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

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ABSTRACT

Objectives: The aim of this study was to assess women's experiences of having an early medical abortion at home and to investigate their perceptions of the information provided before the abortion. The study also aimed to investigate possible differences between groups of women.
Study design: The study is cross-sectional with a descriptive and comparative design. Semi-structured telephone interviews were conducted with 119 women who had undergone a medical abortion at home.
Results: Almost half of the women (43%, n = 51) experienced the bleeding as more than expected and one-fourth (26%, n = 31) bled for more than four weeks. One-third (34%, n = 41) stated a lack of information, especially about the bleeding and pain. The experience of pain differed between groups. Women who had undergone an earlier abortion and women who had previously given birth experienced the abortion as being less painful than that experienced by first-time gravidae ($p < 0.05$).
Conclusions: The finding that women experience information about the pain and bleeding to be insufficient suggests that information in those areas can be improved. The result that women without previous experience of abortion or childbirth stated the pain as being worse than other groups investigated suggests that special attention should be paid to those women.

Introduction

Medical abortion has been available in Sweden since 1992, and is a method that can be used up to a gestational age of 63 days/nine weeks [1]. During 2011, up to 37,750 induced abortions were performed in Sweden; furthermore, in early pregnancy the woman can choose between a medical or surgical abortion. The number of medical abortions is increasing; according to the statistics from the National Board of Health and Welfare, 89% of all abortions performed before nine gestational weeks are medical [2].

According to Swedish national guidelines, a medical abortion starts with the ingestion of mifepristone and within two days after the administration of mifepristone, misoprostol is administered vaginally [3]. Since 2004, Swedish women have the possibility to choose whether they want to take the misoprostol at a clinic or at home; however, the abortion is always initiated at the clinic [4].

The combined regimen of mifepristone and misoprostol has been shown to be a safe and effective method for medical abortion in early pregnancy [5]. Studies have shown that the rate of complete abortions varied between 93 and 98% [5–11]. In 0.5–1.1% of the medical abortions, the pregnancy continues [5,8].

Serious complications with medical abortion are rare [6,10,12]. A review of 65 studies from 2004 found the frequency of diagnosed and/or treated infection after medical abortion to be less than 1% [13]. The bleeding after a medical abortion is usually similar to a rich and prolonged menstrual period [4]. In rare cases, the need for a blood transfusion has been reported [5,11]. Side effects described are pelvic pain, nausea, fever, shivering, vomiting, headache, diarrhea, and dizziness. The symptoms were mostly mild to moderate [14].

One of the most common side effects is pain [14]. Earlier research has shown that women with a gestational age of 50–63 days, younger women, and lower or null parity needed more or stronger analgesia [8,15,16]. Good pain relief is of great importance [3] and the need for extra analgesia had a significantly negative influence on the women's experiences [7].

Earlier research has shown that most women are satisfied with choosing a home abortion and would opt for the same method again if needed, or recommend it to a friend [7,9,17–21].

According to the National Institute of Public Health [22], there are no national guidelines for how information, medical care, and follow-up should be provided in relation to medical abortions at home. Previous research on women's experiences of completing a medical abortion at home has mostly focused on satisfaction with the method. Women who were well informed and supported in their choices experienced good psychosocial outcomes from their induced abortion [23].

The aim of this study was to assess women's experiences of having an early medical abortion at home and to investigate their

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perceptions of the information provided before the abortion. The study also aimed to investigate possible differences between groups of women.

Methods

This is a cross-sectional study with a descriptive and comparative design. The participants were recruited at the outpatient family planning clinic at a university hospital in Sweden, between November 2012 and February 2013. All Swedish- and English-speaking women going through an early medical abortion at home were asked to participate in the study. One assistant nurse performed the recruitment of participants. During the inclusion period, 169 women opted for an early medical abortion at home. Language barriers excluded 12 women. Out of 157 women who met the inclusion criteria, 10 chose not to participate for undocumented reasons. Three women who accepted to participate in the study were away during the interview period and 25 women could not be reached by telephone or chose not to participate via text message. This resulted in 119/169 women reached, a response rate of 76%.

All women seeking an abortion saw a physician who determined the gestational age by clinical examinations and vaginal ultrasound scans. Thereafter, the women who chose to undergo an early medical abortion at home saw a midwife who provided additional information about the method, including what the woman could expect at home, focusing on the bleeding, pain, and side-effects. The midwife also handed out an informational brochure about the procedure and telephone numbers to the clinic. After counseling, the women received mifepristone (200 mg) to be taken orally at the clinic. They were given misoprostol (0.8 mg) to take at home 36–48 hours later and instructions on how to insert it vaginally. The patients received oral analgesics; paracetamol (1 g) and ibuprofen (400 mg) to take when they had administered the misoprostol. They also received two extra ibuprofens (400 mg) and three extra paracetamol (1 g) to take if needed and one rectal diclofenac (50 mg) to take in case of vomiting. Information about other ways to relieve the pain, such as heat and massage, was also given. The women were recommended not to be alone at home during the abortion. The midwife also informed the women about what signs should require immediate medical attention, and that they should take a home pregnancy test four to six weeks after the abortion. The physician or the midwife gave contraceptive counseling.

The assistant nurse informed the women about the study, both orally and by way of an informational letter. She informed them that the study was voluntary, stating that they could withdraw from the study at any time, and that participation in the study would not affect their medical care. She documented all the women she asked to participate, so that the response rate could be calculated. The women who accepted to participate provided their telephone numbers and a preferred time for the interview.

The telephone interviews were conducted approximately six weeks post-abortion, to investigate if the women had taken a pregnancy test as recommended. On the day before the interview, the women were contacted via a text message with a suggested time for the interview. Women who did not answer the first telephone call were telephoned again after 15 minutes. If they still did not answer, a new text message was sent with a suggestion for a new time for an interview. Women who still did not answer were excluded.

The questionnaire contained 31 questions, mainly multiple-choice, but some were open-ended. Four questions were socio-demographic (age, language, partner, and education) and three were about the woman's reproductive history. One question asked about the gestational age and one asked if the woman had taken a home pregnancy test after the abortion. Six questions were about information provided by the clinic and two were about support at home. Two questions related to bleeding and five questions to pain/pain relief. A visual analog scale (VAS) ranging from 0 to 10 was used for rating the intensity of the pain. Contact with medical care was explored in three questions. One question asked if the woman would opt for the same method again if a future termination was required, and if the answer was "no," the woman had the opportunity to explain why not. The last open-ended question gave the participant the opportunity to comment freely on her experiences of the abortion.

Each interview started with information about the aim of the study, and the respondents were assured that their participation was voluntary and that they had the right to discontinue at any time. The telephone interviews lasted between 5 and 31 minutes with an average time of 12 minutes. The responses were documented during each telephone interview.

Data were analyzed using the statistics program SPSS (Statistical Package for the Social Science, version 20). Comparisons between groups were made using Fisher's Exact Test as appropriate for nominal data. The Mann–Whitney U-test was used for ordinal variables. Differences were regarded as statistically significant if $p < 0.05$. Groups that were compared were younger/older women (divided by the median age of 26), women with a partner/without a partner, having children/not having children, previous abortion/no previous abortion, gestational age 4–7 weeks/gestational age 8–9 weeks, and different educational levels. Women with an educational level up to senior high school were considered as a lower educational group and women who had continued to study at a postsecondary level or university were in the higher educational group. In order to control for possible interaction between age and parity we performed a binary logistic regression model with pain (dichotomized as less pain VAS 1–5 and worse pain VAS 6–10) as the dependent variable. As possible explanatory variables we inserted age (continuous variable), previous pregnancy, previous abortion, previous birth and social support of someone present.

The open-ended questions were analyzed using quantitative content analysis, as inspired by Graneheim and Lundman [24]. The entire text was read by the authors separately to identify units of meaning, which were then compared before they were coded and sorted into a number of categories.

The study was approved by the Regional Medical Ethics Committee in Uppsala, Sweden (No. 2012-350).

Results

Demographic and reproductive characteristics of the participants

Demographic characteristics are shown in Table 1 and reproductive characteristics in Table 2.

Both the median and the mean gestational age at the time of the current abortion were seven weeks, ranging from four to nine. One participant did not remember how far along in her pregnancy she was.

Experiences of pain

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

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

About one-fourth of the participants (27%) took extra analgesia at home during the abortion or the days/week thereafter. Besides analgesia received from the clinic, the women mentioned they had used paracetamol, paracetamol and codeine, diclofenac, ibuprofen, naproxenum, tramadol, aspirin, and aspirin and codeine. Some