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RESEARCH IN BRIEF

PERSPECTIVES on Sexual and Reproductive Health

Exploring provider preference and provision of abortion methods and stigma: Secondary analysis of a United Kingdom provider survey

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Abstract

Introduction: Method choice is an important component of quality abortion care and qualitative research suggests that abortion stigma can influence provider preference and provision of abortion methods. This study is the first to explore the relationships between abortion providers' method preferences, their provision of medication or instrumentation abortion or both methods, and abortion stigma.

Methods: We conducted secondary analysis of a survey of United Kingdom (UK) abortion providers ($N = 172$) to describe and compare providers' self-reported method preferences and provision. We used multinomial logistic regression to assess the association between method preference and provider experiences of abortion stigma (measured using a revised Abortion Provider Stigma Scale (APSS)), adjusting for relevant provider and facility characteristics.

Results: Almost half (52%) of providers reported that they only provided medication abortion care, while 5% only provided instrumentation abortion care and 43% provided both methods. Most (62%) preferred to provide both methods while 32% preferred to provide only medication abortion and 6% only instrumentation abortion. There was no significant difference in revised APSS scores by provider method preference or provision.

Discussion: Most surveyed UK abortion providers prefer to offer both methods, but over half only provide medication abortion. This may reflect patients' preferences for medication abortion, and health system and legal constraints on instrumentation abortion. Addressing these systemic constraints on method provision could expand patient choice. Providers' method preference was not significantly associated with provider stigma but future research should consider the influence of structural stigma on method provision at the health system level.

KEYWORDS
abortion, quality of care, service providers

INTRODUCTION

In the United Kingdom (UK), national guidelines state that abortion services should provide information about both medication and instrumentation abortion care[1] so patients can make their own choice up to 24 weeks pregnancy duration.[1] However, method choice has consistently been identified as needing improvement.[2–6] In 2021, 88% of abortions in the UK used medications, up from 47% in 2011.[7–9] This increase partly reflects the gradual removal of legal restrictions on how medication abortion under 10 weeks can be delivered: removal of unnecessary in-person appointments has made medication abortion more patient-centered and accessible.[10,11] However, research suggests several barriers exist for access to instrumentation abortion, including legal barriers that prevent nurses/midwives providing the service, providers' organizational policies to offer early medication abortion as the "default," lack of training opportunities and workforce for instrumentation abortions, and commissioning practices that motivate medication abortion provision due to its lower cost.[12]

Although system-level factors that constrain abortion method choice have been identified,[12] the role of individual provider preferences has not been assessed in the UK, nor has the potential association between provider preferences and abortion stigma. Abortion stigma has been conceptualized most broadly as "a shared understanding that abortion is morally wrong and/or socially unacceptable."[13] International research has explored abortion providers' experiences of stigma[14–18] and studies suggest stigma can influence providers' willingness to offer abortion care, their treatment of patients,[15,19,20] and their preferences over how they deliver care.[21,22] Qualitative studies in the United States (US), Pakistan, Ireland, and South Africa have suggested providers may feel more comfortable providing medication abortion care than instrumentation abortion care because they feel less responsible for the abortion or less engaged in a stigmatized activity.[23–28] Quantitative studies in Ireland found hospital providers reported experiencing higher levels of stigma if they only provided instrumentation abortion care[29] and lower willingness to provide instrumentation abortion care among obstetrics and gynecology trainees as it was considered more "real".[30] However, studies have not assessed the association between provider preferences, provision practices, and stigma. Understanding these relationships can inform policies or interventions that aim to remove provider-level barriers to patient choice.

In this exploratory analysis, we assessed UK abortion providers' preferences for providing medication abortion care, instrumentation abortion care, or both methods and the relationships between these preferences, their provision, and abortion stigma. Specifically, we sought to: (1) Describe providers' preferences for and provision of abortion methods; (2) Compare providers' provision of abortion methods with their method preferences; (3) Assess provider and facility characteristics that may be associated with method preference; and (4) Examine the association between providers' method preferences and their reported experiences of abortion stigma, controlling for other relevant variables.

METHODS

Setting

Abortion has been legally permitted in England, Scotland, and Wales since the Abortion Act 1967[31] which states a pregnancy may be terminated if two doctors certify the abortion is justified under certain grounds (including risk to physical or mental health). To be lawful, the termination must be performed by a doctor and occur in an approved place. Abortion was decriminalized in Northern Ireland in 2020, but abortion outside of the Abortion Act's conditions is still a criminal offense in England, Scotland and Wales.[32]

In Scotland, abortion care is directly provided by the public sector National Health Service (NHS) through hospitals or sexual health services.[33] In England and Wales the NHS commissions three private non-profit organizations to provide most abortion care (77% in 2021).[7] Each organization specializes in abortion care and operates a network of clinics and a telemedicine service. Abortion care provided directly by the NHS in England and Wales (23%) is mostly provided in hospitals.[34] In Northern Ireland, abortion care is provided by public hospitals and sexual health clinics in select regions.[35]

Data

We conducted secondary analysis on a subset of data from a global online survey, which assessed abortion providers' attitudes to abortion and experiences of stigma. We included UK participants only ($N = 172$).

In the UK, we distributed the survey in July 2021 through three abortion provision organizations and five professional associations or advocacy groups, which include both NHS and private non-profit providers. Inclusion criteria were being aged 18 or over, being a clinician providing abortion care, and giving informed consent to complete the survey. We piloted the questionnaire to test comprehension and estimated it to take 15 minutes.

Measurements

We asked participants "which methods of abortion do you provide personally?", and "which method of abortion do you prefer to provide?" Response options were "medical (pills)," "surgical (vacuum aspiration, dilatation and evacuation)," or "both methods" as these terms are commonly used in the UK.

We used a revised version of the Abortion Provider Stigma Scale (APSS) to measure dimensions of provider stigma. It is described in detail elsewhere,[36] but in brief, the scale uses 35-items to measure five dimensions of stigma: disclosure management, discrimination, internalized states, judgment, and social isolation. Each item describes a stigmatizing or positive experience that the provider may have faced, and frequency is assessed on a five-point Likert scale. Items are summed so that higher total scores indicate higher levels of stigma.

Analysis

The APSS was originally designed and validated in the US[36,37] and has been adapted for use in Latin America and Africa.[17] As the APSS has not been validated in the UK and abortion stigma is a local phenomenon, which varies between contexts,[38] we revised the APSS to ensure it measured relevant concepts for the UK's cultural context of abortion provision. We conducted exploratory factor analysis, with methodological details provided in Appendix 1. In the final factor structure, we retained 26 items across four factors (Appendix 2): disclosure, isolation, judgment, internalized stigma. Overall scores could range from 26 to 130 and sub-scale scores could range from 5 to 25, except disclosure (11–55). We used this revised APSS scale for the analysis.

We described and compared method preference and provision (Table 1) and then compared these variables by provider and facility characteristics using Chi-square tests (Table 2). We compared mean revised APSS scale and sub-scale scores by method preference and provision (Figure 1). We used multinomial logistic regression to assess the association of revised APSS scores with a preference for medication or instrumentation abortion provision, versus both methods, adjusting for all potentially relevant variables (gender, age, job type [doctor or nurse/midwife], duration of work experience, sector [public or private non-profit], facility type [hospital, clinic or other]) (Table 3). We selected these variables based on data availability, previous literature,[29,37] and our prior knowledge of factors that may influence UK providers. We used post-estimation commands to directly compare the association of each variable with a preference for medication versus instrumentation abortion.[39] We conducted all analyses in Stata 17.[40]

Ethics

The survey received ethical approval from the Open University (ref: HREC/3994/Hoggart, 19th May 2021). This secondary analysis was exempted from review by the London School of Economics Research Ethics Committee (ref: 104341, 22nd August 2022).

RESULTS

Providers' method preference and provision

Just over half of participants (57%) reported they provide only one method of abortion care (52% medication, 5% instrumentation) while 43% reported providing both methods (Table 1). Almost half (43%) of those who only provided medication abortion preferred to provide both methods, while the remainder preferred providing medication abortion care only.

Overall, the majority (62%) said they preferred to provide both methods (Table 1). Of those who preferred a specific method, medication abortion care was more common (32%) than instrumentation abortion care (6%). Most (93%) who preferred to provide medication abortion care only provided this method.

Preference and provision of both methods was significantly higher among men and those working in facilities that provide or who personally provide services in the second and/or third trimester (Table 2). There was little variation in method preference by sector, job type, or facility type but provision of both methods was significantly higher among doctors and those with more years of experience.

Abortion stigma and method preference

The mean total revised APSS score was 58.4 overall (range: 26–108, out of a possible 26–130, with higher scores indicating higher stigma). Revised APSS scores did not vary significantly by method preference or method provision and variation by sub-scale was minimal and non-significant (Figure 1).

TABLE 1 Method provision and preference of United Kingdom survey participants, by method preferred and method provided.

	Full sample ($N = 172$)			Method preferred by method provided (% [95% CI])		
	n	%	[95% CI]	Medication abortion care	Instrumentation abortion care	Both methods of care
Method personally provided						
Medication abortion care	90	52.3	[44.8–59.7]	56.7 [46.2–66.6]	0.0 [0–0]	43.3 [33.4–53.8]
Instrumentation abortion care	8	4.7	[2.3–9.1]	12.5 [1.7–54.1]	50.0 [19.8–80.2]	37.5 [12.4–71.7]
Both methods of care	74	43.0	[35.8–50.6]	4.1 [1.3–11.9]	9.5 [4.6–18.6]	86.5 [76.6–92.6]
	Full sample (n = 172)			**Method provided by method preferred (% [95%CI])**		
	n	%	[95% CI]	Medication	Instrumentation	Both
Method preferred						
Medication abortion care	55	32.0	[25.4–39.4]	92.7 [82.1–97.3]	1.8 [0.3–12.0]	5.5 [1.8–15.7]
Instrumentation abortion care	11	6.4	[3.6–11.2]	0.0 [0–0]	36.4 [14.2–66.3]	63.6 [33.7–85.8]
Both methods of care	106	61.6	[54.1–68.6]	36.8 [28.1–46.4]]	2.8 [0.9–8.5]	60.4 [50.7–69.3]

Note: 95% CI = 95% Confidence Intervals. The association between method preference and method provision was statistically significant ($p < 0.01$) using a Chi-square test.

TABLE 2 Characteristics of United Kingdom Abortion Provider Stigma Survey participants and their method preference and provision ($N = 172$).

	Sample characteristics		Method preferred (%)			Method provided (%)		
	n	%	Medication abortion	Instrumentation abortion	Both methods of care	Medication abortion	Instrumentation abortion	Both methods of care
Gender*								
Female	155	90.6	**34.2**	**5.2**	**60.7**	**56.8**	**4.5**	**38.7**
Male	16	9.4	**6.3**	**18.8**	**75.0**	**6.3**	**6.3**	**87.5**
Age**								
18–34	31	18.1	29.0	6.5	64.5	54.8	3.2	41.9
35–44	48	28.1	31.3	4.2	64.6	56.3	2.1	41.7
45–54	45	26.3	35.6	6.7	57.8	55.6	6.7	37.8
55–65	42	24.6	28.6	4.8	66.7	42.9	4.8	52.4
65+	5	2.9	40.0	40.0	20.0	40.0	20.0	40.0
Job type								
Doctor/doctor manager	79	45.9	29.1	10.1	60.8	**36.7**	**10.1**	**53.2**
Nurse or midwife/ manager***	90	52.3	34.4	3.3	62.2	**66.7**	**0.0**	**33.3**
Other	3	1.7	33.3	0.0	66.7	**33.3**	**0.0**	**66.7**
Duration of providing or working in abortion								
Under 2 years	47	27.3	46.8	4.3	48.9	**72.3**	**2.1**	**25.5**
2–5 years	41	23.8	34.2	4.9	61.0	**53.7**	**4.9**	**41.5**
6–9 years	24	14.0	29.2	4.2	66.7	**62.5**	**0.0**	**37.5**
10+ years	60	34.9	20.0	10.0	70.0	**31.7**	**8.3**	**60.0**
Sector								
NHS (public sector)	96	55.8	34.4	4.2	61.5	53.1	6.3	40.6
Private, non-profit sector	76	44.2	29.0	9.2	61.8	51.3	2.6	46.1
Type of facility								
Hospital	55	32.0	29.1	7.3	63.6	40.0	7.3	52.7
Clinic or health centre	93	54.1	31.2	6.5	62.4	57.0	2.2	40.9
Other	24	14.0	41.7	4.2	54.2	62.5	8.3	29.2
Service provided by facility								
First trimester	32	18.6	**62.5**	**3.1**	**34.4**	**78.1**	**6.3**	**15.6**
Up to second trimester	112	65.1	**28.6**	**5.4**	**66.1**	**50.9**	**2.7**	**46.4**
Up to third trimester	27	15.7	**7.4**	**14.8**	**77.8**	**25.9**	**11.1**	**63.0**
Post-abortion care only	1	0.6	**100.0**	**0.0**	**0.0**	**100.0**	**0.0**	**0.0**
Services personally provided								
First trimester	86	50.0	**50.0**	**2.3**	**47.7**	**74.4**	**5.8**	**19.8**
Up to second trimester	67	39.0	**14.9**	**9.0**	**76.1**	**32.8**	**1.5**	**65.7**
Up to third trimester	14	8.1	**0.0**	**21.4**	**78.6**	**14.3**	**14.3**	**71.4**

(Continues)

TABLE 2 (Continued)

	Sample characteristics		Method preferred (%)			Method provided (%)		
	n	%	Medication abortion	Instrumentation abortion	Both methods of care	Medication abortion	Instrumentation abortion	Both methods of care
Post-abortion care only	5	2.9	**40.0**	**0.0**	**60.0**	**40.0**	**0.0**	**60.0**

Note: *1 missing response **1 missing response ***The question about methods provided did not assess whether providers were delivering a method themselves or supporting another provider with delivery. Nurses/midwives reported providing instrumentation abortions or both methods as they may assist in an instrumentation abortion service. Results in bold are significant <0.05 using a Chi-square test. Higher scores indicate higher levels of reported stigma. Bold to indicate that they are statistically significant.

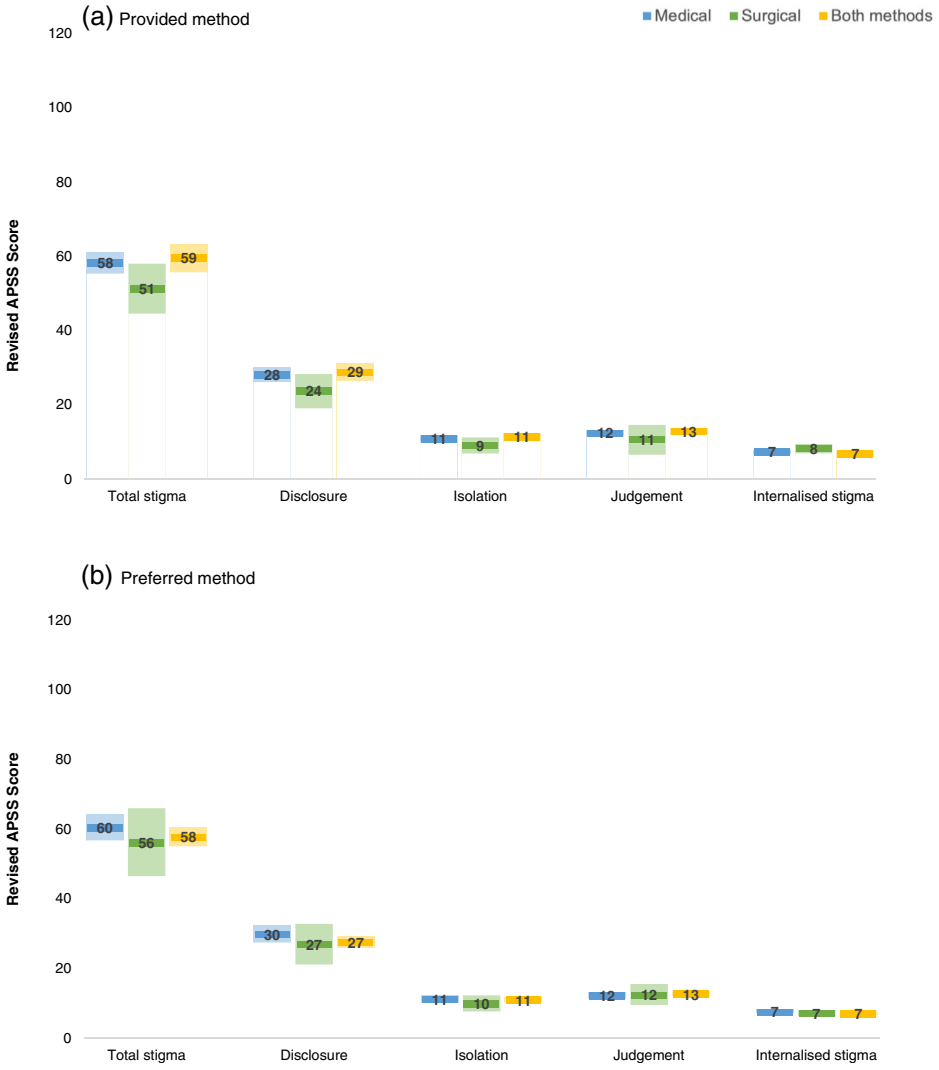

FIGURE 1 Mean revised APSS scores (total and sub-scale) by abortion method (a) provided and (b) preferred, with 95% confidence intervals [United Kingdom Participants of the Abortion Provider Stigma Study, 2021 ($N = 172$)]. Higher scores indicate higher levels of reported stigma.

In the adjusted (Table 3) and unadjusted (Appendix 3) multinomial regression, there was no significant association between revised APSS scores and preference to provide either medication or instrumentation abortion care versus both methods. Those with more than 10 years' experience had significantly lower odds (−1.34; $p < 0.05$) of preferring medication abortion care to both methods in the adjusted model (Table 3). Looking at the full set of coefficients, we found nurses/midwives had significantly higher odds (1.94; $p = 0.05$) of preferring

TABLE 3 Multivariable multinomial logistic regression of factors associated with preferring to provide medication or instrumentation abortion ($N = 165$) [United Kingdom Participants of the Abortion Provider Stigma Study, 2021].

	Coefficient	95% CI		*p* value
Prefer to provide medication abortion (vs. both methods)				
Revised Abortion Provider Stigma Score	0.02	−0.01	0.05	0.16
Gender				
Female	Ref			
Male	−0.69	−3.02	1.63	0.56
Age				
18–34	Ref			
35–44	−0.02	−1.17	1.13	0.98
45–54	0.86	−0.36	2.09	0.17
55–64	0.34	−1.10	1.77	0.65
65+	1.83	−1.20	4.85	0.24
Job type				
Doctor/doctor manager	Ref			
Nurse or midwife/nurse or midwife manager/other	0.33	−0.55	1.22	0.46
Duration of working in abortion services				
0–2 years	Ref			
3–5 years	−0.53	−1.59	0.52	0.32
6–9 years	−0.81	−2.07	0.44	0.20
10+ years	**−1.34**	**−2.58**	**−0.09**	**0.04**
Sector				
NHS (public sector)	Ref			
Private non-profit sector	0.34	−0.68	1.35	0.52
Pregnancy duration personally provided				
Up to third trimester	Ref			
Up to second trimester	14.70	−2283.98	2313.37	0.99
First trimester or post-abortion care only	16.28	−2282.39	2314.95	0.99
Type of facility				
Hospital	Ref			
Clinic or health centre	−0.94	−2.18	0.29	0.13
Other	−0.14	−1.39	1.12	0.83
Prefer to provide instrumentation abortion (versus both methods)				
Revised Abortion Provider Stigma Score	0.00	−0.05	0.05	0.98
Gender				
Female	Ref			
Male	−0.56	−2.71	1.59	0.61
Age				
18–34	Ref			
35–44	−0.60	−2.89	1.68	0.61
45–54	−0.43	−2.88	2.01	0.73
55–64	−1.31	−4.45	1.83	0.41
65+	2.82	−0.81	6.46	0.13
Job type				
Doctor/doctor manager	Ref			
Nurse or midwife/nurse or midwife manager or other	−1.61	−3.47	0.25	0.09

(Continues)

TABLE 3 (Continued)

	Coefficient	95% CI		*p* value
Duration of working in abortion services				
0–2 years	Ref			
3–5 years	−0.10	−2.38	2.18	0.93
6–9 years	−0.34	−3.03	2.36	0.81
10+ years	−0.15	−2.71	2.40	0.91
Sector				
NHS (public sector)	Ref			
Private, non-profit sector	2.01	−0.33	4.36	0.09
Pregnancy duration personally provided				
Up to third trimester	Ref			
Up to second trimester	−1.11	−3.06	0.84	0.26
First trimester or post-abortion care only	−2.36	−4.97	0.25	0.08
Type of facility				
Hospital	Ref			
Clinic or health centre	−1.23	−3.81	1.34	0.35
Other	0.70	−1.90	3.30	0.60

Note: 7 participants excluded due to missing data for gender ($n = 1$), age ($n = 1$), and gestation ($n = 5$). Results in bold are significant at $p < 0.05$. Bold to indicate that they are statistically significant.

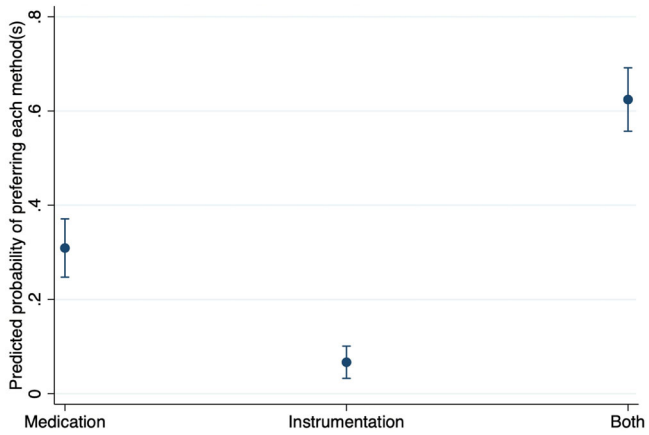

FIGURE 2 Method preference, predictive margins with 95% confidence intervals.

medication abortion care versus instrumentation abortion care (data not shown), but no other differences were significant. Figure 2 shows predictive margins for method preference based on the adjusted model in Table 3.

DISCUSSION

Our analysis is the first to quantitatively assess and compare method preference and provision of UK abortion providers and to explore a possible association with abortion stigma. Among providers who did have a specific method preference, which was usually for medication abortion care, it was common to only provide that method. These findings suggest that provider preference for medication abortion care may influence the methods provided, which may impact patients' ability to choose an alternative method. However, it is also possible that providers tend to prefer the method they commonly provide, as a form of confirmation bias, as both methods are highly safe, effective, and acceptable to patients.[41]

Almost half of providers who only provide medication abortion care would prefer to offer both methods of care. This suggests additional factors may influence the high proportion only providing medication abortion care, such as patient preference for medication abortion, and health system and legal constraints on method provision. In the UK, the policies of private non-profit organizations that deliver most abortion care likely have a significant impact on provider practice, although providers are still able to influence patient decisions through the way they deliver information.[12] Patient choice could be expanded by addressing systemic constraints on method provision, including legal limitations on nurse/midwife roles, provider organizational policies, lack of training opportunities, and commissioning practices that discourage instrumentation abortion provision due to its higher cost.[12] Legal constraints are particularly important in this setting: nurses and midwives can only assist in (not provide) instrumentation abortion care in most UK jurisdictions,[42] despite nurse/midwife provision of vacuum aspiration being World Health Organization (WHO)-recommended[43] and common in many countries.[44,45] Nurses/midwives roles are also limited in that they cannot authorize abortion care or prescribe or dispense abortion medications. In this survey, the majority of nurses/midwives would prefer to offer both methods, presenting an opportunity to extend instrumentation abortion provision to this cadre of health service providers if the abortion law were revised or if abortion was decriminalized.[42]

We also found more experienced providers had lower odds of preferring medication abortion care over both methods of care. This could reflect greater comfort or skill accrued over time, more familiarity with instrumentation abortion care from when it was more commonly provided, or greater familiarity with the varied patient experiences of medication abortion care from when it was an inpatient service. Inclusion of abortion care in formal health workforce education is limited and there are few opportunities for practice-based training in NHS hospitals, meaning most undertake professional development while working in an abortion service.[46] Limited formal training and dwindling instrumentation abortion care provision may limit provision of method choice, as providers require more opportunities to develop relevant skills.

Our analysis had limitations. By necessity, we used purposive, convenience sampling, so the sample is not representative of all UK abortion providers. Hospital-based doctors and NHS providers appear to be over-represented, so we may have overestimated the proportion offering both methods of care. We were not able to disaggregate the results by UK nation, but we expect there would likely be variation in method provision by country. Self-selection bias may have affected reports of stigma if participants who experience more stigma were more or less likely to take part. Social desirability bias may have reduced stigma reporting, although we told participants their employer would not be informed of their response. Our sample was relatively small, but our results were stable when we removed non-significant predictor variables and when we used a logistic instead of a multinomial approach. We did not ask providers about method preference by pregnancy duration, which could be explored in future work. We did not pre-test the method preference question, which could be evaluated using cognitive interviewing in future research.

However, this analysis offers the first quantitative assessment of providers' method preference and its relationship with provision in the UK and is the first to test the association between method preference and abortion stigma. Although qualitative research from other contexts has suggested a relationship between stigma and providers' method provision or preferences,[23–28,30] our study did not identify a significant association. In the UK, most abortion providers have chosen to specialize in abortion care and their practice may be less affected by stigma than when abortion care is integrated into broader health services. However, conscientious objection among health professionals more broadly has been found to limit the capacity of services to offer choice of abortion methods in the UK, which was not assessed in this study due to our focus on abortion providers.[12] Our quantitative measurement of abortion stigma may also not have picked up nuanced dimensions of stigma that affected method preference in qualitative research,[23–28,30] such as feelings relating to responsibility for or distance from the abortion. However, this relationship requires further exploration, as the assumption that there will be lower provider resistance to medication abortion care compared to instrumentation abortion care has informed decisions to only provide medication abortion care in countries where abortion is newly legalized.[47,48] Future research could also assess how structural stigmatization of abortion within the wider health system may influence method availability, including through the practices of policy makers, commissioners, and service managers.

CONCLUSION

Although this analysis identified a preference for medication abortion care among a third of surveyed UK abortion providers, most preferred to provide both methods of abortion care. Despite this, over half only provided medication abortion care. While preferences were not associated with abortion stigma, the discrepancy between provider preferences and provision could reflect patient preference for medication abortion care, as well as health system and legal constraints on method choice, relating to factors such as cost, infrastructure, staffing, and skills. This research highlights the desire among abortion providers to offer both methods of care and the need to strengthen health system capacity to increase abortion method choice.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The dataset upon which this secondary analysis has been conducted is not publicly available.

ENDNOTE

[1] Medication abortion is where a set of medications are taken 24–48 hours apart to end the pregnancy, which usually occurs at home. Instrumentation abortion is where a health care professional uses equipment to remove the pregnancy in a facility setting.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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