

Open Research Online

The Open University's repository of research publications and other research outputs

Normalising abortion: what role can health professionals play?

Journal Item

How to cite:

Maxwell, Karen J.; Hoggart, Lesley; Bloomer, Fiona; Rowlands, Sam and Purcell, Carrie (2020). Normalising abortion: what role can health professionals play? *BMJ Sexual and Reproductive Health*, 47(1) pp. 32–36.

For guidance on citations see [FAQs](#).

© 2020 The Authors



<https://creativecommons.org/licenses/by-nc-nd/4.0/>

Version: Accepted Manuscript

Link(s) to article on publisher's website:
<http://dx.doi.org/doi:10.1136/bmj-srh-2019-200480>

Copyright and Moral Rights for the articles on this site are retained by the individual authors and/or other copyright owners. For more information on Open Research Online's data [policy](#) on reuse of materials please consult the policies page.

oro.open.ac.uk

Title: Normalising abortion: What role can health professionals play?

Authors: Karen J Maxwell, Lesley Hoggart, Fiona Bloomer, Sam Rowlands, Carrie Purcell

Corresponding author:

Dr Carrie Purcell, MRC/CSO Social and Public Health Sciences Unit, University of Glasgow, 200 Renfield Street, Glasgow G2 3AX, UK, 0141 353 7500

Co-authors:

Dr Karen J Maxwell, MRC/CSO Social and Public Health Sciences Unit, University of Glasgow, Glasgow, Scotland, UK

Prof Lesley Hoggart, Faculty of Health and Social Care, The Open University, Milton Keynes, England, UK

Dr Fiona Bloomer, Institute for Research in Social Sciences, Ulster University, Newtownabbey, Northern Ireland, UK

Prof Sam Rowlands, Faculty of Health and Social Science, Bournemouth University, Bournemouth, England, UK

Keywords: abortion, stigma, normalisation, health professionals, qualitative research, reproductive health politics

Word count (excluding title page, abstract, references, figures and tables): 2500

Normalising abortion: What role can health professionals play?

ABSTRACT

Background Despite being a common gynaecological procedure, abortion continues to be widely stigmatised. The research and medical communities are increasingly considering ways of reducing stigma, and health professionals have a role to play in normalising abortion as part of routine sexual and reproductive healthcare. We sought to investigate how health professionals may normalise abortion and challenge prevailing negative sociocultural narratives.

Methods As part of the Sexuality and Abortion Stigma Study (SASS), qualitative secondary analysis (QSA) was conducted on two datasets containing health professionals' accounts of providing abortion in Scotland and England. A sub-sample of 20 interviews were subjected to in-depth, thematic analysis.

Results Four key themes were identified in health professionals' accounts: (1) encountering resistance to abortion from others working in sexual and reproductive healthcare; (2) contending with prevailing negative sociocultural narratives of abortion; (3) enacting overt positivity towards abortion provision; and (4) presenting abortion as part of normal, routine healthcare.

Conclusions It is clear that negative attitudes toward abortion persist both inside and outside of healthcare systems, and need to be challenged in order to destigmatise those accessing and providing services. Health professionals can play a key role in normalising abortion, through the ways in which they frame their work and present abortion to women they treat, and others more widely. Our analysis suggests a key way to achieve this is by presenting abortion as part of normal, routine sexual and reproductive healthcare, but that appropriate support and structural change are essential for normalisation to become embedded.

Key Messages

- Negative attitudes to abortion persist within healthcare systems and need to be challenged in order to destigmatise those accessing and providing services.
- Abortion can be presented as a routine component of SRH, and in positive ways which resist negative framings.
- Health professionals can play a key role in normalising abortion, providing they are adequately supported to do so.

INTRODUCTION

Everyday discourse surrounding abortion is frequently negative, presupposing shame and distress, despite it being a commonly carried out gynaecological procedures [1]. Abortion is represented in popular culture and the media as fundamentally controversial and negative [2-4], and this influences the options available to women to interpret and understand their experiences of abortion. However, recent research has identified discourses which seek to normalise abortion and present alternatives – such as an ‘unapologetic’ narrative – which may ‘increase the cultural legitimacy’ of abortion [5-6].

In the United Kingdom (UK) there is currently heightened interest in abortion rights, driven in part by recent liberalisation in neighbouring Republic of Ireland [7] and, as of October 2019, decriminalisation in Northern Ireland [8] (a UK jurisdiction in which access to abortion has until now remained severely restricted), and the Isle of Man [9]. Organisations currently backing a UK-wide campaign for full decriminalisation include the Royal Colleges of Obstetricians and Gynaecologists, General Practitioners, and Midwives [10]. This campaign, and others internationally, are underpinned by a drive to normalise abortion, arguing that positioning it as routine healthcare is essential to countering stigma and inequity [11].

This paper focuses on ways in which abortion providers can contribute to normalisation. Providers have a heightened awareness of prevailing negative sociocultural attitudes to abortion, often resulting in limited disclosure around their role [12-15]. But providers also resist stigmatisation by reframing their work in ways which emphasise its ‘greater good’ and focusing on their facilitation of women’s choices and rights [13]. This resistance contributes to normalisation, by challenging negative narratives of abortion as ‘undesirable’ and presenting it positively. Arguably, another way that providers might contribute to normalising abortion is by framing it as part of routine healthcare to those they treat, professional networks, friends, family, and others. However, we are not aware of any research studies to date which specifically examine ways in which providers can contribute to normalising abortion. This paper addresses ways in which health professionals might disrupt dominant negative sociocultural narratives of abortion and present destigmatised alternatives.

METHODS

The Sexuality and Abortion Stigma Study (SASS) is an exploratory study bringing together 11 qualitative datasets relating to abortion in the UK for qualitative secondary analysis (QSA)[6]. Here we draw on the two datasets focused on health professionals working in UK abortion provision (the remainder having addressed women’s experiences and general attitudes).

The datasets were produced in England and Scotland, respectively, and have generated a substantial literature [15-22]. They comprised 60 one-to-one interviews with health professionals working in abortion care or referral, including nurses, clinical support workers (CSWs), doctors and clinic managers. They aimed to explore experiences of providing abortion in NHS hospitals, community sexual and reproductive health (SRH), and independent sector clinics. Interviews addressed attitudes to abortion, experiences and challenges of their work. Anonymised datasets held by the original Principal Investigators were shared with the research team based at the University of Glasgow. They were accessed via University of Glasgow data-sharing agreements, and as per consents obtained in the original studies. Issues of access were ameliorated by involvement of the original researchers in the SASS study team and advisory group.

Qualitative Secondary Analysis (QSA)

QSA is a recognised methodology for deriving new insights from existing research [23-25]. It is particularly valuable in health research to maximising learning around sensitive topics or vulnerable populations [26, 27]. In SASS, QSA facilitated pooling of data from multiple studies to give breadth and depth of understanding and allow attitudes and experiences from different contexts to be explored. This included contexts of provision since, in Scotland, almost all abortions are provided from NHS sites whereas, in England and Wales, most are provided by (NHS-funded) independent clinics [28].

Given the volume of data and our exploratory aims, we employed 'amplified sampling' [29], purposively sampling those with direct experience of abortion provision, and excluding those involved only at strategic/policy levels. We then sampled at regular intervals within each dataset, resulting in a sub-sample of 20 accounts, intended as a snapshot across the wider datasets. This comprised eight nurses, two clinical support workers, seven doctors, one sonographer, and two management/administrative staff. Interviews were subject to in-depth thematic analysis beginning with repeated transcript re-readings and exploratory coding of relevant sections. Drawing on this and this wider study's research questions, a coding framework was developed and applied, comprising codes relating to stigma, resistance to stigma, 'normalising' language, and attitudes to abortion. Coding was conducted by KM in close consultation with CP, who met frequently to interpret findings, discuss challenges, and refine analysis. Both also met regularly with FB, LH and SR, to explore interpretations and potential alternative explanations. Ethical approval for the original studies was gained from the original institutions' Ethics Review Committees.

Patient and Public Involvement

As this was a secondary analysis study, patients were not involved in its design or development.

RESULTS

Our analysis identified four interconnecting themes related to normalising abortion in providers' accounts. First, encountering resistance to abortion from SRH and gynaecology colleagues; second, contending with prevailing negative sociocultural abortion narratives; third, enacting overt positivity around abortion provision; and fourth, presenting abortion as part of routine healthcare. Verbatim quotes are followed by project identifiers, participant role and location.

1. Encountering resistance from colleagues

A common theme which emerged from the analysis was health professionals having encountered resistance or hostility from others within SRH/gynaecology. Participants described experiencing little support for the abortion service from colleagues working elsewhere in women's health, which also served to frame abortion services as more stigmatised than other SRH components:

It has opened my eyes a lot about other people, even senior staff, really knowing now, by their behaviour and their attitude and their response of either support or non-support towards us, and I know what their personal feelings are about termination. And it just surprises me that any of these people work in gynae. They don't mind saying that they won't be involved in it, but I find it very difficult how people can work in gynae and not support women. (SASS157, Nurse, Scotland)

Everybody knows terminations happen [...] So I just wish it was a much more open, honest thing and that other staff would come and see we're not evil, we're not horrible and how much these patients need the support. (SASS167, Nurse, Scotland)

Interviewees described how, when working with other sub-specialties such as midwifery (e.g. for later abortions not completed within day ward hours) they encountered some hostility and resistance to providing care:

We had a wee girl in who was... she was a mid-trimester and... they were trying to get her to the labour suite and... [Head midwife] didn't want her in the labour suite. "send her to BPAS". [...] [Head midwife]'s... she's the big, big boss, she's, erm... And you just think "well, if you don't support us, who will?" (SASS173, CSW, Scotland)

Providers described openly-expressed negativity toward abortion and those providing it. This generated stress, affected their wellbeing, and created an atmosphere of conflict:

I think my colleagues and a lot of people, they don't do terminations, we have very few in the department who do terminations, so it's a small group that supports it. It's a constant battle. (SASS217, Doctor, England)

2. Contending with prevailing negative abortion narratives

As with their awareness of colleagues' negative attitudes, providers also indicated awareness of broader negative sociocultural narratives which they had to resist or reject when interacting with others outside the healthcare system. This included the potential for others' disapproval of their work:

I say I'm a sexual health nurse, I work at [clinic]. And I think, you know, that's always a bit of a conversation-stopper in itself (laughs) [...] but perhaps a wee bit more subconsciously I don't say I work here [abortion clinic]. And it's not because... I'm not... I don't mind where I work, it's probably just I can't be bothered with other people's responses. (SASS189, Nurse, Scotland)

I've got quite a bit of faith in the church and I go to church all the time and, y'know, I just think if people knew what I did – and I strongly believe in what I do and I strongly believe in my faith as well – I really do feel I'm doing a good thing. But you don't think that everybody else will see it quite the same way. (SASS164, Nurse, Scotland)

These data suggest that, while providing abortion may be aligned with personal moral views, limited disclosure was common, due to apprehension about negative reactions. For some, negative opinions about abortion were made explicit in challenges from friends and family:

I'll say "well, I'm actually in the termination part as well, three days a week" [...] a lot of them say "I don't know how you can do that" and I'll say "well, somebody has to do it so why not it be me"... (SASS185, CSW, Scotland)

Even probably my family, to be honest, are very much: "why don't you just say 'no', that you don't want to do them?" "Well, because I don't not want to do them, it's part of my job". (SASS177, Nurse, Scotland)

Participants dealt with negative attitudes in numerous ways, from limiting disclosure to challenging negativity and misinformation about abortion. One nurse who also delivered school SRE noted:

I was delivering a session last year and [...] the teacher said “but doesn’t it give you, if you have a lot of abortions won’t it make you infertile?”, she was dying for me to say yes, I said “no, it won’t”. (SASS192, Nurse, England)

Interviewees also described the implications of broader negative abortion narratives for women arrived at clinics expecting negativity and judgement:

I think the stigma [means] they think that the staff are going to be horrible to them, and that's especially true of younger people, they think staff are going to be judging them. So the comments would normally be along the lines of “I wasn’t expecting people to be as nice as they were”, which is good for us but it's a shame the expectations are so low. (SASS213, Doctor, England)

3. Enacting overt positivity around abortion

Providers’ own positivity and personal commitment to providing the service was often clear in their accounts. For some, this took the form of justifying their involvement as something necessary. Many participants stated their moral stance on abortion, their personal commitment to providing a service that they felt was valuable to society, and their support of women’s ‘choice’:

I believe quite passionately in women’s right to choose what the outcome of their pregnancy is, I don’t have a kind of a moral objection to termination. (SASS204, Doctor, England)

I absolutely firmly believe that if a woman wants to have [an abortion], she should do, you know. Clearly, because I work in this clinic. (SASS189, Nurse, Scotland)

Positive attitudes were often interwoven with assertions that access to abortion continues to require improvement:

Access to abortion needs to be made easier so that women can get them earlier [...] We need abortion on demand up to twelve weeks; and that would make a huge difference particularly for young women. (SASS193, Nurse, England)

4. Abortion as normal, routine healthcare

Many participants said that they viewed their work as part of routine, essential SRH. As such, they talked about it in ways which might relate to any healthcare provision, describing the 'good standard of care' and 'timely manner' in which patients were seen (SASS183, Nurse, Scotland). One gynaecology nurse explained how she viewed abortion as just another 'part of her job', and strove to treat patients equitably:

...it's just part of my job as in, y'know, if somebody came in with a miscarriage, I would deal with that, that's part of my job. If somebody has a hysterectomy. then that's part of my job and that is how I see it. (SASS177, Nurse, Scotland)

Participants' presentation of abortion as a routine part of SRH linked closely to their view of it as a valuable and essential service:

Personally, I just think that working within the role that I work, we have a whole array of reasons why women will present to us, and I think [abortion is] a valuable service that should be provided for women. (SASS210, Abortion Clinic Manager, England)

DISCUSSION

Our analysis highlights challenges abortion providers face, but also how they can, and do, contribute to normalisation at an individual level, echoing findings grounded in women's experiences of abortion [6]. Our findings foreground three key points regarding how, and by whom, this contribution can actively be made. Firstly, providers can present abortion as unexceptional, routine healthcare to women undergoing it, their colleagues, and others. In doing so, they can help to shift the default position abortion as stigmatised. Secondly, they might present overt positivity about their work, focusing on their moral stance on women's right to access abortion and the social significance of their work. This would serve to 'refocus the conversation' around abortion, emphasising its moral 'good' and resisting negative framings [6,13]. Thirdly, as we note below, effective top-down support is essential to enable frontline health professionals to enact the normalisation of abortion.

Our findings shed light on providers' awareness of broader negative abortion narratives, and their attempts to counter or resist these. Encountering resistance from professional colleagues, in tandem with broader awareness of negative sociocultural narratives of abortion, may also account for our finding that the language providers used suggested an implied need to defend or justify their work. Language used by providers – 'passionately', 'firmly' believing in women's right to abortion –

signalled not only personal investment in the work, but that abortion rights need to be defended, even in a context of legal provision. As such, providers highlighted an awareness that they were positioning themselves against prevailing negative abortion narratives. As well as emphasising the efforts and willingness of many working in abortion care, this illustrates both the continued stigmatisation of abortion and the ongoing effort required to counter this, if normalisation is to be achieved.

Despite providers positioning their work as important and valuable, our findings underline that resistance from colleagues contributed to the demarcation of abortion as distinct from other routine SRH services, perpetuating stigmatisation for women and providers, even within a context of legal provision. Our analysis highlights that work remains to be done to dismantle abortion negativity embedded in the healthcare system, including demoralising and unsupportive attitudes from management.

It can be challenging in such a context for health professionals to present abortion as unexceptional, normal SRH care, precisely because of the constraining effects of embedded stigma. Moreover, they tread a fine line between presenting abortion as routine healthcare and appearing not to acknowledge its potential significance as a life event for individual women. Hence, for the normalisation of abortion to become embedded in day-to-day care in an appropriate way, change needs to be implemented at a structural level, rather than the burden falling on individual health professionals alone. It is thus essential that support is implemented to enable health professionals to contribute to normalisation, that lasting change might be effected.

Funding

The Sexuality and Abortion Stigma Study (SASS) was supported by the Wellcome Trust (grant no. 207878/Z/17/Z) and hosted by the MRC/CSO Social and Public Health Sciences Unit, University of Glasgow (funding codes MC_UU_12017/11 and SPHSU11).

Acknowledgements

The authors thank the participants in the original studies, the original researchers who generously shared their data and expertise, and the SASS project advisory group for their guidance on the development of the analysis presented here.

Competing interests

None.

Patient consent for publication

Not required.

Ethics approval

Ethical approval for the original studies was gained from the primary studies institutional Ethics Review Committees.

Data sharing statement

No additional data from this study are available.

References

1. Dunn, C. Abortion care: Our responsibility. *Obstet Gynaecol* 2017. Spring 2017; 16-19.
2. Purcell C, Hilton S, and McDaid L. The stigmatisation of abortion: a qualitative analysis of print media in Great Britain in 2010. *Cult Health Sex* 2014; 16(9): 1141-1155.
3. Sisson G and Kimport K. Depicting abortion access on American television, 2005–2015. *Fem Psychol* 2017; 27(1): p. 56-71.
4. Sisson G and Kimport K. Doctors and witches, conscience and violence: abortion provision on American television. *Perspect Sex Reprod Health* 2016; 48(4): 161-168.
5. Baird B and Millar E. More than stigma: Interrogating counter narratives of abortion. *Sexualities* 2018; 1363460718782966.
6. Purcell C, Maxwell K, Hoggart L, et al. Toward the normalising of abortion: Findings from a qualitative secondary analysis study. *Cult Health Sex* 2020; DOI: 10.1080/13691058.2019.1679395
7. Donnelly M and Murray C. Abortion care in Ireland: developing legal and ethical frameworks for conscientious provision. *Int J Gynecol Obstet* 2020; 148(1):127-32
8. Aiken ARA and Bloomer F. Abortion decriminalised in Northern Ireland. *BMJ* 2019; 367: l6330
9. BSACP News, *Isle of Man Becomes First Part of the British Isles to Decriminalise Abortion*, <https://bsacp.org.uk/isle-of-man-becomes-first-part-of-the-british-isles-to-decriminalise-abortion/> (last accessed 17/03/2020)
10. RCOG News, *RCOG/FSRH welcome RCGP vote on decriminalisation of abortion*, <https://www.rcog.org.uk/en/news/rcgp-vote-on-the-decriminalisation-of-abortion/> (last accessed 17/03/2020)
11. Dyer C. Decriminalisation of abortion. *BMJ* 2017; 356: j1485.
12. Harris LH, Martin L, Debbink M, et al. Physicians, abortion provision and the legitimacy paradox. *Contraception* 2013; 87(1): 11-16.
13. O'Donnell J, Weitz TA, and Freedman LR. Resistance and vulnerability to stigmatization in abortion work. *Soc Sci Med* 2011; 73(9): 1357-1364.
14. Duffy DN, Pierson C, Myerscough C, et al. Abortion, emotions, and health provision: Explaining health care professionals' willingness to provide abortion care using affect theory. *Womens Stud Int Forum* 2018; 71: 12-18.
15. Purcell C, Cameron S, Lawton J, et al. The changing body work of abortion: a qualitative study of the experiences of health professionals. *Sociol Health Illn* 2017; 39(1): 78-94.

16. Hoggart L. Internalised abortion stigma: young women's strategies of resistance and rejection, *Fem Psychol* 2017; 27(2): 186–202.
17. Hoggart L. Moral dilemmas and abortion decision-making: Lessons learnt from abortion research in England and Wales. *Glob Public Health* 2018; 14(1): p. 1-8.
18. Hoggart L. "I'm pregnant ... what am I going to do?" An examination of value judgements and moral frameworks in teenage pregnancy decision making. *Health Risk Soc* 2012; 14(6): 533-549.
19. Hoggart L. Preventing teenage pregnancies and abortions: is it attainable?: author's response. *J Fam Plann Reprod Health Care* 2011; 37(3): 191.
20. Hoggart L and Phillips J. Teenage pregnancies that end in abortion: what can they tell us about contraceptive risk-taking? *J Fam Plann Reprod Health Care* 2011; 37(2): 97-102.
21. Purcell C, Cameron S, Lawton J, et al. Contraceptive care at the time of medical abortion: experiences of women and health professionals in a hospital or community sexual and reproductive health context. *Contraception* 2016; 93(2): 170-177.
22. Purcell C, Cameron S, Lawton J, et al. Self-management of first trimester medical termination of pregnancy: a qualitative study of women's experiences. *BJOG* 2016; 124(13): 2001-2008.
23. Bishop L and Kuula-Luumi A. Revisiting qualitative data reuse: A decade on. *Sage Open* 2017; 7(1): <https://doi.org/10.1177/2158244016685136>.
24. Tarrant A. Getting out of the swamp? Methodological reflections on using qualitative secondary analysis to develop research design. *Int J Soc Res* 2016; 20(6): 599-611.
25. Davidson E, Edwards R, Jamieson L, et al. Big data, qualitative style: a breadth-and-depth method for working with large amounts of secondary qualitative data. *Qual Quant* 2018; 53: 363-376.
26. Ziebland S and Hunt K. Using secondary analysis of qualitative data of patient experiences of health care to inform health services research and policy. *J Health Serv Res Policy* 2014; 19(3): 177-182.
27. Long-Sutehall T, Sque M and Addington-Hall J. Secondary analysis of qualitative data: a valuable method for exploring sensitive issues with an elusive population? *J Res Nurse* 2011. 16(4): 335-344.
28. Astbury-Ward E. Abortion 'on the NHS': the National Health Service and abortion stigma. *J Fam Plann Reprod Health Care* 2015; 41(3): 168-169.
29. Heaton J. 2004. *Reworking Qualitative Data*. London: Sage.