse Practitioner)

Vanessa: "There's a sense, there's a sense of failure about it on both sides because erm my ex my expectations would be that you know that you're allowed to slip up once but then you should get it

together. Like you know come on (laughs) erm so where is the failure is on us as the providers, is it her and where does it fit? And I feel a bit its erm more challenging than a woman who's never had an abortion before with the never before you've got a blank slate . . . clean sheet somewhere to start. If you're on number 6 it's a bit . . . where should we start you know what kind of mood am I in, you know? (laughs) Have I, do I have the appetite for being as emotionally available I might need to be to get to the bottom of the story about this woman erm and it may be that it's just an insolvable problem for her" (Vanessa Consultant)

Whereas others as completely consumed by the number of abortions a woman has had.

Lucy: ". . . And I tell you what and this is awful, and I don't really bat an eyelid anymore until I see 3 [as in 3rd request for abortion] . . . I tell you what I have noticed the staff are very too quick to pick them up and pick them out 'oh we've got another one whose 5th request' and I don't know whether that's kinda exasperating them because they're fed up of seeing them" (Lucy Doctor)

Samantha: "We err what came over was right on our computer screen on the front page it will say 3rd, 4th, 5th, 6th, 7th, 8th request and you think oh dear God, so straight away you're been judgemental. So, what the err clinical supervision brought out was does that need to be there and you think no it doesn't. And then you should be, we should be treating them more like it's their first termination and it should be the counsellors that are exploring the reasons why erm and the word was used its their journey not yours and that really hit home to me because I would say yeah, I was becoming judgemental" (Samantha Nurse)

Vanessa goes on to say that she also wants to advocate for the service and by extension the women who access the service.

Vanessa: "Well what I was thinking its more that if I erm if I can see that that person [has] made that comment doesn't understand the perspective of the patient is not able to empathise and that's where I feel I need to be an advocate on her behalf. Which is at odds, with my slightly, do you have to really (laughs) do you have to be back here which is really what I'm thinking. But actually, to the outside world I'm an advocate for them so there's also that dissonance that it causes in me . . . I don't want . . . outside colleagues to think badly of the women in the service and the service you know it's sort of like . . . our erm . . . what is the word I'm looking for . . . reputation it's like our reputation and their reputation is all the same thing. Because you if you didn't know any better, you'd think the quality of care we offered was poor and that is why they've kept coming back, but it isn't like that and I don't want people to think that . . ." (Vanessa Consultant)

There is a sense that some staff want to catch women who return for the repeat abortions in a lie. Although some staff really struggle with this.

Samantha: "They have they have and it's if it's through our service it's on record since we've gone electronic it's all sitting there. And and the worst thing is sometimes you'll have somebody come in and they say it's her 6th request and she'll be in the room and I've seen this, and she'll go they've told me it's my 6th but it's not it's not. And there's actually people looking to prove her wrong and you just think oh dear God just leave it go so you're extra nice to that person then so not for her to feel . . ." (Samantha Nurse)

Karen: "What's more important making sure they're telling the truth or making sure they have the abortion? . . . I think some people . . . this is all confidential isn't it . . . I think some people want to catch them out I know some people kinda want to catch them out in the lie and I think that's cruel. And I think that they are just doing the best they can some of them . . . And I think here the staff here assume that its easy we give them the appointments and we see them, and we give them the tablets and we don't ask too many questions, but I think it's really hard for them" (Karen Nurse)

Vanessa: "Yes previous termination is a factor that we need to know about, but I don't think it needs quite as high priority it gets at the moment (laughs). Getting on the phone they check them out, don't they? 'How many terminations have you had before?' and the woman says 'none' and they're looking at the screen ooohhh you've had 3 . . . You're a liar so not only are you a repeater but you're a liar and I don't like that you know (laughs). I just say to them ah don't worry about it, but they just feel guilty and ashamed . . . it's not helpful" (Vanessa Consultant)

1.c.ii. The need for secrecy as others' judge

Fearing judgement from significant others' both women and staff choose carefully who they tell and talk about their experiences with. There is a veil of secrecy surrounding abortion with both women and staff.

Andrea: "Sometimes I think some people can be so judgemental like obviously with what's going on at the moment. I haven't told many people at all because with my partner I told him I had a miscarriage and erm he's thankfully didn't ask too many questions. Which was an awful thing to do I understand but it was one of those things" (Andrea, 28: 2 abortions)

And as the number of abortions goes up the number of people told comes down, as the guilt heightens. Women find it increasingly hard to discuss multiple abortions with friends and family.

Rebecca: "I haven't told many people about the third one like. I told, I had to tell one of the girls in work because erm there was no other cover apart from me and her on that day so I had to say I'm giving you a heads up . . . Oh, definitely like like I say I say to the girls about it like, a couple of girls know about my first one and then the number just gradually went down by my third one (laughs) but I like to talk" (Rebecca, 22: 3 abortions)

Andrea: "Yeah definitely that's probably why I haven't told or confided in many people cos it's it's . . . well it's sort of politically incorrect and it's such a controversial . . . thing to talk about. Some people are really dead set, and what have you, and I think being one minded sort of thing. But I think the majority of people who are against it have never really being in a tough situation where they've actually had to make that decision, and to think that is the better outcome as what's going on. So, I'm not saying all people they could well be in that situation and go the other way but yeah, I think there's just so, I think you've got to be more open minded these days but yeah there's definitely a lot of stigma around it. Yeah that's why I haven't, and I not like I said I haven't got many friends lately, but I know the ones that would take it better like my sisters open minded" (Andrea, 28: 2 abortions)

Women are careful about who they tell in their own close inner circle, but they feel stigma from 'others' including the general public. This promotes silence regarding abortion as women are worried about being judged on the number of abortions they have had.

Judith: "Oh yeah I wouldn't say to people like I've had abortions cos they'd look at you thing. But like I said everyone's thing is different like I do feel for people who can't have children but then that's not my fault that I'm too fertile" (Judith, 36: 4 abortions)

Angela: "So, I think that there is a big stigma on how many you have done, and I think you do get treated differently and you do get looked down your nose at to be honest" (Angela, 31: 7 abortions)

Danielle: "People will still label you it's horrible it's horrible and I suppose I worry about being labelled. I worry about it and I think that's why women get the stick so bad with stuff like this. If you go through with having a kid if you go through having an abortion"

Interviewer: "Is it worst if you've had multiple abortions?"

Danielle: "Yeah yeah like I am pret, I am I wouldn't broadcast the fact that I've had a few in it though? They haven't been like 1, 2, 3 in the same year or something. Like one was when I was 18 and I'm now 32 next week do you know what I mean? So right one was when I was 18, one was a few years ago and one was now but still to say you've had 3 abortions would be like had 3 abortions (lowers tone) you know" (Danielle, 32: 4 abortions)

Although women are careful about who they tell they would like to talk about abortion as can be seen from the following quotes from Naomi.

Naomi: "I didn't tell them, they didn't know I never told them my husband knows and apart from my husband, my mum and my best friend nobody knew" (Naomi 32: 3 abortions)

Where she has limited to telling only three people but later in the interview acknowledges that the topic of abortion needs to be talked about.

Naomi: "Yeah yeah I mean it is difficult and if anybody tells you that they've been through it and its not then they're lying, or they've got no heart or no thought for anybody. And it is, it is a difficult subject that needs to be talked about cos I think a lot of it you don't know how people are gonna react" (Naomi, 32: 3 abortions).

Whereas, women kept silent regarding their abortions staff preferred to say they worked in sexual health in general or expressed their job title rather than the service they work in. Staff did not openly admit to being stigmatised by the work that they do but they quietly navigated telling others about their abortion work.

Abigail: "I tell them that I work for sexual health, very rarely tell them I run the abortion service obviously my husband knows the children know . . . When my mum was alive, I don't think I told my mum erm . . . My close friends probably know not quite so close friends and my regular acquaintance don't know I work for an abortion service" (Abigail Administration Officer)

Hannah: "I don't hide it; I don't don't I know that some people don't tell. I just say, I just say that that if somebody asks me what clinics I do I just say unplanned pregnancy I don't say that it's a termination clinic I just say unplanned pregnancy" (Hannah Administration Officer)

Steven: "Yeah yeah but not I'm I am always careful who I tell cos you don't know what they will . . . and it's one of those stigma things isn't it . . . I normally just say I'm a counsellor do you know what I mean or a health advisor and something like that. That's what I put on forms health advisor actually probably or counsellor cos otherwise you've got to go through the whole thing" (Steven Counsellor)

Helen: "Oh, good god no no I'm proud but I don't want no I just tell them I work sexual and reproductive health. But as an abortion side of it if someone asked about [the abortion] clinic I'll tell them, but I've got no stigma whatsoever the thing I protect the client if they say I've seen you" (Helen Counsellor)

Staff understand that this type of work is 'dirty work' (Joffe, 1978), and that being known to work in abortion services could have serious consequences.

Jessica: "Mmm nobody has ever being negative in what I do either so I'm lucky in that way and I have to say I do think I do care about my patients. And I don't really know how to put this into words, but it is just a job, I'm not here to judge anybody it's just my job it's what I do. That doesn't mean I don't care about people, but I guess it's a way of putting it into a compartment and dealing with that. Cos if you think about the fact that I'm helping all these people to terminate their babies on a weekly basis that's quite a big thought isn't it that's a quite a big thing to process?. . ." (Jessica Nurse)

Vanessa: "Yeah I think you're right I'm not sure I want to leave medicine known as an abortionist (laughs) . . . hanging up my bullet proof vest (laughs)" (Vanessa Consultant)

1.c.iii. Judging me judging you

Women struggle with their own judgements about multiple abortions comparing themselves with others either on number of abortions or number of children.

Andrea: "I'm still quite double not double standards bit hypocritical"

Interviewer: "ambivalent?"

Andrea: "Yes yes because in all fairness I I now (inaudible) each to their own. Don't blame people who go out and have one-night stands and all but I in a sense one of the girls I know she lives up the road has well she's had, I'm sure she's had 3 cos they wouldn't let her have the 4th cos you're only allowed 3 or something. And erm they were all because she has one nights stands and being open to the fact that she don't use contraception, that's not, it's not a form of contraception that's different" (Andrea, 28: 2 abortions)

Danielle: "Oh god yeah some people are dead against it, I know someone dead against it and she has 7 kids like a crazy person but then that's her view you know. She doesn't want to do it and that's fine but then she's looked at I know this sounds like [points at son] it's his dads' mum it is and erm loads of people were like she's got 7 kids. As long as she's looking after her kids that's fine, but some people are like she's got 7 kids by different dads, now that to be honest with you, that was another thing towards me going to do this. Cos I would have had 3 different dads and I know what people are like in this world and to me it doesn't matter who the dad is, but people look at you. Literally before I slept with the person, I hadn't slept with someone for 8 no almost a year, you know. I hadn't so the last person no it was his dad [youngest] so nearly 2 years you know but people don't look at it like that like a one off you've made a mistake" (Danielle, 32: 4 abortions)

Although most women did make judgements in their interviews, they also were very negative about people judging them. Women are making decisions that are right for them, they struggle with their own judgements. In that, they hold judgemental attitudes of others but request that they are not judged.

Angela: "Yeah oh yeah yeah because erm people just don't agree with it at all and then they judge you and nobody should be judged. You don't understand the situation until you're in it yourself, so people haven't got the right to judge people. So, I'll only tell people who I'm very very close to cos I don't think it's fair to judge somebody" (Angela, 32: 7 abortions)

Danielle: "No I don't want people think she's up there again, she's there again do you know what I mean? Cos people do they, you know they look at you even though it's a mistake. They do look at you like that; the world is a horrible place and people are nasty erm. Its I just I feel I it's my business it's my business if it's something that I've got to do there could be someone out there who's dead against them and it's gonna be horrible about it but at the end of the day it's not their life its mine" (Danielle, 32: 4 abortions)

2. The experience and expectation of avoidance coping style

Coping is the conscious effort to reduce stress, women accessing this abortion service tended to verbalise that their preferred coping strategy was to move on and not dwell on the abortion. Most women discussed how they coped with their abortions all who did used avoidant coping mechanisms.

Angela: "I don't know . . . I genuinely don't know I don't know if I do I think I just shut off, I'm very busy all the time I've always got something to do so I shut off I think I plan my time with my children as well . . . Erm I try not to think about them if I'm honest I don't think about them. I know that sounds really heartless, but I don't think about them cos you could just torture yourself, if I started to think

about them. I'm the type of person who will constantly think about it and go over what I could have done differently, did I make the right decision? What if I got rid of one of my children that I've got now, and I'm very blessed I've got 2 beautiful children so; I would just plague my mind with things that I can't change so I just shut off . . ." (Angela, 31: 7 abortions)

Mandy: "Erm erm I wouldn't even say I don't know I wouldn't even say relief, but it was just it was how I I suppose how I dealt with it. Very matter of fact and that is that now and that is done and that's probably how I tend to deal with a lot of things. Anyway, so I was like yep that's that then now I can move on erm . . . yeah" (Mandy, 32: 2 abortions)

Danielle: "You're making a decision to get rid of it why that's why I don't you know I might be wrong, but I think if you're making a decision obviously, there's a reason behind you making that decision. You know and that's why I said to all my friends that know, they are like are you alright? Are you alright? And I'm absolutely fine and that might sound a bit selfish it might sound a bit hard faced but it's my decision . . ." (Danielle, 32: 4 abortions)

Rebecca: "It's the fact that I'm talking and interacting with someone like nobody is in my house and I don't know what time anyone is home so sitting at home twiddling my thumbs isn't good. So being out and I think that helps me with every single one. The last one before I had this, I was going on holidays straight away then it was summer so I had loads planned and then the first one I had we booked an holiday after that so we went for 2 weeks we were literally straight from that into a nice part and that was the summer again and hence we had loads booked. I think it only hits me when everything stops, and I overthink it then but then like that'll only be for a couple of hours but then my life will be like in gear 100 again so I think that's sort of my way of getting around it"

Interview: "so, you cope by keeping yourself going?"

Rebecca: . . . I said to my mam I need to go out I need to forget about it I know I'm gonna feel awful on Sunday and I know drink is a depressant and it's all gonna come back. But then on Sunday the child I work with its his birthday, so we'll all be going out for that with work then. So even though I'll wake up with a hangover it'll be like 2 hours of feeling sorry for myself and then I'll be back out then and

then on Monday I'll be working all day then, so I just keep on going and going and it's only when I'm left on my own that I overthink it" (Rebecca, 22: 3 abortions)

Staff discussed how they felt women coped with having requested multiple abortions non-counselling staff report that women have a variety of coping responses when they return to the service.

Vanessa: "That's another complete diversity completely diverse group. Some women absolutely cringe with embarrassment I'm here again so sorry I'm so embarrassed and its let me down and they've got a story about what actually happened to them and then there are others that are a bit like ppppfffffff yeah unlucky aren't I ppppfffff (laughs) yeah (laughs)" (Vanessa Consultant)

Whereas the counsellors within the service seem to expect denial in its various forms including the denial of a previous event (i.e. abortion) or the denial of feelings associated with previous abortions.

Nicola: "Cos I'm interested in finding out how you coped you know 'oh yeah yeah I forgot about that one' and they just generally either don't want to tell you they have genuinely forgotten about it. Possibly put it back into the subconscious or one woman she de-compartmentalised it as in she treated it, she she had four, but she treated two as a miscarriages"

Interviewer: "right"

Nicola: "She didn't disclose the three she'd had she disclosed one and then when she was prompted afterwards, she was 'oh yeah there were miscarriages. And when we explored that a little bit further, she admitted that's how she liked to think of it that was a coping mechanism for her so that's how she coped and that was ok and erm" (Nicola Counsellor)

Lisa: "One of them just sat there with us a smug look on her face 'I don't care' you know 'I'm here for a termination' social services will take the baby off me otherwise. And I just didn't rise to any of it and just treated her like I would treat any other person but that poor girl that's how she is that's how she's survived what she's gone through?" (Lisa Counsellor)

Steven: "No no I've had one where she was quite blasé about it and by the end of the session, I was like fine love cos if you're fine about it you're fine about it. No there's no prerequisite to be so miserable and depressed about the fact that you've had an abortion and I remember saying that to her. It's not written in stone you have to be depressed now cos you're having your 6th abortion no . . . No more so than if someone's got chlamydia 6 times or whatever. . ." (Steven Counsellor)

Vanessa goes on to report that other medics not working within the abortion service are amazed at how these women present at appointments.

Vanessa: "I'm always I'm always erm I don't know what my reaction is really but I'm always surprised erm when we're doing the sTOP lists when we have a junior anaesthetic person comes in and they start asking about a service and as they start to realise that for quite a few women this is not the first time. They've been through the service that people who have not ever worked closely with women having abortions think that number one they're gonna be psychologically scarred and screaming banshees and no actually they're quite normal (laughs). And they could just go shopping afterwards and secondly the idea that they're having this more than once is really shocking you know that just that knowledge of those facts and I just think . . . and they say things like this shouldn't be allowed . . . to have another one they should be made to use contraception and things like that and I think . . . erm" (Vanessa Consultant)

3. Imperfect contraception

Where contraception is concerned staff gave examples of women who had never used it and returned to the service. Women who took part in this study discussed

how they had engaged with contraception. Both staff and women agreed that there can be problems with contraception including it failing or that the side effects are not tolerable.

Vanessa: "I think that's the best way to go really if if we could find something that is helpful that would be brilliant. It's a bit I don't know I suppose they've made breakthroughs in smoking cessation cos people need to make 7, 8, 9 attempts at quitting to stay quit. And they are often quite old by the time they do it ain't they just another one of those things so . . . erm I'm open to suggestions (laughs) that doesn't involve flogging . . . and putting them in the stocks"
Interviewer: "You were saying that when the women turn up there's a sense of failure on both sides?"
Vanessa: "Yeah yeah . . . helplessness really absolutely somehow it reflects how ungrateful she was last time fancy not keeping that implant in but maybe she bled like a stuffed pig (laughs)." (Vanessa Consultant)

Rebecca: "I tried the needle, but I had it cos I was under anaesthetic but if it agreed with me cos, I do have reactions to everything but if it agreed with me, I would just have to suck it up and get it done every 12 weeks, but it didn't. I think I bleed for 6 months on and off after and that when my mam was worried cos the operation went on for so long maybe something had gone wrong but when I went down family planning eventually then cos the doctors examined me and they were it wasn't the abortion it was the contraception you were on so I was like I'm not having that again. Like I bleed for 6 months I think I had it done when was it July or June I want to say but it didn't stop till early January but then I didn't have a period for 4 or 5 months after it . . ." (Rebecca, 22: 3 abortions)

Women have a negative view of contraception with some staff acknowledging that and understanding that there are other people out there with more persuasive views than theirs.

Karen: "And we're not cool they're not gonna listen to us, are they? I think and the only time people talk about contraception is when its gone wrong if people have had problems with their coil you see girls girls coming to me I say about the coil or the implant and they're like 'oh my friend had a terrible time with that' and I said yeah but the people who have had an okay time with their coil aren't running up to you in the street saying 'let me tell you about my coil its fantastic' they only wanna tell you when its gone wrong. Apart from us out there the only talk about contraceptive is negative so no wonder they don't want anything cos their friends and families are telling them horror stories so there's nothing there's not positively reinforced we're talking about contraception but no one else is positively reinforcing it then" (Karen Nurse)

Samantha: "Most women don't like contraception they don't want to take it they not that they haven't found anything that suits them. It that they just don't want hormones and coils my God it's like it's like you're a vampire and you go up to them and they cross themselves like that [acts out cross]" (Samantha Nurse)

Sharon: "I was thinking about going back on the pill, but I think I'll probably go for something else like the injection, my mum had the coil and she she she ended up having a hysterectomy she had like fibroids you know and she mentally links that with having the coil which has put me off. Which is not true at all of course but she had it she had the fibroids when she had the coil and that kinda played on her mind and I couldn't have an implant in my arm . . . but erm the thought of the coil and the implant those things just creep me out a little bit so I will probably end up having the injection but . . ."

Interviewer: "do you think contraception is the answer?"

Sharon: "It's gotta be contraception hasn't it and doing it properly (laughs) and erm you know no one enjoys using condoms no one whose got time for that to deal with that (laughs) it. I think ultimately, it's a woman's responsibility it happens to you so you should protect yourself it's not up to a boy to bring along his pack of condoms in his wallet to protect himself I think it's our responsibility to minimise the risk not not the males . . . If you don't want to have to go through having an abortion you should do everything to minimise the risk and contraception is it" (Sharon, 26: 2 abortions)

As from the previous quote the responsibility of contraception rests on women which again impacts on the guilt that a woman feels for either not taking contraception, for not taking it properly or even if it fails.

Helen: "Contraceptive future contraceptive they don't take responsibility cos it comes back to multiple abortions which comes back to today. . . Erm the multiple abortions this afternoon this morning oh what shift am I working erm. . . she was on her 5th, it was all responsibility with blood clotting issues that she's got and contraceptive doesn't work not taking any contraceptive and sort of you could have used condoms we did explore that and everything else it's not her problem it's not her fault at all but we didn't want to blame fault we didn't look for blame it's about responsibility what you doing everything else. . ." (Helen Counsellor)

Naomi: "I mean it's a woman's responsibility for contraception isn't it cos you are the one who has take it you have to make sure . . . and I think that's silly really but if they have already got three kids and having 6 terminations that would be 10 kids or sorry 9 kids well that's just absolutely absurd . . . but they are obviously doing everything really wrong" (Naomi, 32: 3 abortions)

Samantha: "I think in this day and age society expects them to be more responsible and perhaps you know be a little bit more savvy and more active in doing something to prevent it you know because there is a lot out there, but we are criticised as well because we do turn people away for contraception" (Samantha Nurse).

These results begin to present the complexity of why women return to have multiple abortions and the interplay between different levels of society. The psycho-socio-political impact of stigma has a major bearing on both the women and staff who took part in this research. With the influence of stigma, avoidance coping may seem an ideal act to protect oneself from any increase in the guilt and shame associated with

multiple abortions. However, contraception is not perfect, and this research presents that some women find it problematic. The discussion will begin to examine the interaction between the themes that have been proposed in these results.

Discussion

Three main themes have been uncovered in this research they are the psycho-social-political impact of stigma, avoidance coping and imperfect contraception. The findings suggest that stigma is an issue within abortion care, it permeates all levels of abortion care from the personal through the interpersonal up to the political. In theme one, abortion stigma encompasses all aspects of the abortion journey for both women and staff. Previous research has found that abortion stigma manifests itself at multiple social levels: media, law and policy, institutions, communities, relationships and individuals (Cockrill & Biggs, 2017; Kumar et al., 2009; Major & O'Brien, 2005). Major & O'Brien (2005) have suggested that the psychological implications of stigma are profound. These effects of stigma within this research group will be discussed.

The second theme from this research is the utilisation of avoidance coping by women requesting multiple abortions which is also expected or anticipated by the staff. Avoidance coping is thought of as a negative coping mechanism as it suggests that individuals who utilise this method of coping have poorer psychological outcomes. The perspective of avoidance coping that were employed within this research sample will be explored.

Finally, the third theme was the imperfection of contraception, for some women there was an expectation that the uptake and adherence to contraception will reduce multiple abortions. However, women are still experiencing difficulties with

adherence for many reasons. Open communication regarding contraception is problematic in a heightened stigmatised environment and this will be discussed.

Previous research on abortion care has been quantitively focussed, this study fills the research gap where there is a dearth of qualitative studies that explore the experiences of abortion patients; especially patients who have requested multiple abortions. Other research has either focussed on women requesting abortions or the staff that provide them, this research is unique as it looks at the experiences of both women and staff concurrently. By exploring the experiences of both women and staff together has enabled this research to look at the interactions between them. This provides a new perspective on why multiple abortions are thought of as problematic but also to suggest interventions.

Within my research results there is a premise that a 'dance' is going on between the women and the staff. The dance takes different forms Steven (p.83) says that he always feels that women who attend and see him are trying to justify why they are returning, and he feels that the women think he has the power to decide whether they have an abortion or not. Whereas Danielle (p.96) is experiencing internalised stigma as she does not "want people to think she's up there again". This interplay between women and staff also plays out in other ways. Staff acknowledge that women suffer from abortion related stigma and at times overcompensate for that with some staff acknowledging that women may have already faced some stigma (i.e. a GP refusing to sign a HSA1 form), and other staff discussing the barriers that are in place in the abortion service that increase the stigma. The complex interplay

between the power differentials of the actors and the stigmatised nature of abortion care play out in this dance within the abortion clinic. Medical settings such as an abortion clinic prescribe and perpetuate roles for all the players within it (Prilleltensky & Prilleltensky, 2003). Within this hierarchical system the role of the woman requesting an abortion is diminished in power and self-determinism whereas the role of the staff is increased as they have the ability to make decisions for the women. Prilleltensky & Prilleltensky (2003) suggest that all actors are at risk; women are disempowered, and staff are at risk of becoming paternalistic. Power resides in interpersonal exchanges in daily acts of resistance (Fox et al., 2009), as we saw with Naomi (p.81) she wanted to resist this power and have autonomy over her own body. It's not only power over their own bodies that women struggled with it was also the perceived judgements they faced.

Women within my research struggled with negative judgements about themselves and perceived negative judgements from others, including staff. The power differential between staff and women also fed into this with women presenting with feelings of shame and guilt. Researchers have suggested for decades that shame and guilt are the two most common manifestations of internalised abortion stigma (Bleek, 1981; Kumar et al., 2009; Lithur, 2004; Mojapelo-Batka & Schoeman, 2003). Shame is a negative self-evaluation it is experienced when a core aspect of the self is judged as defective, inferior and inadequate (Dickerson et al., 2004; Fallon, 2013; Gilbert, 1998; Irvine, 2009; Tangney, 1995). Women in this research acutely felt stigma, shame and guilt and at times tried to distance themselves from these feelings through 'othering' (Jensen, 2011). Which is the construction and identification of the

self as an in group and the other as an out group. In this research 'the other' consisted of women with multiple children by multiple fathers or parents with multiple children but with no means of supporting these children except by the state. The use of this concept 'othering' is employed to reduce the shame felt by women requesting multiple abortions. Reducing stigma and shame may have health enhancing properties as it has been suggested that shame is a key affective component in the psychobiological response to threats to the self, culminating in an increase in an individual's vulnerability to adverse health outcomes (Dickerson et al., 2004). As this research also garnered staff's experiences, they too have to manage abortion stigma.

This research provides some evidence that staff are also targets of abortions stigma and although this may not have been overtly verbalised by staff it was seen in the way that they discussed their job roles. It is important to remember that abortion stigma felt by staff, at times, can manifest as negative affect, negative attitude and negative behaviour related to abortion (Cockrill & Biggs, 2017). In fact, it has been suggested that nurses who work in abortion services hold more negative views on abortion than those who do not (Hanna, 2005; Marshall et al., 1994). This leads to, as we saw in the results, a cognitive dissonance between what staff do and think. In which they struggle with their own feelings of stigma regarding women requesting multiple abortions. Thus, staff may become the 'shamers' (Probyn, 2005) as women and staff reported in this study because however unwittingly, they actively evoke feelings of shame in women. This enacted stigma and shaming did lead women to try to reduce those feelings especially with trying to buy medication on the internet

and then the woman would not have had to attend clinic which prevents constructively addressing real issues with imperfect methods of contraception. Staff may be acting this way as they are also feeling stigmatised with some suggesting that this could be due to abortion being thought of as 'dirty work' (Joffe, 1978). Dirty work is associated with three taints, that is, the physical (blood or foetal parts), the social (contact with stigmatised individuals) and the moral ('sinful' status of abortion) (Harris et al., 2011; Joffe, 1978). Dirty workers, like all stigmatised individuals, risk adverse psychosocial consequences, including status loss, discrimination, and disclosure difficulties (Goffman, 1963; Major & O'Brien, 2005).

Staff must manage their own relationship to abortion and just like the women who request them they must cope with their own feelings and thoughts. We saw that staff at times struggled with wanting to provide a good service to women and managing their own person judgements regarding abortion especially with women who request multiple abortions. This also extended to women's fertility in that when attending an abortion service women's fertility is policed by staff, as in what is the most effective contraception staff can get women to leave with. Although staff do acknowledge that contraception can have side effects (see Vanessa p.100) which can affect individuals' choices. However, only contraception is discussed as an option to reduce women returning, contraception in the UK is marketed as the only avenue to reduce multiple abortions. Staff suggested that they feel a sense of failure when women return for subsequent abortions as in some way; they, the staff, got it wrong. Due to free and easily available contraception an unintended conception marks a woman as irresponsible (Hoggart, 2017). Framing contraception as the best choice

and abortion is a misfortune, promotes the enduring stigma attached to abortion (Løkeland, 2004). Using this narrative blames the woman suggesting that she has somehow failed and should justify herself. This circular thinking that both the women and staff get into, promotes the enduring stigma regarding abortion care and thus having an open conversation about contraception use/non-use.

It is useful to help women to control their reproduction in a way that suits them rather than as a way to reduce multiple abortions (Hoggart et al., 2017; Rowlands, 2007). Women having an abortion are more highly motivated to change to a more effective method of contraception post abortion (Bulut, 1984). Determining what women value in their contraceptive choice may help to prevent unnecessary discontinuation and overall dissatisfaction with their method (Brown et al., 2011). Having choice and control over choosing the contraception that may be right for them is important for women, but this will mean different things to different women. Women's own priorities about her contraception should be positively endorsed (Gomez et al., 2014) as there may be a plethora of reasons for her choice.

Within the contraception field men are relatively invisible, in the completed systematic review only one study incorporated men. Although the study (Zhu et al., 2009) was a randomised control trial it was of poor-quality, it included men into the intervention arm of the study which increased uptake of more effective contraception. Within this study men were not interviewed but within the imperfect contraception theme there was a sense of where the responsibility for contraception landed. There was a feeling that contraception should be a shared responsibility

however this was not felt to be the case. Wigginton et al. (2015) believes that this gendered approach implies that heterosexual men do not take an active role in contraception choice and thus use. With Terry & Braun (2011) finding this approach problematic as it labels men as uninterested in such issues. These issues have led some researchers to talk about the "feminisation of contraception use" (Oudshoorn, 2004; Tone, 2012; Wigginton et al., 2015) which excludes men. Thus, women are expected to plan or control their fertility (Wigginton et al., 2015) with an emphasis on women exploring and finding a contraceptive fit. Again, gendering this health need (Moore, 2010) which places an unequal burden on women as compared to men.

The legal status of abortion also contributes to gendering this health need both the access of abortion and the stigma surrounding it (Keogh et al., 2017), both women and staff feel the influence of this. Within the UK, the abortion system increases the stigma that both women and staff experience as, the laws and policies that need to be followed in order to attain an abortion feed into structural stigma (Burris, 2006; Corrigan et al., 2005). Structural stigma from abortion laws and policies has profound impact on women's bodily autonomy. Chrisler (2011, p. 207) has termed this as a "battle to control women's bodies". This suggests that there is something inherently wrong with women no matter what they do. For example, there is stigma attached to pregnancy (Taylor & Langer, 1977), infertility (Maill, 1994; Spector, 2004) and abortion (Astbury-Ward et al., 2012). There are also negative attitudes towards mothers especially working mothers (Crosby et al., 2004; Cuddy et al., 2004; Masser et al., 2007), or young mothers (Ellis-Sloan, 2014) and also toward women who

choose not to have children (LaMastro, 2001; Russo, 1976). The cultural ideal of being a 'good' woman promotes a form of structural violence (Kleinman, 2000) that constricts women's sexuality, fertility and maternity. Thus, women's pregnancy experiences and their subsequent childbearing decisions are strongly influenced by their attempts to avoid social stigma for themselves and their families (Ellison, 2003). There is a fear therefore, of failing to meet culturally entrenched ideals of female sexuality and socially accepted forms of maternity (Ellison, 2003).

Foucault focussed upon sexuality as a key area of political struggle (Foucault, 1986, 1990, 1998). Along with feminists (Butler, 1990; Sawicki, 1991) both expand the domain of the 'political' to include forms of social domination associated with the personal sphere including, but not explicit in Foucault's work, abortion. They are critical of biological determination and the growth of medical knowledge (which we saw in the introduction) is linked with the emergence of abortion laws but as Foucault and feminists have argued these are "subtle mechanisms of social control" (Sawicki, 1991, p. 49). Foucault used the term bio-power to describe those ways in which power is exercised on the bodies and minds of individuals (Boyle, 1997). Foucault described two forms of bio-power which are related to abortion and have been seen in my research. The first consists of laws relating to birth, death, marriage, health and reproduction. The second form of bio-power is disciplinary power which operates through social institutions and social relationships (Boyle, 1997). These social relationships are explored further in the sub-themes of 'choose your words wisely' and 'stigma in action'.

Foucault proposed that power and by extension bio-power is understood via discourses (Foucault, 1998) with the language of abortion having powerful connotations. There has long being an issue with the terminology surrounding abortion with Ball (1974) commenting that in the research she undertook in a service, at no time was the word abortion used. Previous research has commented on the use of various labels surrounding abortion and how they are applied to women in different contexts (Kumar et al., 2009). These labels have included promiscuous, dirty, selfish, irresponsible, heartless or murderous (Belenger & Hong, 1999; Ganatra & Hirve, 2002; Koster-Oyekan, 1998; Kumar et al., 2009; Roe, 1989; Schuster, 2005; Whittaker, 2002). Within this research, the women I interviewed discussed how they felt or looked at their decision as being selfish.

Within this research women discussed how the language surround abortion affected them but there was no distinction between using termination of pregnancy or abortion. In their research on language and terminology, Cameron et al. (2017) found that fewer women found the phrase 'termination of pregnancy' distressing as compared to 'abortion' (18% compared to 35%) and nearly half of the 2259 respondents preferring the use of 'termination of pregnancy' with only 12% preferring 'abortion'. Showing a clear preference on the terminology used. In fact, Grimes & Stuart (2010, p. 94) argued that termination of pregnancy should not be used "because of its ambiguity. All pregnancies terminate, but not all abort".

It is not just the term relating to the act that is contentious, so too is the language used to describe the women who request an abortion. Women who request more

than one abortion have vicariously been termed as ‘repeat aborters’ or women requesting ‘repeat abortions’. As highlighted in this study, some individuals found this very negative with connotations associated with the criminal justice system whereas others, mainly staff, used the term in common parlance. Hoggart et al. (2017) argue that this type of language carries a value judgement suggesting a cycle of repeated risky sexual and contraceptive behaviour and of not learning from previous mistakes. The use of language surrounding multiple abortions is a concern and can be used in a stigmatising manner, other barriers include having to get two doctors’ signatures or having to attend various appointments.

Having to overcome these barriers reinforces the need for secrecy which in itself intensifies the stigma, shame and guilt felt by women int this study. Abortion stigma is a concealable stigma as it has to be disclosed to others. This leads to the lack of dialogue around abortion at structural, institutional and personal levels which have seen in the results presented. Within this study both the women and staff tried to manage the stigma they felt through secrecy or selective disclosing (Cockrill & Biggs, 2017; Harris et al., 2011; Merin & Pachankis, 2010; Shellenberg et al., 2011).

The fear of social disapproval due to stigma, is one of the most common reasons for keeping significant life events secret (Cockrill et al., 2013; Cockrill & Biggs, 2017; Kimport et al., 2011; Lane & Wegner, 1995; Major & Gramzow, 1999; Moore et al., 2011; Pennebaker, 1993; Shellenberg et al., 2011; Shellenberg & Tsui, 2012; Smart & Wegner, 2000; Wegner et al., 1993). Women who have had an abortion often do keep it a secret from others. Prior research indicates that most women

(approximately 85%) tell their conception partner of their pregnancy, but typically only two-thirds tell a friend and less than a quarter tell their parents (Major et al., 1990, 1997; Major & Gramzow, 1999). Shellenberg & Tsui (2012) found that 58% of women wanted to keep their abortion a secret and that up to 64% of women concealed their abortion from someone they were close to. As seen from Rebecca (p. 91) who reports that as the number of abortions goes up the number of people discussed with goes down. Concealing an abortion from others may provide a number of immediate benefits, at least in the short run. It may allow a woman to avoid the disapproval of others, avert social conflict and subsequent discrimination all of which can be detrimental to mental health (Frost, 2011; Lepore, 1992; Major et al., 1997; Major & Gramzow, 1999; Pagel et al., 1987; Vinokur & van Ryn, 1993).

However, concealment can have longer-term costs. Disclosure of stressful life events to others is an important part of the coping process (Tait & Silver, 1989). Furthermore, failing to discuss or disclose emotion-provoking life events with others is associated with anxiety, depression, poorer physical health and lower subjective well-being (Cole et al., 1996, 1997; Frijns et al., 2013; Kelly & Yip, 2006; Larson et al., 2015; Larson & Chastain, 1990; Lehmiller, 2009; Merin & Pachankis, 2010; Pennebaker, 1989, 1997; Slepian et al., 2017). Attempts at suppressing stigmatising secrets leads to cognitive encumbrance, which can promote intrusive thoughts over which one has no control (Frost, 2011; Merin & Pachankis, 2010; Slepian et al., 2017; Smart & Wegner, 2000). Women who took part in this study discussed how they coped with their abortions most women shared that they actively tried not to think about their abortions either by keeping themselves busy or by compartmentalising

them. Staff also expressed that their experiences with women who had requested multiple abortions were that they actively tried to avoid thinking or reminiscing about their abortions. With one member of staff expressing that one woman had re-framed some of her abortions as miscarriages.

Research has established connections between stigma-related stress and health risk behaviours via maladaptive coping strategies (Ramirez-Valles et al., 2010). Coping refers to the efforts to master, reduce and tolerate demands that are created by the stress we endure throughout our lives (Weiten et al., 2008). The range of reactions to stressful situations and coping styles is large, dynamic and complex (Skinner et al., 2003). One such broad conceptualisation dichotomises coping into emotion-focused and problem-focused coping styles (Lazarus & Folkman, 1984), although other dichotomies, such as active and avoidant coping have also gained attention (Cherenack et al., 2018; Gore-Felton et al., 2006; Hansen et al., 2013; Moskowitz et al., 2009; Rodino et al., 2018; Roth & Cohen, 1986; Sanjuán et al., 2013).

Active coping involves attempts to change the situation using techniques such as problem solving, cognitive reframing and seeking social support. Whereas avoidant coping involves attempting to reduce negative emotions utilising distractive behaviours related to the event. Avoidant coping consists of several subcategories; avoidance, withdrawal, wishful thinking, distancing, emphasising the positive, self-blame, tension reduction, inaction, self-isolation and substance use, among others (Boals et al., 2011; Carver et al., 1989; Chao, 2011; Cherenack et al., 2018; Rodino et al., 2018).

Within this research women tended to opt for an avoidance coping style which have been termed as maladaptive (Carver et al., 1989). In that they try to avoid any negative affective emotions that were due to the abortion including not thinking about the abortion or keeping themselves busy so there was no time to dwell on the abortion. It has been suggested that employing an avoidant coping, such as denial, individuals will experience greater emotional ease to begin with but will pay for that ease with continued vulnerability on subsequent occasions. Whereas those who face the threat at the onset will suffer more distress but better prepared to handle the threat at subsequent occasions (Holahan et al., 2005; Lazarus & Folkman, 1991; Rodino et al., 2018).

Avoidant coping strategies are problematic as they are negatively related to psychological and physical health outcomes (Boals et al., 2011; Littleton et al., 2007; Penley et al., 2002; Rodino et al., 2018; Tangney, 1995). Littleton et al. (2007) completed a systematic review and meta-analysis on 39 studies that had a variety of stressful events found that the use of avoidant coping strategies was consistently related with increased psychological distress. Other research has linked the increased use of avoidant coping style with poor physical health outcomes (Billings et al., 2000; Lawler et al., 2005; Stilley et al., 2010). Avoidant style coping is also related to poorer behavioural health outcomes such as drug/alcohol use, poor sleep, smoking and weight gain (Aldao et al., 2010; Gormack et al., 2015; Homan et al., 2007; Rodino et al., 2018; Rooney & Domar, 2014).

Avoidant coping is also linked with poor adherence to medication, numerous studies of HIV-positive individuals (regardless of substance use status) have demonstrated that patients who rely more heavily on avoidant forms of coping evidence poorer adherence to medication (Balfour et al., 2006; Gore-Felton et al., 2006; Grassi et al., 1998; Hobfoll & Schröder, 2001; Ironson et al., 1994; Jacobson et al., 2006; Martinez et al., 2012; Vosvick et al., 2003). Although there is a difference in outcomes for not adhering to HIV medication and not adhering to contraception. Examining and understanding the link between abortion status, avoidance coping, and adherence may help understand the dissatisfaction and discontinuity rates in contraception. However, due to the silence that surrounds abortion this can contribute to women struggling with their own fertility again as they may feel unable to return to discuss problematic contraception. This blocks open discussion regarding contraception which may leave women at risk of returning for a subsequent abortion. This circularity of silence aiding stigma which may lead to avoidant coping which closes down any open discussion regarding women's reproductive choices, including contraception use/non-use. The powerful interplay between reinforces how much influence stigma has on women's reproductive choices.

As we have seen abortion stigma is a prevalent and permeates all levels of society from the interpersonal to public policy, in line, with the social ecological model of public health (Polit & Beck, 2012). Hatzenbuehler et al. (2013) suggest that due to its pervasiveness, stigma should therefore be considered alongside the other major organising concepts, such as, socioeconomic status for understanding social determinants of population health. The core concept of an ecological model is that

behaviour has multiple levels of influences these include the intrapersonal (biological, psychological), interpersonal (social, cultural), organizational, contextual and policy.

The ecological model of abortion (figure 3) sets out the different levels that may influence abortion behaviours. From the top down these include UK policy that sets out how, when and where abortions can take place. The contextual level encompasses how society culturally views multiple abortions. The organisational level is how both statutory and third sector organisations influence abortion policy but also how they provide services for individuals. The interpersonal level explores how those personal interactions may affect individuals' reaction to multiple abortions. Finally, intrapersonal is the experiences, thoughts and attitudes that an individual may have towards multiple abortions.

This research provides evidence from a small sample that stigma is still an issue within abortion care, the implication for both practice and research are to work with providing psychologically informed environments. For practice as a health psychologist this means being an advocate for women who need abortions. There has been a shift from being concerned with the individualist nature of multiple abortions, that is, being over concerned with women's choices regarding contraception and abortion. To becoming a more critical health psychologist understanding the power differentials that work on the women's reproductive choices. From the overarching political (the law) to the social (silence of abortion) to the interpersonal (communications between staff and/or friends regarding abortion)

to the individual personal perspectives of the women themselves. There is a need to move beyond a 'blame the victim'; only understanding abortion as an individuals' issue legitimises only individual solutions (Fox et al., 2009) such as, contraception is the only way forward.

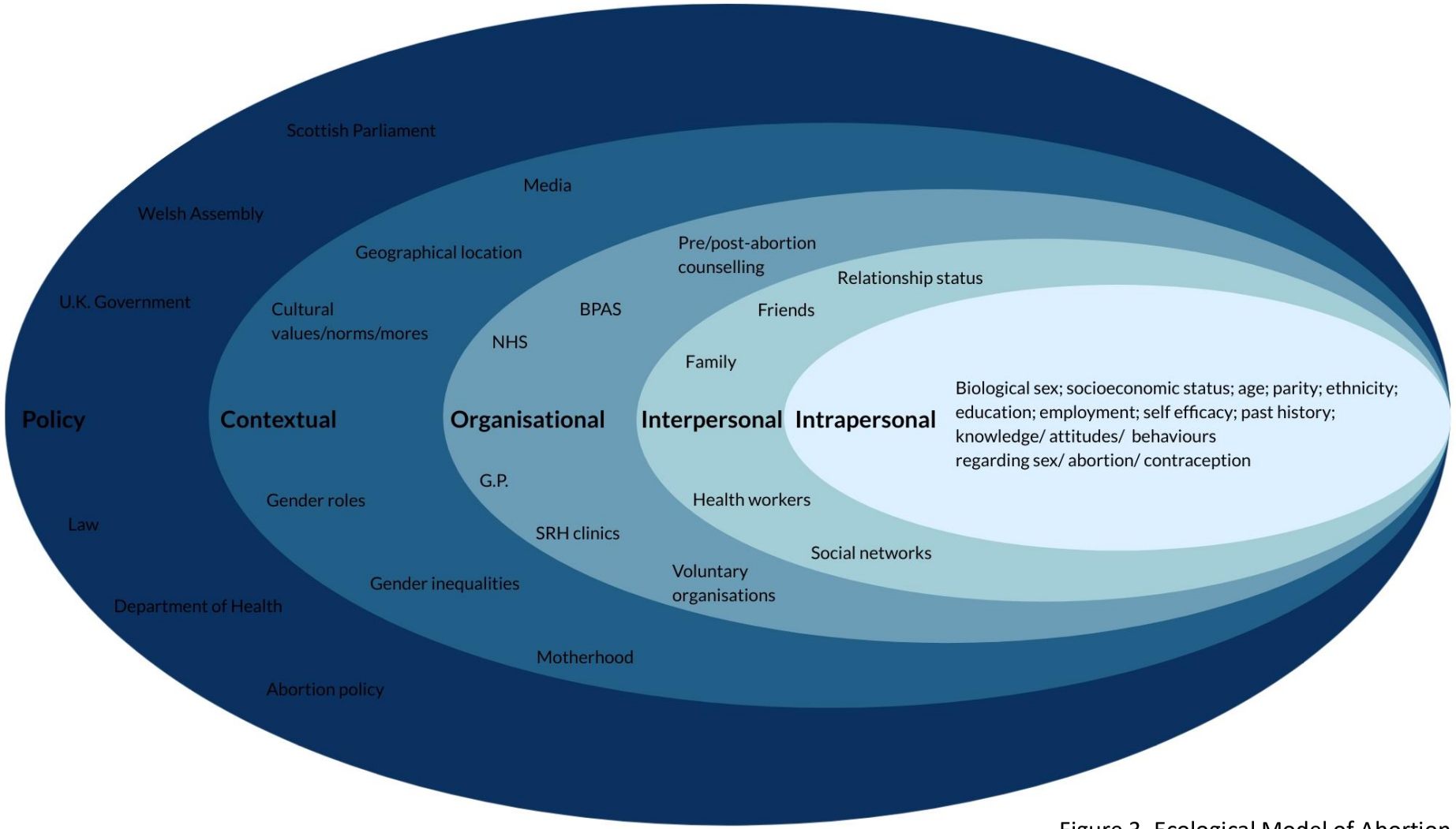

Figure 3. Ecological Model of Abortion

Interventions

From looking at the systematic review that I completed which provided evidence that improved contraception counselling improved uptake of contraception at time of abortion, but no intervention reduced returning abortion rates. And now hearing from women and staff the struggle they have with imperfect contraception; the issue seems not to be with uptake of contraception but with adherence over a lengthened period of time.

My systematic review also provided evidence that m-technology and thus by extension e-technology may assist in offering longer term assistance in adherence to contraception. Women will stop using contraception due to method dissatisfaction and/or when side effects outweigh the benefits (Dixon et al., 2014; Fruzzetti et al., 2016; Hoggart et al., 2013; Moreau et al., 2007). Assisting women to engage with services when they first begin to have problems with their contraception could help with adherence.

However, from this research there seems to be a need to move away from the reductionist ideology of reducing numbers but to move to a care focussed approach of supporting women regardless of number of abortions. Right from the moment women attend an abortion service.

A model of this could be psychologically informed environments (PIE's) which were first utilised in working with the homeless can be extended to working with anyone who has experienced trauma. One observation from this study that did

not make a theme was that 80% of women in this study requesting multiple abortions had a history of domestic violence. Understanding that these women requesting multiple abortions could be vulnerable treating them in a psychologically informed manner could assist in either engaging them with contraceptive/sexual health services but could also reduce the stigma surrounding multiple abortions.

Psychologically informed environments have 5 key areas, these include, developing a psychological framework, the physical environment and social spaces, staff training and support, managing relationships and evaluations of outcomes. Developing these environments does not mean that staff will become therapists but more likely adapting, defining and utilising therapeutic approaches in their everyday worker (Department for Communities and Local Government, 2012).

Utilising the framework set out in PIE's within an abortion service especially for women who are requesting multiple abortions, firstly we have the set out the psychological framework. Acceptance and commitment therapy (ACT) is a psychological framework that would be suited to this type of work. As one to the premises of ACT is to accept thoughts, feeling and situations without giving them a value judgement which would reduce the shame, guilt and stigma that women/staff face and internalise. The second step it to managing physical the physical environment can be more difficult as working for the NHS clinical spaces are often shared with other specialities. However, the inclusion of art in waiting

areas could soften the area to look less clinical. Although, within clinical areas there are infection control guidelines that must be adhered to. The third step of PIE's is staff training and support is important to help them implement a psychologically congruent environment. Reflective practice is central to this key area which could be implemented through clinical supervision for the staff team. Clinical supervision will allow staff time to reflect on managing relationships with women requesting multiple abortions by exploring their own feelings and thoughts in relation to these women. Thus, lowering their own sense of paternalism that is evident when discussing contraception. ACT also deals with what we can control and assisting staff in understanding that they have no control over women returning may reduce their sense of failure, but hands back the control to women. The final key area is evaluation of outcomes, Breedvelt (2016) suggests that these outcomes should be on a policy, service and individual level.

Another important intervention should be looking at how we can address the wider structural reproductive rights of women. Although abortion is free and safe in Britain there are still structural barriers that should be address the main one of these is that it is still technically illegal to have an abortion via an act of parliament that was passed in 1861, unless 2 doctors agree which supplemented the act in 1967. BPAS actively support total decimalisation through their 'We Trust Women' campaign which actively lobbies Member of Parliament. Only through this top down change can real changes be made in the in the power differentials that are felt by women accessing abortion care in the UK. Some political parties are now endorsing decriminalisation of abortion. This would be a major shift from the now

legal framework to a healthcare framework removing barriers to accessing services. Other agencies across the world are also promoting safe and legal access to abortion care for all women.

Limitations

Within qualitative research quality is influenced by the researcher's personal biases and idiosyncrasies. Thus, rigor is more difficult to maintain, assess, and demonstrate. The researcher's presence during data gathering, which is often unavoidable in qualitative research, can affect the subjects' responses. Due to the volume of data, makes analysis and interpretation subjective in nature. Within this research, to reduce the subjective impact of the researcher and to improve rigor a research diary was utilised. Also, at each stage of the results formation was reviewed by another researcher.

Findings cannot be extended to the wider population. As this research took place in only one abortion service and was subjected to their clinic protocols. Another abortion service may work in a different way. Such as having more than one doctor on site which would reduce the issue of getting two signatures. Giving the two parts of the medication at the same time for medical abortions which reduces barriers to access but increases risk of the abortion not completing. Also, since this research took place the legal standing on where the second part (taking misoprostol) can take place has changed in South Wales where this research took place. Thus, women requesting a medical abortion only need to have one

appointment with the service and then get given the medication to take home to complete the procedure. This has reduced barriers to attending services.

Replication of results for qualitative research is also difficult as a different researcher may interpret the results in a different way depending on their own ontological and epistemological standing. Although the results will be difficult to replicate other services may find them transferable. Tracy (2010) terms this as resonance which suggests that a study may be valuable across contexts, perspectives and situations.

Recruitment for women to take part in this study was difficult with many more women agreeing to take part than actually did. The women who did decide to take part may have different experiences of repeat abortion that the women who decided not to take part suggesting a self-selection bias.

Ethnicity of the group women who took part in this research was limited to women who identified as White British. Within the introduction the epidemiological evidence suggested that other ethnicities have differing repeat abortion rates. This research can therefore not be extending to other areas where the population is more ethnically diverse. Also, cultural heritage and religiosity will impact on how women both view multiple abortions and how then subsequently cope with them. This research did not collect those demographics and thus the results do not reflect how culture or religion may impact on stigma and coping.

In this research consultation was carried out with two women who had had abortions with regards to the interview schedule. They provided invaluable feedback on question construction and on question order. However, it is a limitation not to utilise patient public involvement (PPI) in a collaborative manner. Utilising PPI in a collaborative manner is more inclusive as PPI members are embedded in the full research cycle. It has been noted that this is an advantage in health research (National Institute for Health Research, 2018). However, due to time constraints this was not possible for this research. Bonevski et al. (2014) concluded that including vulnerable/hard to reach groups in health research, there needs to be acknowledgment of the prerequisite for extended time frames for the research to be inclusive.

Moving on, using PPI from inception of research especially with vulnerable/hard to reach groups could aid in all aspects of the research process. In that belonging to an in-group can have advantages (Le Gallais, 2008) including sharing experiences that may be deemed as socially unacceptable. Having these shared experiences can direct a researcher in the research proposal, methodology, gathering and analysing data as well as write up. Embedded PPI would have assisted in participant recruitment in this research as they would have been able to direct how best to engage and thus recruit women who were requesting multiple abortions.

Implications for health psychology

There are several implications for health psychology. Several of the themes are associated with poorer health outcomes. Stigma as a whole is associated with poorer psychological and physical health. Thus, research that examines how to reduce the stigma of abortion will also have implications for the reducing the burden of poorer health. Abortion stigma is pervasive and impacts at every level of the social ecological model of health, from the interpersonal to public policy. Working within the health psychology framework this means we need to understand abortion in terms of individual health psychology though to critical health psychology.

Avoidant coping is also associated with poorer psychological and physical health outcomes but also with poorer behavioural health outcomes. Research into working with individuals who utilise an avoidant coping style could improve outcomes. Also, avoidant coping is associated with adherence to medication within other areas of health. This may also be a factor within the contraception field however, this a yet to be researched.

Whilst this research was taking place several health psychology interventions and health psychology informed practices were implemented. Some of these fit into the psychologically informed environments model. The physical environment within the clinic has been transformed to include art in non-clinical areas. These have been situated in the waiting room, hallways and counselling rooms to soften the clinical feel. Also, as this abortion service is in a shared building there are pop-

up boards that are clear and not overcomplicated with words to meet women at the entrance on arrival to the clinic. Hopefully, these lessen anxiety on arrival and reduce the need to request directions.

Women in this research were concerned about how staff viewed them as women requesting multiple abortions and felt that when asked about previous abortions this was intrusive and increased stigma. Within the service it has now being stopped that women are asked about previous abortions on their first contact with staff. The only time previous abortions are discussed is with safeguarding staff. This is due to the finding that 80% of women in this study had history of domestic violence and it was felt that this is the perfect opportunity to discuss both these issues with either qualified counsellor or psychologist.

There has been ongoing training within the abortion service provided by the health psychologist trainee to provide motivational interviewing training. The method was chosen as it can help staff to discuss contraception or abortion in a manner that is guided by the professional rather than paternalistic consultations. The health psychology trainee also carried out clinical supervision with staff in the abortion service, so they had a forum to discuss and reflect on their practice.

Results of this research have been shared with the British Society of Abortion Care Providers (Welsh Branch) to promote good working practices. As reduction of stigma could reduce negative coping and increase wellbeing.

Future Research

Future research could examine whether psychologically informed environments facilitate lowering stigma with women requesting abortions but especially those women requesting multiple abortions. There is also a need to reduce stigma faced by staff who provide abortion services. Psychological informed environments promote supervision with all staff as a way to reduce stress/stigma. Implementing and evaluating PIE's within an abortion service to promote improved outcomes for women.

Recommendations for Policy/Practice

This research has provided some evidence that abortion is still a stigmatised area of healthcare and reducing that stigma would be a positive step. Introducing a PIE framework into abortion services would be a recommendation. Also, there has been a focus on how many abortions a woman is requesting there is a need to move away from this paternalistic concern. Moving towards an approach that is holistic.

Conclusions

Abortion stigma was the major theme that came out of this research it cut across all areas of abortion work and permeated every level from the top down. The three different stigma stages were all seen within this research from the perceived to the internalised to the enacted in both women and staff participants. Which then manifested in the clinical consultations.

There was a distinct dance of power between the women and the staff within the service which disenfranchised women who were requesting multiple abortions. Also, the power of silence that surrounds multiple abortions increased the problematic nature of having open discussions around contraception use/non-use. Contraception is seen as the only way to reduce abortions, this policing of women's reproduction through imperfect contraception presents and promotes barriers to accessing services. Abortion is a gendered health care provision in which the burden is on women however, due to the stigmatised nature of this the power does not lie with the individual women themselves.

However, by working to reduce stigma this will help to reduce maladaptive coping and thus increasing wellbeing which will be beneficial to all women requesting abortions. Examining and understanding the link between abortion status, avoidance coping, and adherence may help understand the dissatisfaction and discontinuity rates in contraception. By continuing to utilise and provide health psychology theory/input to the abortion service will assist in this undertaking.

Conducting this research has enabled the promotion of health psychology theory and findings into clinical practice, promoting service development and thus benefitting all women who access for abortion services.

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Appendices

Appendix 2

'Perspectives on Repeat Abortion'

Participant ID: PRA/SP/01

Please initial each box

I confirm that I have read the information sheet dated April 2016 (version 1.1) for the above study. I have had the opportunity to consider this information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. ☐

I understand that my interview will be audio recorded, transcribed verbatim and that direct quotes may be used. ☐

I understand that any direct quotes used will be anonymised ☐

I agree to take part in this research ☐

Signed participant:_____

Print name:_____

Preferred method of contact:

Mobile:_____

Landline:_____

Email:_____

Signed researcher:_____

Date:_____

Appendix 3

Interview Schedule

- Tell me about your family
    - Partner
    - Children
    - Personal set up

- Tell me about your most recent abortion/abortion decision?
    - How was the decision made?
    - Did partner have input
    - Pre/post contraception use
    - When was it?

- Tell me about your previous abortions
    - Is the decision making same/different?
    - Are the abortions same/different?
    - Partner involvement
    - When was/were these abortions?
    - Contraception decisions

- Coping

- What social support have you had
    - How has that impacted on your decisions

- Have you experienced stigma?
    - How has that made you feel

- If you could tell the world one thing about repeat abortion what would it be

- Any other comments, have I missed something

Interview schedule for staff

- Tell me about your role in the Beth Service
    - How long
    - Has role changed
    - Any previous abortion works

- How do you discuss your role within the Beth Service with others?
    - Social support
    - Stigma

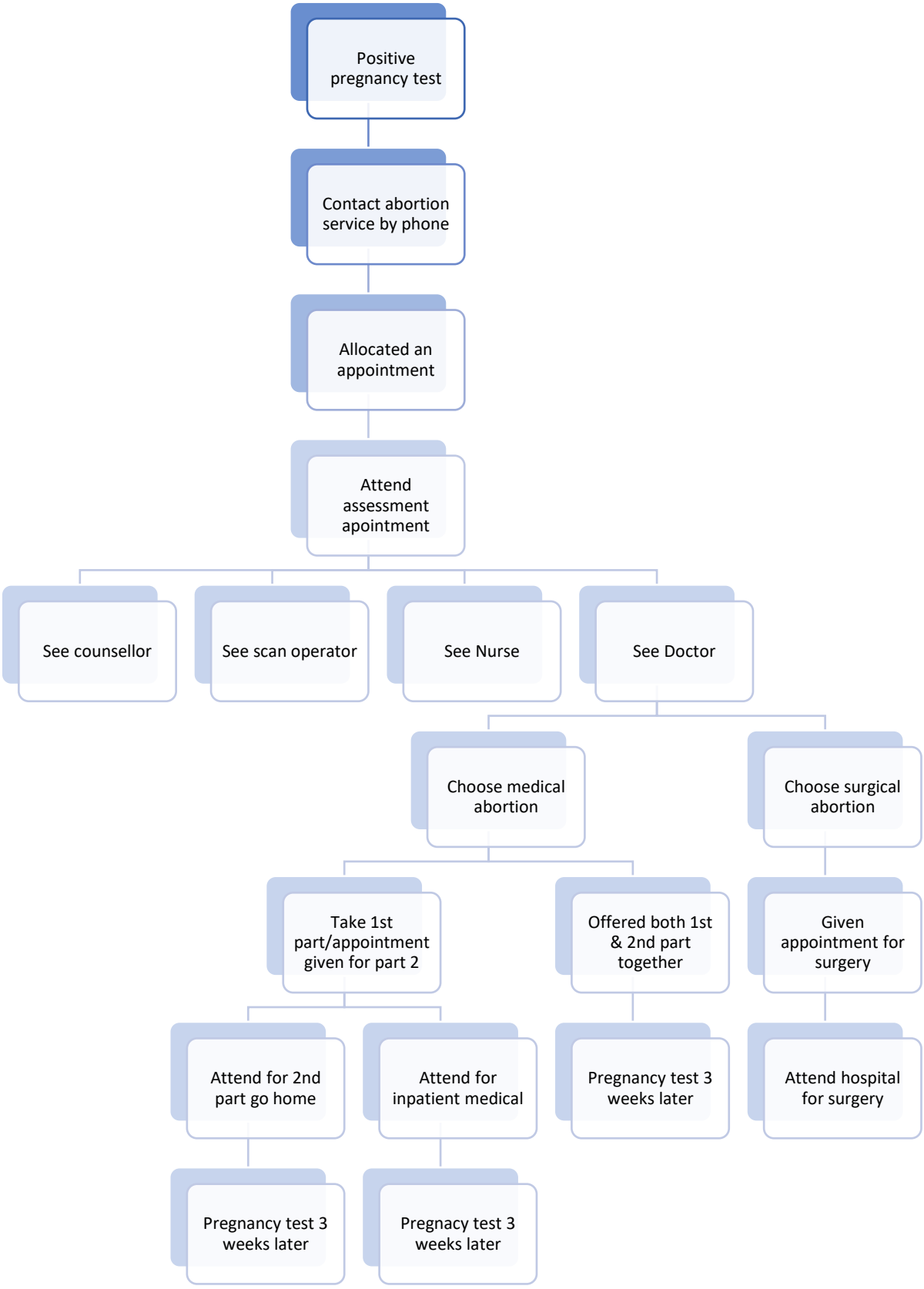
- Tell me about your stance on repeat abortions
    - How does providing repeat abortion care affect you
    - Do particular cases stand out, why?

- What are the contexts that repeat abortion occur in?

- What do you think is the best way to reduce this phenomenon, if any?

- Is there anything you would like to add?

Appendix 4


Positive pregnancy test
Contact abortion service by phone
Allocated an appointment
Attend assessment apointment
See counsellor
See scan operator
See Nurse
See Doctor
Choose medical abortion
Choose surgical abortion
Take 1st part/appointment given for part 2
Offered both 1st & 2nd part together
Given appointment for surgery
Attend for 2nd part go home
Attend for inpatient medical
Pregnancy test 3 weeks later
Attend hospital for surgery
Pregnancy test 3 weeks later
Pregnacy test 3 weeks later