Women's experiences of self-referral to an abortion service: qualitative study

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ABSTRACT

Background Guidelines from the UK recommend that women should be able to self-refer to abortion services. In 2016, a self-referral system was introduced to the abortion service in Edinburgh, Scotland, as an option for women. Women could telephone a dedicated phone line during office hours and speak to an administrative assistant working in the abortion service who provided them the next available appointment to be seen in the service. This study aimed to evaluate a self-referral service to abortion by investigating its impact on women's experiences of the referral process.

Methodology 21 semistructured interviews of women attending a specialist abortion service in Edinburgh, Scotland, were conducted. Interviews were transcribed verbatim and thematically analysed. The interviews focused on women's experience of the referral process.

Results Three main themes arose from the interviews, including reasons for choosing self-referral, experience of self-referral and challenges to using self-referral. Reasons for choosing self-referral were related to convenience, privacy and autonomy. Women found the experience of self-referral to be pleasant, non-judgemental and patient-centred, and self-referral prepared them for the appointment at the specialist abortion service. However, some women felt rushed, and self-referral made them anxious to attend the appointment. Challenges were difficulty with getting through on telephone lines, varying levels of support required for different individuals and awareness about the option of self-referral.

Conclusion Women valued the option of self-referral. Women felt that the service should be expanded to increase availability,and promoted to women more widely within the community .

Key messages

- The necessity to request abortion referral from a healthcare provider creates a barrier for women accessing abortion.
- Self-referral was valued by women for its convenience, privacy and autonomy.
- Self-referral was able to give a positive impression of the specialised abortion service to women.

INTRODUCTION

In Great Britain, most women seeking abortion have been referred to abortion services from their general practitioner (GP).[1 2] This can introduce unnecessary delay and distress for women.[3–5] In one UK study, up to 56% of women reported having to wait more than 21 days after their first appointment with their referring doctor to have the abortion.[1] The earlier the abortion is conducted, the less pain and bleeding there is,[6–10] so delays in receiving an appointment with the specialist abortion service reduce the likelihood that the woman can have the abortion at an early gestation.

More worryingly, some surveys have reported that 20%–29% of British GPs identified as being antiabortion, or practised conscientious objection towards abortion.[1 11–13] Negative GP attitudes can adversely impact on women's experiences,[1–4] and in some cases, women have reported that deliberate actions were taken by the GP to try and prevent the woman from pursuing abortion.[3 4 14]

Recent guidelines from the National Institute for Health and Care Excellence recognise the barriers women face to obtain an abortion referrral and recommends that abortion services should provide women with the opportunity to self-refer.[15]

NHS Lothian (Edinburgh and surrounding region) operates a centralised referral service for abortion: Lothian Centralised Abortion Referral Service

(LARS). This was first introduced in 1988 as a central service that GPs in the region could contact in order to receive the next available appointment for their patient to be seen in the specialist abortion service in NHS Lothian.[16]

In 2016, LARS introduced the option of self-referral, where women could telephone LARS directly from Monday to Friday 09:00–15:00 to book an appointment. During the phone call, the women would have some details taken, given the next available appointment and directed to the clinic website with information about the clinic visit and abortion process. This option was promoted using posters displayed in GP surgeries, pharmacies and sexual health clinics throughout the region. The information was included in relevant NHS web pages and circulated to GPs in the region.

This study aimed to evaluate the self-referral service by exploring the experiences of women using the service. Specifically, the reasons for choosing self-referral, the impact of using self-referral on the women's experiences leading up to abortion, challenges to using self-referral and any areas of improvement in the self-referral service were explored. A qualitative design was used in order to fully explore the women's perspective.

METHODS

Semistructured interviews were conducted between January and March 2019, facilitated by a topic guide (online supplementary figure 1). Participants were women presenting for abortion at the main abortion service in NHS Lothian at Chalmers Centre.[17] In order to be eligible to participate, women had to be at least 16 years old and should not require an interpreter. Participants recruited using convenience sampling were a mixture of women who self-referred and via other routes to the service. Women who did not self-refer were also included to garner the views of women who chose not to self-refer, or who did not know about self-referral. Eligible patients, identified by the reception staff, were given a study information sheet when they registered for their appointment. Women who agreed to participate could choose to be interviewed during the wait for their consultation with the clinician or to be interviewed at a later date.

All interviews were conducted by a single researcher, STL, and took place in a private interview room at the clinic. All but one participant was interviewed before the consultation. Participants signed a consent form. Audio recordings were transcribed verbatim within a week. No identifying information were included. All data were kept in a password-protected computer.

Steps for data analysis were adapted from Mason.[18] After interviews were completed, familiarisation with the data was carried out, and possible codes were generated. Then, transcripts were coded manually; key themes were identified; and similar subthemes clustered together. Finally, data were interpreted according to each theme.

Patient public involvement

This student project did not involve patient or public involvement in the design or recruitment. Feedback from initial interviews were useful in refining the interview guide. The summary of the study will be made available in the abortion service waiting area.

RESULTS

Twenty-one women were interviewed. Seventeen had self-referred and four had referred from another healthcare provider (HCP). Details about participants' age and method of referral are shown in table 1. The mean age of the participants was 25 years (range 19–40 years old).

The interviews explored three key areas: reasons for choosing self-referral, experience of self-referral and challenges to using self-referral. Participants who

Table 1 Age and method of referral of participants

Participant	Age (years)	Method of referral	Participant	Age (years)	Method of referral
SR1	25	Self-referred	SR9	28	Self-referred
SR2	33	Self-referred	NSR3	20	Family planning clinic
SR3	20	Self-referred	SR10	22	Self-referred
SR4	22	Self-referred	SR11	29	Self-referred
SR5	21	Self-referred	SR12	40	Self-referred
NSR1	25	GP	SR13	22	Self-referred
SR6	22	Self-referred	SR14	28	Self-referred
SR7	21	Self-referred	SR15	21	Self-referred
NSR2	32	GP	SR16	19	Self-referred
SR8	19	Self-referred	SR17	21	Self-referred
			NSR4	36	GP

GP, general practitioner; NSR, non-self-referral participant; SR, self-referral participant.

did not self-refer were asked about their experience of referral by an HCP and what they thought about self-referral.

Reasons for choosing self-referral

Women were asked why they chose their method of referral. Broadly, women who self-referred spoke about convenience, privacy and autonomy.

Convenience

Women who self-referred generally preferred the quick nature of self-referral and being able to bypass perceived long waiting times for GP appointments. One woman was living outside the UK when she discovered that she was pregnant, and self-referral facilitated access to the service.

> I think in terms of something like this - the easier the better…it was just so good and reassuring to go straight to the service rather than detour around…. SR9

Three of the four non-self-referral participants (NSRs) said they would have preferred self-referral to 'save everyone's time'.

Privacy

Many participants appreciated the discreet nature of self-referral, which meant they only had to divulge the pregnancy to as few people as possible. They did not see the point of involving a 'middle man' and liked that self-referral saved them from having to 'explain it to a doctor'.

> …it isn't something I want a lot of people to know about, so the fewer people I can tell the better. SR17

One NSR said she would have appreciated self-referral as she 'felt judged going to the GP'. Other participants, both SRs and NSRs, commented how helpful the confidential nature of self-referral can be for abortion, a topic that is still taboo, especially for women who find it uncomfortable and women in difficult or in abusive situations.

> …sometimes it can be a bit of an uncomfortable subject, and yeah, (it) made it easier. SR8

Autonomy

Women appreciated the independence self-referral gave them to make the referral and decisions 'in the comfort of your own home'. One participant felt strongly about maintaining her autonomy regarding her own health.

> … it was nice to be able to just pick up the phone and say I want to do this, know that I would have medical discussions when I got there but not have to be persuading doctors and explaining myself and explaining myself before I got there. SR14

Women also thought it was better for them to make the referral as they understood their situation best, rather than a doctor.

> I think it's a very sensitive issue, and I think it's only something that you can understand yourself. I think that if all the information is there… you can work through everything and decide if you want to self-refer - you're not going to self-refer yourself if you don't want to. SR11

Experience of self-referral

Women who self-referred were asked to describe their experience of the process, as well as to point out any positive aspects or negative aspects of the service. The majority of participants (14 of 17) had an overall positive experience of self-referral, while the rest (3 of 17) felt negatively. Positive and negative aspects are summarised as follows, with quotes in table 2.

Positive aspects

Participants described having a pleasant phone call. It helped normalise the situation for some participants, with one participant saying that it 'made it seem like a good choice'. One participant appreciated that it was a woman on the phone, saying that the gender of the receptionist would have affected the conversation. The phone call was commonly described as straightforward but helpful. Participants expected a similar environment at the clinic, including the 'level of professionalism' over the phone, which helped them feel more comfortable and confident about attending the appointment.

Table 2 Quotes from women describing positive and negative aspects of their experience of self-referral

Positive aspects	Negative aspects
'…obviously something like termination is not something that you necessarily want to do, but because the phone call was reassuring I think it made it a whole lot more approachable'. SR9	'…in this situation I feel like it could have a bit more of, you know, understanding someone's needs, and how hard it probably is to pick up the phone and book something like this'. SR1
'… she was just making sure that everything worked around me rather than like, "you have to come at this hour, if you have work it doesn't matter". She was just like totally open, she was like letting me decide…'. SR7	'…it just made me very nervous and anxious to come today, because that's the first person you speak to so you wonder if everybody else here is kind of the same way'. SR17
'I knew kind of what to expect and if I was struggling I could phone rather than struggling on my own and not knowing what to do, so it's definitely helpful'. SR8	

SR, self-referral participant.

Many participants expressed anxiety about making the phone call and about the whole situation in general. Nine women who were self-referral participants (SRs) found the phone call reassuring due the 'calm' or 'relaxed' nature of the administrative assistant, having their questions answered, as well as just the fact that they had made the referral. Three participants appreciated that the administrative assistant proactively helped calm them by talking them through the process or by subsequently seeking a nurse to speak to the woman.

Participants appreciated not being questioned on their decisions. One NSR felt 'judged going to the GP', and one SR said she feels her GP 'might have influenced me in other ways'. The process of self-referral was described as 'non-judgemental'.

Many participants described how the patient-centred nature of the phone call made a positive impact. They appreciated feeling like the referral focused on their needs when it came to appointment options, preparation for the appointment and their feelings.

Four SRs felt satisfied with the amount of information received on the phone, which helped them feel more prepared mentally and practically. Participants generally felt supported after self-referral. There was a feeling of trust towards the abortion service.

Negative aspects

In contrast, three SRs perceived a lack of empathy over the phone. One participant thought the phone call was 'harsh' and 'cold', while others felt rushed. They had unanswered questions, and in contrast, one participant felt overwhelmed by the information she received. Two participants felt like their experience made them anxious to attend their appointment.

Challenges to using self-referral

Throughout the interviews, challenges to using self-referral were identified from the women's experiences. These were the phone line, varying levels of support required by different individuals and finding out about self-referral. Some participants gave suggestions to improve the service and discussed what barriers may be faced by others seeking abortion.

Phone line

Seven SRs found the phone line difficult to get through. Some mentioned how it was inconvenient, or impossible to call during work. Two of the four NSRs opted for GP or a family planning clinic referral as they felt anxious after not being able to get through.

Varying levels of support required by different individuals

Some women felt dissatisfied with relying on online resources and thought it was too long to wait before speaking to someone face-to-face. Two participants also preferred having someone else help them make the referral. Some participants were directed to self-referral from their GP surgery without being offered the option for a GP referral.

In terms of information, some participants wanted more details, while some preferred being given resources to read through in their own time.

> …I kind of preferred to do my own research, like if they guide me to where to go, so that was quite good. SR4
>
> I don't want to go online and read bibles of information… I don't have time to sit and go through everything to do with patient leaflets. SR1

Finding out about self-referral

Participants felt it was important to increase awareness about self-referral. Ten participants had not seen posters in their GP surgery; 3 thought they might have seen posters or leaflets; while only 1 was sure that she had. Participants found out about self-referral via the internet or were signposted to it from other healthcare services.

Some participants felt very positively about posters being put up in more public spaces, believing it could have a good impact by normalising abortion, reassuring people and increasing awareness about the different options available. One participant was sceptical about how other people would receive this, saying she would prefer it if they were promoted more discreetly.

> I don't think you see it as often enough as you should… if anything you should get it …more shown, so people know that they've got the option and what to do. SR15
>
> I don't know how well people will take the advertisements, so I think it's more like discreet, which is always what you want. I don't think - even I wouldn't like to see like this big posters like in your GP. SR6

DISCUSSION

Analysis of the interviews revealed that women choose self-referral for reasons relating to convenience, privacy and autonomy. The majority of women had an overall positive experience of self-referral, with a minority reporting a negative experience. Positive aspects included the phone call itself being pleasant and reassuring, non-judgemental and patient-centred, and gave women positive expectations for the subsequent appointment, as well as feeling supported and prepared. The reported negative aspects included a perception of lack of empathy from a receptionist on the phone, women feeling 'rushed' during the phone call and when the call gave them a negative impression of the service. Three challenges to using self-referral were identified: a busy phone line, varying levels of support required by different individuals and awareness of the self-referral option.

Other UK studies confirmed the need for and value of self-referral as an option. Consistent with our findings, qualitative studies report women's preference for

a quick and straightforward referral,[2 4] which is not the case if they consult an HCP who does not directly refer them at their request. Studies show that privacy is important to some women but is sometimes made difficult for women who have to make arrangements at work or for childcare to attend appointments, or women living in small communities.[3 5] Women's experiences of HCPs undermining women's decisions are common.[3 4] Women seeking abortion approach the health service for information and support,[4] or a space to talk through inner conflicts and reflect,[19] rather than influence on their decision-making. This is in line with WHO guidance on provision of safe abortion to respect women's informed and voluntary decision-making and autonomy.[20]

The majority of SRs in this study described a positive experience of their self-referral phone call, with a minority who felt rushed during the referral and required more support. In comparison, other UK qualitative data report participants feeling unsupported and judged during their GP appointment, as well as feeling distressed between referral and appointment.[1–4] This could be further elevated for people in dangerous situations of domestic abuse or for women with relevant mental illnesses.[5]

Expansion of phone-based self-referral service inevitably leads to a busy telephone line on occasions. It would be difficult to predict how many women abandon the option of self-referral, or how much it would impact or delay their process of seeking abortion. If staff are busy, then the phone call could also come across as rushed. A solution would be to have more staff or phone lines and extending the opening of the phone line. However, this will inevitably have cost implications for a service.

Alternative routes of self-referral could also be offered, for example, an online booking system with clear information and directions to appropriate resources. However, given many participants appreciated being able to speak to someone and the reassuring nature of the phone call, it is likely that phone referral will remain a popular option. Some participants preferred face-to-face interactions or to have been referred by an HCP. Thus, the option for a GP or a local family planning clinic referral should be maintained with other options for referral made available.

A qualitative study in England highlighted challenges faced by patients during their process of referral, noting that, although self-referral was available in that area, it was not known by HCPs and the general public.[4] Indeed, word of mouth via healthcare settings has proven helpful as many participants were informed about self-referral through their GP surgery.

Most participants in this study found out about self-referral via the internet, suggesting the value of the internet as an important facilitator to accessing safe abortion. Promotion of self-referral should then target people who would not routinely rely on the internet for information.

No participants mentioned gaining information about self-referral through posters. This might suggest a suboptimal impact of the poster campaign. Nevertheless, having posters in public spaces could help destigmatise abortion in the general public, as mentioned by some participants. Promotion in public transport or social media can reach a significant proportion of the population. Places such as commercial settings where people buy pregnancy tests can also be considered to increase the chances of those needing the service being informed.

This study is one of few studies evaluating a self-referral system for abortion. Use of semistructured interviews allowed us to explore the participants' experiences in more depth, and most participants were interviewed on the day of their clinic appointment, which minimised recall bias.

Weaknesses of the study include that it was conducted in a single centre and so may not be representative of self-referral processes elsewhere. In addition, self-selection bias among participants was possible. Young women under the age of 16, and those requiring an interpreter were excluded.

CONCLUSION

Women choosing abortion considered self-referral to be a valuable option and capable of providing a positive experience of the referral process. The availability of self referral for abortion should be promoted further throughout the UK.

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REFERENCES

1 Finnie S, Foy R, Mather J. The pathway to induced abortion: women's experiences and general practitioner attitudes. *J Fam Plann Reprod Health Care* 2006;32:15–18.
2 Mason L. Referral to a national health Service-funded abortion clinic. *J Fam Plann Reprod Health Care* 2005;31:117–20.
3 Heller R, Purcell C, Mackay L, *et al*. Barriers to accessing termination of pregnancy in a remote and rural setting: a qualitative study. *BJOG* 2016;123:1684–91.
4 Kumar U, Baraitser P, Morton S, *et al*. Decision making and referral prior to abortion: a qualitative study of women's experiences. *J Fam Plann Reprod Health Care* 2004;30:51–4.
5 Aiken ARA, Guthrie KA, Schellekens M, *et al*. Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain. *Contraception* 2018;97:177–83.
6 Aiken AR, Digol I, Trussell J, *et al*. Self reported outcomes and adverse events after medical abortion through online telemedicine: population based study in the Republic of Ireland and Northern Ireland. *BMJ* j2011;2017.
7 Goldstone P, Walker C, Hawtin K. Efficacy and safety of mifepristone-buccal misoprostol for early medical abortion in an Australian clinical setting. *Aust N Z J Obstet Gynaecol* 2017;57:366–71.
8 Lederle L, Steinauer JE, Montgomery A, *et al*. Obesity as a risk factor for complications after second-trimester abortion by dilation and evacuation. *Obstet Gynecol* 2015;126:585–92.
9 Westhoff C, Dasmahapatra R, Winikoff B, *et al*. Predictors of analgesia use during supervised medical abortion. *Contraception* 2000;61:225–9.
10 Davis A, Westhoff C, De Nonno L. Bleeding patterns after early abortion with mifepristone and misoprostol or manual vacuum aspiration. *J Am Med Womens Assoc* 2000;55:141–4.
11 Theodosiou AA, Mitchell OR. Abortion legislation: exploring perspectives of general practitioners and obstetrics and gynaecology clinicians. *Reprod Biomed Online* 2015;30:197–202.
12 Cook PA, Cosgrove P, Robin A, *et al*. Review of sexual health services in the North West, 2003. Available: http://nwph.net/nwpho/Publications/nwsexhealthreview.pdf [Accessed 7 Feb 2019].
13 Francome C, Freeman E. British general practitioners' attitudes toward abortion. *Fam Plann Perspect* 2000;32:189.
14 Purcell C, Cameron S, Caird L, *et al*. Access to and experience of later abortion: accounts from women in Scotland. *Perspect Sex Reprod Health* 2014;46:101–8.
15 National Institute for Health and Care Excellence (NICE). Guideline for abortion care, 2019. Available: https://www.nice.org.uk/guidance/ng140/resources/abortion-care-pdf-66141773098693 [Accessed 01 Oct 2019].
16 Glasier A, Thong JK. The establishment of a centralised referral service leads to earlier abortion. *Health Bull* 1991;49:254–9.
17 Smith JL, Cameron S. Current barriers, facilitators and future improvements to advance quality of abortion care: views of women. *BMJ Sex Reprod Health* 201910.1136/bmjsrh-2018-200264. [Epub ahead of print: 26 Apr 2019].
18 Mason J. *Qualitative research*. SAGE Publications, 2002.
19 Kjelsvik M, Sekse RJT, Moi AL, *et al*. Beyond autonomy and care: experiences of ambivalent abortion seekers. *Nurs Ethics* 2019;26:2135–46.
20 World Health Organization (WHO). Clinical practice Handbook for safe abortion, 2014. Available: apps.who.int/iris/bitstream/handle/10665/97415/9789241548717_eng.pdf?sequence=1 [Accessed 15 Apr 2019].