Unintended Pregnancy, Abortion and Prevention

Women and Men’s Experiences and Needs

MARLENE MAKENZIUS
Dissertation presented at Uppsala University to be publicly examined in Gustavianum, Uppsala, Uppsala, Friday, September 21, 2012 at 13:15 for the degree of Doctor of Philosophy (Faculty of Medicine). The examination will be conducted in Swedish.

Abstract

Women and men’s experiences and needs in relation to induced abortion, and their views on the prevention of unintended pregnancies were explored through questionnaire studies at 10 and 13 Swedish women’s clinics (Papers I–IV). Among 798 women in age range 14 – 49, 35% had experience of at least one previous abortion, and in the age range 20 – 49, 41%. The risk factors for repeat abortion were having children (Odds Ratio [OR] = 2.57), lack of emotional support (OR 2.09), unemployment or sick leave (OR 1.65), tobacco use (OR 1.56), and low educational level (OR 1.5). Among 590 men in age range 16 – 63, 32% had been involved in at least one previous abortion. The risk factors were, being a victim of violence or abuse (OR 2.62), unemployment or sick leave (OR 2.58), and having children (OR 2.0). Tobacco use was common, among both women (33%) and men (50%), and among those with repeat abortion 41% and 57%, respectively. Some considered societal efforts important for prevention, (Paper I–II).

Overall care-satisfaction (Paper III) was high (74% of women and 52% of men). For women, factors associated with high care-satisfaction were being well treated by the staff (OR 11.78), sufficient pain relief (OR 3.87), adequate information about the gynaecological examination (OR 2.25), suitable contraceptive counselling (OR 2.23), and accessibility to the clinic by phone (OR 1.91). For men, the factors were being well treated by the staff (OR 5.32) and adequate information about the abortion procedure (2.64).

Existential experiences and needs related to abortion were investigated among 499 women. Three components were identified (Paper IV): existential thoughts (61% of women), existential practices (48%), and humanisation of the foetus (67%). A higher presence of existential components correlated with difficulty in deciding to abort and poor psychological wellbeing after the abortion.

Interviews with 24 women and 13 men on their experiences and needs related to home abortion and views on the prevention of unwanted pregnancies revealed two overarching themes (Paper V). Home abortion increased autonomy: both women and men demonstrated self-care ability. However, autonomy was related to dependence: the desire to be treated with empathy and respect on equal terms and receive adequate information adapted to individual needs. They were motivated to avoid a subsequent abortion, but planned contraceptive follow-ups were rare.

Both individual and societal challenges were implied: women and men experiencing repeat abortion appeared more disadvantaged and abortion involved complex aspects beyond medical procedures and routines. Thus, abortion care should be continuously evaluated to ensure care satisfaction, safety, and contraceptive adherence. Preventive efforts would include work opportunities, sex and relationship education, and cheap and effective contraceptives. Minimising differences between socioeconomic groups is important, and both individuals and society should share the responsibility for these efforts.

Keywords: Induced abortion, Risk factors, Unwanted pregnancy, Repeat abortion, Patient satisfaction, Prevention, Existential expression, Home abortion, Care

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To my family
List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.


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<td>CI</td>
<td>Confidence Interval</td>
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<td>CT</td>
<td>Chlamydia Trachomatis</td>
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<td>ECP</td>
<td>Emergency Contraceptive Pill</td>
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<td>IUD</td>
<td>Intra-uterine device</td>
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<td>Maternal-foetal attachment</td>
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<td>NBHW</td>
<td>National Board of Health and Welfare (Socialstyrelsen)</td>
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<td>PIN</td>
<td>Personal Identification Number</td>
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<td>SNIPH</td>
<td>Swedish National Institute of Public Health (Statens folkhälsoinstitut)</td>
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<td>OC</td>
<td>Oral contraceptive</td>
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<td>OR</td>
<td>Odds Ratio</td>
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<td>SMI</td>
<td>Smittskyddsinstitutet (Swedish Institute for Infectious Disease Control)</td>
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<td>SRE</td>
<td>Sex and Relationship Education</td>
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<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>VIPS</td>
<td>VIPS is a model created to support systematic documentation of nursing care in patient records through the keywords Well-being, Integrity, Prevention and Safety</td>
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<td>WHO</td>
<td>World Health Organization</td>
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My experiences of client-centred work as a midwife shed light on the larger context of my current work as a public health planning officer. In order to understand and create healthy societies that promote wellbeing among citizens, my vision is that the approach needs to be holistic, irrespective of whether it concerns political policies or client-centred work. All individuals have their own stories, circumstances, and abilities to attain their goals in life. However, society is always present and may encourage or discourage the individuals’ efforts.

According to the World Health Organization (WHO), health is defined as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity (1). Reproductive health is a part of the definition of health and addresses the reproductive processes, functions and systems at all stages of life (1). Reproductive health implies people are able to have a responsible, satisfying, and safe sex life with the ability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this is the right of every woman and man to be informed of and have access to safe, effective, and affordable methods of fertility regulation and the right to access appropriate health care services regarding pregnancy and childbirth, and unintended pregnancy and abortion (1).

Although “unintended pregnancy” is the most commonly used term in this thesis, it may vary, as there is variability in the terms reflecting intentions prior to an induced abortion, such as "unintended", “unplanned”, and “unwanted" (2-7). These terms are often used without sufficient attention being paid to their meaning or the context they are derived from (7). In addition, a wanted pregnancy can become unwanted, and vice versa, and contraceptive failures do not always result in an unintended pregnancy. Therefore, the concept of pregnancy intentions is essential in understanding fertility, preventing unwanted childbearing, and promoting an individual’s ability to determine whether and when to have children (7).

Every day, approximately 125,000 pregnancies worldwide end with an induced abortion. In 2011, almost 40,000 abortions were performed in Sweden. Even so, there is limited research in this area. The choice of abortion is woman’s fundamental right (8), which should not be questioned, however, unwanted pregnancies are partly preventable, and in this context men should be included.
Unintended pregnancies and different dimensions

The measurement of pregnancy intention is important in understanding fertility-related behaviour, forecasting fertility, estimating unmet needs for contraception, and predicting health impacts (2, 7, 9, 10).

Different dimensions may be involved in the context of an unintended pregnancy, for example, emotional, existential, cultural and contextual dimensions (7, 11). Emotional and existential factors are often related to personal values about childbearing (6, 11-13). Cultural and contextual dimensions of pregnancy intentions highlight the complex set of relationships within which pregnancies occur. They concern the women’s relationships to their partners, family, and peer groups, as well as the preparation for pregnancy, life goals, and socioeconomics (3, 4, 14-17).

Regardless of pre-conceptive intentions, decision making on abortion can evoke feelings of ambivalence in both women and their male partner; abortions provoke feelings of relief, while simultaneously, the termination of the pregnancy is experienced as a loss, with feelings of grief and emptiness (6). For some women, the abortion procedure triggers existential experiences of life, meaning, and morality (13), and some women express a need to reflect upon the existential aspects and/or to reconcile their decision emotionally (13). Maternal-foetal attachment (MFA) is considered vital for a woman’s psychological adjustment when deciding to carry a pregnancy to full term (18), but has rarely been studied in relation to induced abortion. A qualitative Swedish study (13) highlighted variety in MFA among young women choosing to abort, some women hold dehumanised images of the foetus, while others describe the foetus as a human being and have inner pictures of the foetus as a child.

Thus, the decision to abort is often the product of multiple and complex aspects. Similarly, there is a need to consider the attitudes, intentions, and behaviour of male partners and the influence of partners on women’s pregnancy intentions, contraceptive use, and fertility decisions (4, 6, 17). However, most surveys focus exclusively on women’s experiences and needs in the context of an unintended pregnancy.

Abortion legislation and practice

Legislation

Forty per cent of the world’s women live in countries with restrictive abortion laws, which allow only abortion to protect a woman’s life or her physical or mental health, or strictly prohibit abortion (19,20). The prohibition of abortion increases both the incidence of unsafe abortions and maternal mor-
tality (20). Most unsafe abortions occur in countries where abortion is illegal (20). The legalisation of abortion on request is a necessary part of efforts for decreasing maternal mortality. In Sweden, access to safe and legal abortion is a fundamental right and is not a controversial political issue.

Abortion in Sweden was first legislated by the Abortion Act of 1938, which stated an abortion could be legally performed upon medical, humanitarian, or eugenical grounds (8, 21). That is, a woman could request an abortion if the pregnancy constituted a serious threat to her life, if she had become pregnant through rape, or if there was a considerable chance a serious condition might be inherited by her child. In 1946, the law was altered to include socio-medical grounds, and in 1963, the risk of serious foetal damage was included into the Act. A committee investigated whether these conditions were met, and found that due to the prolonged process, abortion was often not granted until the middle of the second trimester (8, 21).

The current Abortion Act of 1975 states that up until the end of the 18th week of the pregnancy, the choice of an abortion is entirely up to the woman, for any reason whatsoever (8). After the 18th week, a woman needs permission from the National Board of Health and Welfare (NBHW) to have an abortion. Permission for late abortions is usually granted for cases in which the foetus or the mother are unhealthy (21). Since 2009, non-resident women have been permitted to undergo an abortion in Sweden (21).

Abortion - settings and practice in Sweden

Abortion procedures in Sweden are strictly regulated by NBHW to ensure abortion care is safe, undertaken by physicians (who may delegate part of the care to midwives), affordable, and sustainable within hospitals in the public health care system. Abortion Services are considered emergency care, with the main professionals involved during the abortion process being gynaecologists, midwives and nurses, and voluntary counselling with a social health worker has to be offered to all women.

Although Swedish midwives are responsible for, and the main caregivers of, reproductive health services, including contraceptive services and pre-abortion counselling, they did not become actively involved in abortion care until the beginning of the 1990s. As the number of medical abortions increased, gynaecologists began delegating duties, such as counselling and care of the woman, to the midwives during the procedure. Thus, programs for the management of medical abortion care have gradually been converted from physicians to mid-level providers (22).

A pregnancy can be intentionally terminated in many ways and the method of choice depends upon the gestational age of the embryo or foetus. Medical abortion is a non-surgical procedure that uses pharmaceutical drugs, and is the most common method used in Sweden (89%) during the first nine weeks of gestation. Early termination, before the 9th week of pregnancy,
reduces complication risks after the abortion. A common medication for initiating a pharmaceutical or medical abortion is 200 mg Mifepristone taken orally, followed by 0.8 mg Misoprostol administrated vaginally after 36-48 hours. The final pharmaceutical treatment of a medical abortion may be administered at home, depending on gestational length, woman’s choice, and the clinic’s routine (23).

Most women are satisfied with the possibility to administer the prostaglandin portion at home. They consider it more “natural”, and a majority would choose home administration again if they required another medical abortion (24-27). However, some women have difficulty coping with the pain and bleeding (28).

Surgical abortions are performed by vacuum-aspiration, usually before the 12th week and for later pregnancy terminations: depending on gestational length, different medical drugs are combined and sometimes followed by a surgical procedure (29).

Treatment practices vary widely across the country, with regard to both the proportion of medical abortions and whether the woman is allowed to complete the final pharmaceutical treatment at home (23). The reason for this variation is unknown. Women appear to be able to obtain a medical abortion faster when the final treatment is carried out in the home than when it is done entirely in the clinic (23). As abortion care is considered emergency care, the NBHW suggest all counties in Sweden should offer the option of completing a medical abortion at home, when it is medically appropriate and when the woman wishes it (23).

Although abortion methods are regulated, additional nursing/midwifery care within the abortion process and prevention of subsequent abortion are not specifically regulated in the guidelines. The goal of all abortion services is that no woman should have to wait from first contact to the first visit (21). Nevertheless, waiting times during the abortion process differ between counties and between clinics within the same county (23).

Care and nursing/midwifery
Addressing the harmful health consequences of unsafe abortion obligates appropriate abortion care, including post abortion care and contraceptive counselling. Swedish abortion care (21, 23) is in accordance with international guidelines (19, 20, 30). Fundamental components of high-quality abortion care include:

- Ensuring women have the right and opportunity to make choices about their bodies and health, without interference from others.
- The woman’s right to determine whether, and when, to become pregnant, and to continue with, or terminate, a pregnancy.
- Provide decentralised safe, high-quality abortion services at the most local level possible.
- Services are affordable and acceptable for all women.
- Health-care providers must ensure confidentiality, privacy, respect, and positive interactions between women, partner and health care providers. This is essential for understanding each woman’s particular social circumstances and individual needs.
- Provide accurate, appropriate care and contraceptive counselling in order to reduce the number of unwanted pregnancies and abortions.
- Identify and serve women with other sexual or reproductive health needs (8, 21, 23, 31).

In Sweden, nurses and midwives commonly use the evidence based VIPS-model (Well-being, Integrity, Prevention and Safety) to describe and document nursing and midwifery care (32-34). The main concepts of the model represent the different parts of the nursing/midwifery process:
- Well-being - considers holistic outcomes, such as existential needs, comfort, wellness, and health of the whole person.
- Integrity - covers respect, being sensitive to the patient as a person with individual differences, and responsive to each person’s experience of vulnerability.
- Prevention - concerns diseases and disability, and encompasses individual, families and communities.
- Safety - concerns the use of safe and secure practices and techniques for preventing injury, and providing feelings of trust and security in a patient (32-34).

These concepts are documented through “keywords” (32-34). According to the VIPS-model, health care providers should consider a patient’s vulnerability, living conditions, and environment in order to prevent adverse health outcomes (32-34).

**Abortion rates**

Globally, an estimated 40-50 million women every year face an unwanted pregnancy and decide to have an abortion (20), corresponding to approximately 125,000 abortions per day. About 19-20 million of those abortions are unsafe abortions, performed by people without the requisite skills, or in environments below the minimum medical standard, or both (35).

In settings where abortion is restricted, women have to resort to clandestine interventions to terminate an unwanted pregnancy. As a consequence, high rates of unsafe abortion (8-39 per 1000 women) occur in some countries, such as in Sub-Saharan Africa (19). Globally, an estimated 66,500 –
70,000 women die every year as a result of unsafe abortions (19, 30, 35), and a far larger number of women experience short- and long-term health consequences (19, 20). Nearly all unsafe abortions (97%) are performed in low-income countries and the main causes of death are haemorrhage, infection, and poisoning (35).

**Abortions in the European Union**

In Ireland, Malta, and Poland, there are restrictive abortion legislations, and Luxembourg only permits abortion on physical and mental health indications. Additional socio-economic indications are included in abortion legislation in Cyprus, Finland, and the United Kingdom. In all other EU member states, including, Sweden, abortion can be performed in early pregnancy on request by the woman. Abortion rates have declined in the European Union; in 2008, an average of 10.3 abortions per 1000 women aged 15–49 years was reported. The rate was 12.3/1000 for countries requiring a legal indication for termination, and 11.0/1000 for countries allowing termination on request; however, northern Europe had substantially higher rates of abortions among teenagers (36).

**Abortions in the Nordic countries**

In the Nordic countries, 80,900 induced abortions were performed in 2009, of which 37,500 were in Sweden, 16,200 in Denmark, 15,800 in Norway, 10,400 in Finland, and 970 in Iceland. Although the total number of abortions has increased during the 2000s, it is still below the rates during the 1970s and 1980s. During the 2000s, the abortion rates have remained relatively stable in Finland, Denmark and Iceland, but have increased in Sweden and Norway. In 2009, Finland had the lowest number of induced abortions (8.9 per 1000) and Sweden had the highest number of induced abortions (17.8 per 1000) (Figure 1). The figures for Norway were the same as the Nordic average (14.1 per 1000), with Denmark (12.9 per 1000) and Iceland (12.4 per 1000) being slightly lower (Figure 1). Proportionally, the number of induced abortions is highest in the age group 20–24 years (37).
Abortions in Sweden

In Sweden, where safe induced abortions are a human right, statistical data on abortions are reported to the NBHW, which compiles annual reports used to track trends in abortion rates.

The overall number of abortions and births appear to correlate and comply with economic cycles: the numbers fell during the 1990s economic downturn, and increased again during economic boom in the 2000s. However in Sweden, there is no register data on the socio-economic characteristics of the women having an abortion, except age, abortion method, gestation week, parity, residence, and number of previous abortions (38).

About 25% of the total number of pregnancies and 80% of teenage pregnancies end in abortion, with 79% of induced abortions being performed before the end of the 9th week of pregnancy (38). The proportion of medical abortions continues to increase, and in 2011, constituted 89% of all abortions before the end of the 9th week of pregnancy, compared with 86% in 2009 (38).

Since 2000, abortion rates in Sweden have increased slightly (Figure 2), although the teenage abortion rate has decreased since 2006. However, the percentage of repeat abortions, which has been constant at 37-38% of annual abortions since the 1990s, has begun to increase: 39.3% in 2009, 40.3% in 2010, and 41.5% in 2011 (Figure 3) (38). The major increase is among the younger women, Figure 3.
Figure 2. Number of induced abortions per 1000 women by age 1975 – 2011. Source: National Board of Health and Welfare (38).

Figure 3. Proportion (%) of repeat induced abortions by age (1983 – 2011). Source: National Board of Health and Welfare (38).
Vulnerable groups

Teenagers and adolescents

Adolescent sexual behaviour has become more risky (39). An increasing proportion of young people hold the opinion it is not necessary to be in love with someone in order to have a sexual relationship. Accordingly, sex on the first date is more frequent, and in 2007, was reported by more than one-third of women and men aged 16–24 years (40). Between 1989 and 2007, the prevalence of several sexual partners and casual sexual intercourse without the use of a condom doubled for women aged 16-24 years, and in 2007, there was no difference between young men and young women (40).

Other risk behaviours, such as alcohol use and smoking, are associated with unprotected intercourse and are more prevalent among vocational high school students than among students in academic programmes (41-44). Similarly, there are associations between early sexual initiation and increased risk for sexual transmitted infection (STI) and unintended pregnancy (45), suggesting early sexual intercourse is an indicator for a hazardous lifestyle and problematic life situation (46).

The reduction of teenage pregnancies is one objective of the Swedish Public Health Policy (47), as becoming a mother during adolescence is associated with adverse health effects for both the mother and her child (48-50). A Swedish study (48) compared teenage mothers (15-19 years) with older mothers (25-32 years), and found teenage mothers are more socially vulnerable, have more experience of school failure, and generally have more risky lifestyles. Teenage mothers also feel they receive less support from their environment, and have lower self-esteem and more symptoms of depression than older mothers have (48).

Women at risk of repeat abortion

Previous studies, mainly from outside Sweden (4, 51-55), conclude the risk of repeat abortion is associated with immigrant status, low education, weak social network, poverty, and unemployment. Older age and previous children are more common among women experiencing repeat abortions (54-56). However, as older women have more years to experience having children and/or an abortion, age and previous children may be considered more as confounders than true risk factors (54, 55). A history of physical or sexual abuse (53), substance abuse (57), and daily smoking (4, 52) are more common among women experiencing repeat abortion than among women without these experiences.
Men involved in abortion

A Swedish study (44) indicates 18-year-old men whose partner experiences an unintended pregnancy have more risk-taking life-styles than similar aged men without a history of unintended pregnancy in a female partner. Among this group, there is more use of tobacco and anabolic steroids, and more experience of sexually transmitted infections and sexual abuse, than among peers without a history of unintended pregnancy (44). Moreover, the risk of involvement in a new unintended pregnancy increases for men who have faced this problem (44, 58).

Preventive efforts

Public Health Policy in Sweden

The overriding objective of public health is to create social conditions for good health on equal terms for the entire population. In 2002, the Swedish Government adopted the Swedish national Public Health Policy in the legislative proposition, “Objectives for public health” (59), which consists of 11 objectives. These objectives cover important determinants of Swedish public health and structural issues related to health outcomes, such as welfare, finances and labour market, and those related to health behaviour, such as sexual behaviour, use of tobacco, alcohol, illicit drugs, physical activity, and eating habits (60). Public authorities at all levels should be guided by the 11 public health objectives. One objective covers sexuality and reproductive health, and the determinants unprotected sex, STI and abortion rates, easy and instant access to abortion care, and sexual crimes are used to evaluate progress within this objective. This in turn supports political decision-making, as determinants can be influenced by certain types of political measures (39).

Sweden has a long tradition of education regarding sexuality and relationships: an area regarded as a cornerstone in public health work. Safe and enjoyable sexuality is considered fundamental to an individual’s perception of health and well-being, which implies freedom from prejudice, discrimination, coercion, and violence. Therefore, society should govern and develop areas such as sex and relationship education (SRE), Youth Health Clinics (YHC), abortion care, family planning services, and maternity health care (MHC)(39).
Contraceptives and counselling

Worldwide, low and inconsistent use of contraceptives by young people contributes to unintended pregnancies. In an international perspective, the accessibility and quality of contraceptive services vary widely (61). Fulfilling unmet needs for contraception is cost effective, as expenditure on the prevention of unintended pregnancies is less than the cost associated with the consequences of unintended pregnancies and births (61). However, the quality of contraceptive services is important. For example, in Uganda, the quality of contraceptive services provided to young people is low with regard to client’s needs (partly), choice of contraceptives, information, client-provider interpersonal relations, constellation of services, and continuity mechanisms for developing the facilities for contraceptive services (62).

Midwives in Sweden are responsible for the woman’s maternal health care (MHC) during pregnancy, delivery, and the post-partum period. All midwives educated since the late 1960s are registered nurses, with an additional 18 months education in midwifery, obstetrics and gynaecology (63).

In the 1970s, concurrent with the introduction of the Abortion Act, the midwife received a new important task to make contraceptives easily accessible. Throughout the country, midwives were additionally trained to provide contraceptive services as a part of the services in MHC and in the YHC. On completion of training, midwives were authorised to prescribe hormonal contraceptives and to insert intrauterine devices (IUD) (63). This was the beginning of placing the main responsibility for contraceptive services onto midwives within the primary health services, including YHC: midwives now provide 80% of contraceptive services in Sweden (22).

All contraceptive methods are available and some are subsidised, especially for the youngest women. More modern and expensive contraceptives (usually not subsidized) are commonly used by women with higher incomes than by women with lower incomes (64). The individual patient cost for hormonal contraceptives depends on the supplier’s price and subsidisation within the county, which varies throughout the country. County council subsidies for hormonal contraceptives range between 0 and 100%. In most counties, the subsidies cover 50% or more of the total cost. However, a correlation between the degree of subsidisation of oral contraceptives and abortion rates has not been proven (64).

The approach in which contraceptive counselling is provided has an impact on women’s contraceptive decisions (65, 66). Contraceptive failure in teenagers who have had an abortion may in part be due to insufficient contraceptive counselling during abortion visits and insufficient knowledge about what to do if side effects occur (67). The prescriber’s attitudes and counselling skills are important factors for women’s contraceptive choice, use, and adherence (65-67). Consequently, continuous improvement in the quality of contraceptive services is important (62, 65, 67-69).
Emergency contraception

The emergency contraceptive pill (ECP) is a method used after unprotected intercourse and with the intention of preventing a pregnancy. The current ECP method was introduced in Sweden in 2000, and ECP has been available as an over the counter drug since 2001. ECP is well known among women and teenagers in Sweden (70), but has not been demonstrated to reduce the number of abortions or have an impact on contraceptive practice, even when given as advance supply (71). The use of ECP by teenagers is inconsistent (72-74), sometimes because of an unrealistic assessment of the risk of getting pregnant (74). However, since 2006, abortion rates among teenagers have decreased (56), which may partly be due to over-the-counter sales of ECP, and that ECP is free at the YHC.

Young people have some general knowledge on how to protect themselves from STI, but there is limited knowledge on the role or involvement of men in reducing the risk for unplanned pregnancy after unprotected intercourse. In a Swedish study among 18-year old men (43), 18% suggested or had given ECP to their partner, indicating some young men are informed about this second chance and are both willing and able to play an active role in avoiding an unintended pregnancy.

The copper IUD is effective as an emergency contraceptive and has the advantage of offering continued long-lasting contraception. Despite the IUD being more effective than ECP, it is rarely offered by providers as an alternative method, particularly in nulliparous women (75).

Youth and Student Health Services

Youth Health Clinics were introduced in Sweden during the 1970s. At these clinics, young people (up to 20-25 years) receive advice, counselling, information, medical examination, treatment, and therapy within the field of psychosocial development and well-being, relationships, and sexual health (76, 77). The YHC staff includes midwives, social workers, psychologists and physicians (gynaecologists, venereologists). The attitudes and skills of the staff are vital for successful adolescent healthcare (39, 77).

It is reasonable to assume the YHC promote a positive approach towards sexuality and reproductive health, which contributes to the prevention of STI and unintended pregnancies. However, the conditions at the YHC vary between counties and there is no evaluation of the YHC at national level (39). Therefore, there is a need to evaluate the YHC with the aim of monitoring the service and improving the quality of care and accessibility for different groups, such as homosexual, bisexual and trans people, young people with disabilities, socio-economically disadvantaged, young people who have recently arrived in Sweden, and young people who have suffered from abuse.
There is also a need to expand the number of YHC for young adults, especially in university cities (39).

YHC-visits may be one possible reason why women are more knowledgeable about sexual and reproductive health matters than men are, as women visit YHC more frequently and receive individual information (78). Currently, young females predominantly visit YHC, whereas, only about 11.5% are male-visits. Even the staff at the YHC are predominantly women and only around 20% of YHC in Sweden offer counselling to young men whose partner became unintentionally pregnant (79), despite their need of support during the decision-making process for an abortion (14). Male involvement both directly and indirectly influences contraceptive decision-making (80-83), and the presence of male staff in YHC could make it easier for young men to apply for counselling and STI testing (16, 84).

In 2008, YHC on the web, UMO (www.umo.se) (85), was launched and has delivered large amounts of quality assured information on SRHR. Different professionals within the area can use UMO website.

Swedish schools also have a long tradition of providing health care services to children and adolescents (86). A common name for this team is Student Health, and there is access to nurses, physicians, social workers, and psychologists (86). With its base in the school and regular contact with and proximity to students, Student Health services have the opportunity for promoting health and preventing diseases at both the individual and general level. Student Health is a resource for the school’s overall responsibility for each student’s health, development, and learning, which includes perspectives of sexual and reproductive health.

Sexuality and relationship education in School

One important primary prevention strategy for preventing STI and unintended pregnancy is sexuality and relationship education (SRE), which has been a compulsory subject in Swedish schools since 1955 (87). The four main aims of SRE are gender equality (boys’ and girls’ sexuality), promotion of a healthy lifestyle (risks and safe sex), dialogue with students (interactive lessons, pupils influence over content and methods), and factual knowledge and reflection (anatomy, physiology, abortion, STI, norms, attitudes, and values concerning heterosexuality, bisexuality, and homosexuality). In 2000, the Swedish Board of Education evaluated SRE education and exposed large national, regional, and local differences in quality (87). A need for further teacher education was identified. SRE has not been part of the curriculum for teacher training (87), but has been included since 2011 (88).
Monitoring

Public health policy considers the importance of monitoring and addressing efforts for reducing the unfair disparities in environmental conditions for promoting good health on equal terms, regardless of where people live in Sweden (89). However, accessibility to YHC for STI testing, counselling, and care partly depends on where in the country the teenagers live: there are similar concerns regarding SRE in school (39).

The lack of register data and national demographic surveys on abortions that include socioeconomic and cultural aspects makes it impossible to analyse differences between groups. Consequently, abortion care cannot be evaluated at national level, as for example in Finland, where abortion rates are lower than in Sweden. Differences between groups need to be considered for the prevention of unintended pregnancies (39).

Theoretical framework

Gender theories

Sex refers to biological differences, such as chromosomes, hormonal profiles, and internal and external sex organs. Gender describes the characteristics that a society or culture defines as masculine or feminine (social construction). While sex as male or female is a biological fact and is the same in any culture, what sex means in terms of the gender roles as a 'man' or a 'woman' in society can be different cross culturally. In sociological terms, gender role refers to the characteristics and behaviours different cultures and societies attribute to the sexes. Children learn early in life to categorise themselves by gender. A part of this is learning how to display and perform gendered masculine or feminine identities (90).

In gender studies, hegemonic masculinity refers to a culturally normative ideal of male behaviour. The concept of hegemonic masculinity implies a hierarchy of masculine behaviour, and that most societies encourage men to represent a dominant version of masculinity. Consequently, hegemonic masculinity is competitive, and reflects a tendency for males to dominate other males and subordinate females (91).

As gender roles have an impact on the health of the individual (92-94), it is important to consider the surrounding culture and contexts within which events take place when looking at factors of health. In other words, the culture within which people are raised and currently live and the meaning that culture attaches to certain aspects of their lives is essential for understanding what truly affects an individual’s health (93, 95).

Gender equality is the absence of discrimination due to a person’s sex in the opportunities available, allocation of resources and benefits, or access to
services. Gender equity refers to fairness and justice in the distribution of benefits and responsibilities between individuals, but is never separate from race, ethnicity, language, disability, income, or other diversities that define us as human beings. Gender mainstreaming is the process of assessing the implications of a planned action for both women and men, including legislation, policies or programmes, in any area, and at all levels (81).

The commitment to promoting gender equality, equity and mainstreaming in health issues often focuses on women’s empowerment, and is mainly driven by women because women are the more disadvantaged through patterns of gender inequality, for example in health issues related to sexual and reproductive health and rights (SRHR). However, this has led many to assume gender issues are only about women and of no concern to men and boys (81). According to WHO, women and men need to work together for greater gender equality, and not merely blame each other for the inequalities and inequities (81). For the benefit of all, this means men’s awareness concerning the causes and results of their attitudes and actions on the people in their lives needs to be raised (81). Although this focus is now changing in many western European countries and maternal and child health services have made efforts to involve men, many men feel marginalised and excluded in their contact with family planning, and maternal and child health services (96-98).

The Theory of Sexual Script

The theory of sexual script, developed in the 1970s by Simon & Gagnon (99), is based on symbolic interactionism, in which "self" is created through interactions. This means individuals’ sexual practice can be understood as being created through continuous interactions between self and others. Thereby, sexuality is given meaning through the context in which it exists.

The theory implies that for centuries, society has intervened in individuals’ sexual lives through legislation, norms, and rules within churches, schools, and work places. These norms and rules are interwoven with social conditions such as social networks, housing, and family policies (99).

Humans follow a so-called "script" when they have sex. However, this is a learned script, and is still perceived as personal. Simon & Gagnon consider society, religion, culture, position, relationship, and individual aspects influence the content of these scripts. These influences constantly change, which implies sexuality is constantly changing. Thus, how, when, where, and with whom people have sex is not a simple coincidence (99).

To be able to understand the effects of these scripts, Simon & Gagnon created a model to cover some analytical levels. This model consists of social, interpersonal, and individual scripts. The social scripts include social edicts, such as cultural, religious, and social positions. The interpersonal script is more specific and varies between groups, according to sub-culture,
social network, and interaction between people. The individual scripts are created in relation to both social and interpersonal scripts (99).

Gisela Helmius (100) considers that even though sexuality and reproductive ability appears “given by nature”, it is formed by social determinants: whenever two people are together sexually, society is present as the third party. Sexuality is not static, unequivocal, or pre-determined, which should be a fundamental basis for public health work. Otherwise, it is not worthwhile devoting effort and resources to try and influence sexual behaviour, if it is determined by nature (100).

Social Model of Health

Sexual behaviour is one of many aspects of a person’s lifestyle, and lifestyle determines attitudes towards sexuality. Group-specific sexual normality is a result of people generally having common features and sharing the same interests and lifestyle (99, 100). However, national public health work must be relevant for all type of groups. Consequently, knowledge about different groups is important for understanding different behaviours and addressing preventive efforts. Through health and medical policy, society is expected to contribute resources for treatment, care, and preventive measures corresponding to the needs of individuals (47).

The Social Model of Health (Figure 4) by Dahlgren & Whitehead (1991) highlights the changes in a social environment that produce changes in individuals, and that support for individuals is essential for implementing environmental and social changes (101).

![Figure 4. Social Model of Health by Dahlgren & Whitehead (101). Adapted by the Swedish National Institute of Public Health.](image-url)
According to the Social Model of Health, (sexual) behaviour, life style and living conditions influence health and wellbeing. The structure and resources within both society and social and cultural networks can be supportive, or not, of certain behaviours, for example, legalisation and health care services are important for easy access to abortion care, and accessibility of contraceptives and counselling are important for supporting safe sex practices. Furthermore, the model indicates socioeconomic factors affect health-related choices and outcomes, which might be sexual behaviour and decisions on abortion (101).

Therefore, the planning and design of a health promotion programme within the sphere of sexuality needs to be based on knowledge of current sexual patterns within the population and norms within society in order for it to be adapted to the intended target groups, as suggested in Figure 4 (101).

Self-Care Deficit theory

The Self-Care Deficit Theory developed by Dorothea Orem (1914-2007) is a combination of three theories, i.e. theory of self-care, theory of self-care deficit, and the theory of nursing systems. The main objectives of the theory are to identify the needs of the patient, demonstrate an effective communication and interaction with the patient, select and apply a proper strategy according to the needs and deficits of the patient, and to evaluate the extent to which the process is fruitful.

The major assumptions in Orem’s theory are:

- The self-care agency is the acquired ability to perform self-care, which will be affected by elementary factors such as age, gender, health care system, family system etc.
- Self-care is carried out to fulfil the self-care requisites; however, there are three types of self-care requisites, such as universal, developmental, and health deviation self-care requisites.
- Whenever there is an inadequacy in any of these self-care requisite, the person will be in need of self-care or will have a deficit in self-care.
- The role of the nurse is to identify the deficit through thorough assessment of the patient.
- Once needs are identified, the nurse has to select required nursing systems to provide care, which could be an entirely compensatory, a partly compensatory, or a supportive and educative system.
- The care will be provided according to the degree of deficit the patient presents.
- When care is provided, the nursing activities and the use of the nursing systems are to be evaluated to determine whether the mutually planned objectives are met or not.
Scientific justification for this thesis

Since the law on abortion was introduced in 1975, one million safe abortions have been performed in Sweden, and in 2011, almost 40,000 safe abortions were performed (56). However, abortion patterns are relatively unexplored in Sweden, especially with regard to the male partners involved. In the context of preventing unintended pregnancies, it is important to increase men’s awareness and responsibility in family planning and reproductive health (39, 79, 80, 102, 103). Men are often neglected in these matters (81, 102-104), and few studies have explored the characteristics of men involved in an abortion.

With the sparse information in NBHW statistics concerning abortions, any patterns in the differences between groups in terms of socio-economics, life style behaviour, and living conditions, as suggested in the Social Model of Health (Figure 4), are impossible to analyse. Such knowledge may be important when adapting preventive efforts to addressing certain groups at risk for unintended pregnancies (39).

Abortion seeking women and their partners expect to be met with sensitivity adapted to their unique situation, including existential aspects, by health care providers (13). However, the sparse information available at NBHW means the quality of care at national level, and based on experiences and needs from the patient’s perspectives is difficult to investigate (39).

This thesis may add new important knowledge to this field.
Aim

The overall aim of the thesis was to investigate women’s and men’s experiences and needs in relation to induced abortion, and elicit their views on the prevention of unintended pregnancies. The specific aims were:

- To investigate risk factors among women and men with repeated experience of abortion
- To investigate satisfaction with abortion care among women and their male partners and to identify factors associated with high overall care satisfaction
- To investigate the prevalence of existential experiences and needs among women who have requested an induced abortion
- To explore women’s and men’s experiences and needs related to care in the context of a home abortion, and elicit their views on contraception and prevention of unwanted pregnancies.
Materials and Methods

Materials and methods will be described in this section, and a summary of the papers are presented in Table 1.

Table 1. Design, methods, and participants in the studies for Papers I-V.

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Papers I and II

A cross-sectional survey among Swedish women seeking induced abortion, and their male partners, in 13 clinics in both rural and urban areas in Sweden during 2009. The descriptive design aimed to describe characteristics of women and their male partners seeking an abortion, and to identify differences between those with first time experience and those with previous experience of an induced abortion. The exclusion criterion was if the woman was unable to understand Swedish. Questionnaire packages (n=1580) were consecutively distributed to abortion-seeking women: the male partner was invited by the woman. The majority of questions were study-specific and constructed in collaboration with both experts and abortion-seeking women: the questionnaire was pre-tested. When the women came to the clinic for their first medical appointment, oral and written information about the study was provided, including the voluntary nature and anonymity of participation. Two pre-stamped envelopes were provided to enable both the men and women to return their questionnaires separately within four weeks after the abortion.

Half of the women (n=798; 51%) and 590 men returned the questionnaire. The internal non-response rate varied between zero and four percent.

Questionnaire and measures

The female questionnaire contained 46 multiple-choice and three open-ended questions: the male questionnaire contained 37 multiple-choice and two open-ended questions. The questionnaires also contained questions regarding experience of care and counselling; these results are presented in Paper III. The questions used for Papers I and II were:

1. Age, residence, country of birth, parents’ country of birth, education level, occupation, relationship with the men/women involved in the pregnancy, children, and experience of previous induced abortions and abortion method.

2. Lifestyle, such as daily smoking or/and use of oral tobacco (snuff), physical, psychological or sexual violence or abuse over the past 12 months, mental well-being before pregnancy and after the abortion (5-point Likert scale: ‘fully disagree’ to ‘fully agree’), and emotional support.

3. Two questions about contraception (only for women).

4. One open-ended question about the reason for the termination (only women), one open-ended question concerning whether any societal action or support could have prevented the current abortion, and one option for the respondents to provide free comments.
Statistics
To determine differences between women and men with experience of repeat abortion and those involved in their first abortion, Pearson’s Chi-square test was used: the significance level was set at 0.05. A binary logistic regression model was used to assess risk factors associated with the dependant variable repeat abortion. The associations are presented as OR with 95% confidence intervals (CI). For all analyses, PASW (Predictive Analytics Software) statistics version 18.0 was used (105). The open-ended questions were analysed by content analysis, as described by Graneheim and Lundman (106).

Ethical considerations
Women applying for induced abortion are in an extremely vulnerable situation, and there is a risk they can feel pressure to participate and have concerns about confidentiality related to their personal data. Careful consideration was paid to the formulation of the questions in order to not evoke or strengthen feelings of shame or guilt. All informants received both oral and written information about the studies, and that participation was voluntary and confidential and they could withdraw at any time, and they could decline participation without affecting the treatment and care they were given. However, it was assumed many women and men would appreciate their opinion being regarded as important. According to the Helsinki Declaration, it was considered the benefits would outweigh the risks. The heads of the clinics and the Regional Ethical Committee in Uppsala, Sweden, approved the project.

Paper III
This study used data from the same questionnaire used in Papers I and II. The questionnaires (for both women and men) contained questions regarding satisfaction about care and counselling in the context of an induced abortion. The perception of overall satisfaction with care was graded on a 7-grade Likert scale (1= very dissatisfied, 7= very satisfied): for all other questions, a 5-grade Likert scale was used (1= fully disagree, 5= fully agree). The perception of satisfaction was measured through the ease of reaching the clinic by phone, contraceptive counselling, counselling with a psychosocial professional, participation in the decision regarding abortion method, information about the vaginal examination, the possibility of having someone close during the abortion, and attention from the abortion personnel in the context of the abortion process.

As the data was skewed, it required dichotomisation. The 7-grade scale measured overall care-satisfaction and was transformed as 1-5 = dissatisfied and 6-7 = satisfied. Ratings on the 5-point scale for agreement on the care they had received were transformed as disagree =1-3 and agree = 4-5. To
determine factors associated with high overall care, binary logistic regression models were used
For ethical consideration, see Papers I and II.

Paper IV
This study was a cross-sectional survey among Swedish women requesting an induced abortion. The questions covered existential experiences and needs in relation to an induced abortion. Data was collected during January to August 2009 from 10 clinics in Sweden, representing both rural and urban areas. Further procedure and ethics are described under Papers I and II.

Questionnaire packages (n=1041) were consecutively distributed to the women seeking an abortion: the response rate was 48% (n=499). The internal non-response rate for the multiple-choice questions generally varied between zero and four percent, with two exceptions: questions two and three in the section about thoughts, practices and needs related to an induced abortion had a non-response rate of seven percent.

Questionnaire and measures
A questionnaire with 51 multiple-choice questions and five open-ended questions was used. The questions were study-specific and constructed in collaboration with experts and abortion-seeking women: a pilot test was conducted (see Papers I and II). The questions included in this study were divided into three domains:

1. Eleven background questions: age, residence, country of birth, parents’ country of birth, education level, occupation, relationship with the man/woman involved in the pregnancy, children, involvement in previous induced abortions, and religious or spiritual beliefs.
2. Two questions (7-point Likert scale) for women about the difficulty of making the decision to abort and physical/psychological problems after the abortion. One question (5-point Likert scale), for both men and women, was about mental well-being before the pregnancy and after the abortion.
3. Four questions about thoughts, practices and needs related to the abortion, and ways of talking about the pregnancy (these contained items of existential character), and two open-ended questions about thoughts, practices and needs related to the abortion.

The ordinal data were dichotomised by transforming the scales into yes/no, high/low, prevalence/no prevalence, and computing nominal data (i.e. spiritual = belief in god/spirit/force of life, non-spiritual = no belief/do not know).
Statistics
To identify components of existential experiences and needs, a Principal Component Analysis (PCA, or factor analysis) was conducted on the 25 items from the third domain (items concerning thoughts, practices, and needs related to the pregnancy and abortion). This analysis resulted in a 10-item scale with the items distributed over three components, which were labelled humanisation of foetus, existential thoughts, and existential practices (i.e. existential components). Spearman’s test was used to determine correlations between the three components and psychological wellbeing pre- and post-abortion, and between humanisation of foetus and the two other components. The significance level was set at p<0.05. The open-ended questions were analysed by content analysis, as described by Graneheim and Lundman (106). For all analyses, PASW (Predictive Analytics Soft Ware) statistics version 18.0 was used (105). For ethical consideration, see Papers I and II.

Paper V
A qualitative interview study with 24 women and 13 men who had experienced home abortion, recruited from five abortion clinics in Sweden during 2009/10. The inclusion criteria were the woman and her partner should be Swedish-speaking and at least 18 years of age, and they should have decided to perform an induced medical abortion at home. All interviews (by telephone) were performed within six weeks after the abortion.

Data collection
The interviews were guided by a semi-structured interview guide with study-specific questions developed in collaboration with researchers, gynaecologists, midwives, nurses and social workers within the field. The guide was first tested on one midwife, one man and two women, and adjustments were then made. Finally, minor adjustments were made after the first three interviews.

The telephone interviews lasted between 20 - 60 minutes, the average time was 40 minutes for the women, and 30 minutes for the men. Each interview started with information about the aim of the study; respondents were assured participation was voluntary, that they had the right to discontinue at any time, and that the data would be treated confidentially and only used for research purposes. The interviews were recorded and transcribed verbatim.

The interview guide focused on reasons for choosing abortion and for completing the abortion at home. Additional topics were experiences of the abortion procedure and views on contraceptive use and prevention of unintended pregnancies.

For ethical consideration, see Papers I and II. In human research, the risk of harm must always be considered against the potential for benefit to individuals and society. The main ethical principles of research involving hu-
mans (107) were considered throughout the construction of the interview guide, the data collection, the analysis and the writing process.

Analysis
Content analysis was performed according to Graneheim and Lundman (106). The interviews were read several times to obtain a sense of the whole and to extract meaning-bearing units related to the objective, which constituted the units of analysis. The meaning units were condensed and each was labelled with a code, and compared for differences and similarities, then grouped into subcategories. Finally, themes that unified the content in the categories were formulated.
Results

Papers I and II

Women
Among the 798 women (51%) responding to the questionnaire, the median age was 25 years (range 14-49 years) and the mean age was 26 years. The induced abortion methods were:
- Medical (hospital) (37%; n = 295)
- Medical (completed) at home (31%; n = 245)
- Surgical (29%; n = 230)
- Late medical abortion (2.5%; n = 20).
- Eight women did not state which abortion method had been used.

The women’s reasons for having the abortion (open-ended question: response rate= 98%; n= 773) were divided into several categories, however, some reported multiple reasons
- The pregnancy was unplanned, untimely in their lives (60%).
- Unstable relationship or problems in their relationship (32%).
- Socioeconomic factors: unemployment among themselves or partner, poor economy, and uncertain housing (30%).
- Already had the number of children they wished (21%).
- Health problems affecting the woman, her partner or previous children (8%).

Thirty-five percent of women (n=282) had experience of at least one previous abortion, but in the age range 20-49, this proportion was higher (41%, n=251). The majority of women (88%, n=702) were Scandinavian in origin, of which 640 women were of Swedish origin: with respect to first abortion and repeat abortion, no differences were identified between women originating within or outside Scandinavia. The majority lived in a stable relationship and had not used contraceptives at the time of conception.

In the age group 20-49 years, several differences were found between women with repeat abortion and women without a history of previous abortion. The proportion of women with children was higher among women with a history of previous abortion (66%) than among women without experience of previous abortion (46%). Daily tobacco use was more common among
women with repeat abortion (41%) than among women seeking a first abortion (28%). Furthermore, more women with experience of repeat abortions did not have a university education, and were more frequently unemployed or on sick leave than women without experience of previous abortions were.

A higher proportion of women with repeat abortion (11%) lacked emotional support, i.e. someone close with whom they could share their innermost thoughts and feelings than among women seeking their first abortion (5%). Nine percent had been victims of physical, psychological, or sexual violence or abuse over the past 12 months, but no difference was found in relation to previous abortion experience. Psychological violence dominated over physical or sexual violence and abuse. Seventy-four percent of the women estimated their mental wellbeing, on a five-point scale, before the pregnancy as "good" or "very good". Regardless of the estimated value before the pregnancy, 34% of the women scored lower mental wellbeing after the abortion. A higher proportion of women who were either unemployed or on sick leave (22%: n=128) reported “bad” or “very bad” mental wellbeing before the pregnancy than those who were employed or students (13%: n=670) (p = 0.006).

Although no difference in contraceptive use at the time of conception was found between women seeking their first or repeat abortion, sub-analyses indicated a higher proportion of contraceptive users (p=0.041) among women (20-49 years) with university education (12%) than among women with elementary or college education (7%). Almost 98% (n=773) responded to the question concerning the women’s reason for requesting an abortion, and some women reported multiple reasons.

Risk factors identified for repeat abortion were already having children, lack of emotional support, being unemployed or on sick leave, daily tobacco use, and low educational level.

**Men**

Among the men, 32% had experience of causing at least one previous pregnancy that ended in an induced abortion. The male partners of women who requested an induced abortion had a median age of 28 years (range 16-63 years) and the majority were born in Scandinavia, representing 88% of all responders.

No differences were identified between men originating from in or outside of Scandinavia. About 90% lived in a stable relationship, and the proportion of men with children was higher (56%) among those who had previously experienced their female partner choosing to abort than among men without this experience (38%).

Men with repeated experience of abortion had a lower educational level and were more frequently unemployed or on sick leave than those without experience of previous abortion. Furthermore, more men with previous abortion experience were tobacco users (57%) than men who had no previous
experience of being the partner of a woman who chose an induced abortion (47%).

Having someone close with whom they could share their innermost thoughts and feelings was reported by 12% of men with previous experience of being the male partner of a woman who elected to abort and 22% men without such experience. Over the previous 12 months, 12% of men with previous experience of being the male partner of a woman who elected to abort had been a victim of physical, psychological or sexual violence, or abuse, compared to 6% of men without previous abortion experience. Physical violence dominated over psychological or sexual violence or abuse. Mental wellbeing, on a five-point scale, before the woman became pregnant was estimated as "good" or "very good" by 78% of the respondents: regardless of the estimated value before the pregnancy, 27% of the respondents scored a lower mental wellbeing after the abortion. Five percent of students or employed and 15% of those on sick leave or unemployed estimated their mental wellbeing before the pregnancy as “bad” or “very bad”: the corresponding figures for mental wellbeing after the abortion were 11% (students/employed) and 21% (unemployed/sick leave).

Risk factors associated with repeated experience of being the male partner of a woman who elected to abort were being a victim of physical, psychological and/or sexual violence or abuse, being unemployed or on sick-leave, already having children, and being older than 19 years.

Preventive efforts
A majority of respondents (two-thirds) did not believe or were unsure if any efforts within society could have changed the abortion decision. However, some women and men made suggestions about preventive efforts and the following categories were identified:

- Socio-economic support and work opportunity would have enabled the women to carry the pregnancy to full-term
- Availability of education, healthcare services, and contraceptives
- Changing norms and attitudes within society.

Paper III
Most women (74%) and half of the men (52%) were highly satisfied with the care in relation to the induced abortion. For women, independent factors associated with high overall satisfaction with care were to receive empathic attention from the health care staff, sufficient pain relief, satisfactory information about the gynaecological examination, and contraceptive counselling. Furthermore, ease of access to the clinic by phone was considered an important factor associated with high overall care satisfaction among women.
For men, the independent factors were empathic attention from the health care staff and receiving adequate information about the abortion procedure.

Sub-analyses indicated differences in sub-groups with regard to single aspects of care and overall care satisfaction, for example:

- Teenage girls (14-19 years) were more satisfied with the help and support given by healthcare staff than women aged 20-48 years were (p= 0.002).
- A greater proportion among teenage girls considered it difficult to reach the clinic by phone than women aged 20-48 years did (p< 0.001).
- Fewer teenage girls than women aged 20 or more felt they were involved in the discussion with the physician on the choice of the abortion method (p= 0.017).

Half of the respondents (women 52%, men 51%) estimated the decision on abortion was easy (1-3 on a 7-point scale), whereas, 39% of the women and 36% of the men felt it had been difficult to reach a decision (5-7 on a 7-point scale).

The main findings in this paper were one in four women and half the men were not satisfied or completely satisfied with care related to an induced abortion, which implied there is scope for improvement in the quality of care from a patient perspective, especially with regards to men. The human aspect of the care appeared the most important factor associated with high overall care satisfaction.

Paper IV

Three aspects of existential experiences and needs (existential components) related to abortion were identified:

- humanisation of foetus
- existential thoughts
- existential practices

Humanisation of foetus and existential thoughts and practices were common among women. Women did not necessarily think about the pregnancy in an impersonal or objectifying manner: 67% of the women thought about the pregnancy in terms of a child. For 61% of women, existential thoughts about life and death, meaning and morality were related to the abortion experience. Almost every second women (48%) had done, or had wanted to do, a special act to end or mark the process.

There were no differences among the three components regarding age, educational level, number of children or abortions, abortion method, or relationship with partner. Women, who reported physical or psychological problems post abortion, or who thought making the decision to abort was difficult, reported a higher level of humanisation of foetus and a higher degree of
existential thoughts and practices. Women who described themselves as spiritual reported a higher degree of existential practices and humanisation of foetus.

Women who reported a lower degree of psychological wellbeing after the abortion were also more likely to report a higher degree of humanisation of foetus and existential thoughts/practices. Those who had a high degree of humanisation of foetus were also more likely to have a high degree of existential thoughts and practices.

Paper V
Two overarching themes were identified in the analysis of women’s and their partner’s experiences of having the final treatment of an induced abortion at home: Autonomy – the decision to undergo an abortion and the choice of method were mostly considered choices by the woman and supported by the partner. The home environment increased their privacy, which helped them to freely express and share emotions. The couples felt they could control the situation and trusted the signals of the body, and did not hesitate to contact the health care provider if needed. Both women and men were motivated to avoid a subsequent abortion and considered it an individual responsibility; however, contraceptive follow-up visits were rare.

Dependence – an explicit desire to be treated with empathy and respect by care providers and to receive credible information, adapted to their individual needs. Societal support was considered important for preventing unwanted pregnancies, such as, employment, improved communication/education, and subsidised contraceptives with high quality counselling.

The interpretation of these themes was women’s free choice might be indirectly influenced by life circumstances that to varying degrees force women (and their partners) to decide to have an abortion.

Health care staff have great authority and their views might impact a woman’s free choice. Moreover, women have the choice to use different kinds of contraceptives, but this free choice could be hampered if contraceptive counselling is unsatisfying or limited, if the chosen method is not affordable, or causes undesired side effects. Thereby, dependence does occur in different aspects, which is a critical element in understanding a woman’s free choice (autonomy), in relation to a home abortion.

Women and men perceived the abortion as a private occurrence, which they usually did not openly talk about with friends and relatives. For some respondents, the interview was perceived as a relief, a kind of processing of the experience, and a chance to reflect openly on the decision, procedure, and the future.

In the light of the Theory of Self-Care Deficits, the women and their partners demonstrated self-care ability when they were treated with empathy and
The findings of *autonomy* and *dependence* could be described through the citation

“It’s an important issue, it’s not only a question of the care, it’s bigger than that, an issue for the entire society” (W 37 years)

The findings are also summarised in a model (Figure 5), which aims to reflect experiences and needs in relation to an abortion in both an individual and a public health perspective.

*Figure 5. A model of experiences and needs related to a home abortion and the prevention of unwanted pregnancies in an individual and a public health perspective.*

- **Prevention of unwanted pregnancies**
  - **Individual level**
  - Individuals have responsibility for preventing a subsequent abortion
  - **Societal level**
  - Liberal Abortion Act, increased work opportunities, improved communication and education, subsidised contraceptives
Discussion

The main finding in this thesis was 35% of abortion seeking women and 32% of their male partners had experience of at least one previous abortion. Those with experience of repeat abortions appeared more vulnerable than those without previous experience did. Both women and men suggested structural efforts within society for preventing unintended pregnancies and enabling childbearing. Satisfactory contraceptive counselling in connection with abortion was considered important, but a planned follow-up was rare.

Among both women and their partners, to be well treated by the health care staff was the most important factor associated with high overall care satisfaction related to an induced abortion. Even in cases when the abortion procedure was completed at home, the human side of care, i.e. empathy, respect and sensitivity from health care staff prior to the abortion, was considered important.

Another notable finding in this thesis was that six out of ten women had existential thoughts about life and death, and meaning and morality in connection to the abortion process. Existential views correlated with the difficulty in making the decision on abortion and poor psychological wellbeing after the abortion. As this has previously received little attention, it requires serious consideration, as it is in coherence with the explicit need in women and men to be treated with empathy and sensitivity by health care staff.

These findings are challenging for the gynaecologists, midwives and social health workers who care for these women and their partners, as the situation involves complex aspects over and above medical procedures and routines.

Socioeconomics and repeat abortion

Risk factors for repeat abortion among women were already having children, lack of emotional support, unemployment or sick leave, tobacco use, and low educational level. Risk factors among men were to having been a victim of violence or abuse over the past year, unemployment or sick leave, and having previous children. Scandinavian studies have previously demonstrated associations between repeat abortion and low socioeconomic status (51, 54, 108, 109), and this has also been highlighted in an American investigation (55). These studies in combination with other studies (110, 111), sug-
gest socioeconomic characteristics may influence risk assessments with regard to the prevention of unwanted pregnancies. Thus, safe sex might be considered a lesser priority in relation to other problems surrounding the individual.

However, associations between (repeat) abortion and socioeconomics are rarely investigated in Sweden. According to a Swedish study by Kero et al. (12) including 211 women, legal abortion is requested by women in many circumstances and is not confined to those in special risk groups. Although, it was twice as common among women with repeated abortion to report aspects of poor income, this was not significant, probably due to the relatively small sample (n=211 women) (12). This suggests, in accordance to other Scandinavian studies (51, 54, 108, 109), including this thesis, there are differences between women having a repeat abortion and women with a first time experience of abortion.

These risk factors for repeat abortion were partly in line with the qualitative analyses of reasons women reported for having the abortion (Papers I and V), such as problems in their relationship, being too young or too old, already having the number of children they wished, unemployment among themselves or partner, poor economy and uncertain housing. This could be compared to statistics from Finland (112) where social grounds account for about 92% of induced abortions and are the most commonly used indication for abortion, other common reasons for abortion are the patient being over 40 (3%), under 17 (3%), or having given birth to four children (2%): these reasons are in accordance with other international studies (4, 15, 52, 113).

There were no differences between participants originating from within Scandinavia or from outside Scandinavia with regard to repeat abortion (Papers I and II). However, other Scandinavian studies indicate abortion rates are higher among foreign-born women (51, 108), and that foreign-born women are more often unemployed, have a low income and have two or more children (51, 108). From a Scandinavian perspective, these aspects are probably more relevant for the risk of repeat abortion than being foreign-born is.

Although Finland has a low proportion of immigrants, repeat abortion is associated with low socioeconomic status among Finnish women (52). Finland has a well-developed abortion register providing data on abortion care, which enables investigation of associations with socioeconomics and the reasons for abortion, lifestyle behaviour, contraceptive use, and follow-ups (52). Sweden has the highest abortion rate in the Nordic countries, but lacks register data regarding socioeconomics, lifestyle (for example contraceptive use), or health outcome for women having an induced abortion. The lack of such data makes it complicated to investigate the associations between repeat abortions and socioeconomics.
Contraceptives and counselling in abortion care

This thesis adds evidence that some socioeconomic factors may increase the risk of repeat abortion. However, is this relevant for abortion care and counselling? The answer to this is yes, as providers should consider this as a risk for subsequent abortion, and therefore, a priority during abortion care. These findings indicated routines for contraceptive follow-ups after an abortion varied and a pre-booked appointment for follow-up of contraceptive choice and adherence was rare. This is in line with an investigation indicating praxis in contraceptive counselling, prescription patterns and follow-up visits varied between prescribers in Sweden, and counties across Sweden had different subsidies for contraceptives (33). Structured counselling is important as it facilitates a tailored choice of contraceptive methods for most women (65).

A greater proportion of teenage girls considered it more difficult to contact the clinic by telephone than older women did (Paper III). National statistics show the proportion of repeat abortions tends to increase (Figure 3), especially among teenagers, whereas, the total number of abortions has decreased for several years (56). This indicated the difference between groups among teenagers is increasing. In general, teenage girls are considered a vulnerable group that should be prioritised in reproductive health issues, such as unintended pregnancy and abortion (52, 67, 74, 114), and is an important aspect of abortion care and the prevention of a subsequent abortion among teenagers.

Exactly which way socioeconomics should be considered within contraceptive counselling needs further investigation. A Finnish study suggests initiation of any contraceptive method reduces the risk of repeat abortion (52). Therefore, guidelines and routines in contraceptive counselling could be improved by addressing the risk of repeat abortion, for example, the offer of follow-up visits after an abortion may be more important than previously considered. Although the IUD is most efficacious in comparison with combined oral contraceptive use in reducing the risk of repeat abortion (52), it could be an obstacle for women, as the cost for hormonal IUD varies between different counties in Sweden (12 -150 dollar), and this cost could affect women’s contraceptive choices (Paper V). This is discussed in relation to the results in Paper I, which indicated women with higher education were more likely to use contraceptives than those with lower educational level. Likewise, an American study (110) revealed contraceptive failures, including pills, condom, withdrawal and fertility-awareness methods, are greatly affected by socioeconomic characteristics of the users involved. These findings are similar to a Swedish investigation (64), in which modern and expensive contraceptives are more used by women with higher income than those with lower income, suggesting national guidelines for subsidisation of contraceptives and adapted contraceptive counselling are important structural efforts that improve contraceptive usage and adherence.
Satisfaction with abortion care

Most women (74%), but only half of men (52%) were fully satisfied with care in relation to an induced abortion (Paper III). The human aspect of care appeared the most important factor associated with high overall care satisfaction among both women and men. For women, independent factors associated with high overall satisfaction with care were receiving empathic attention from the health care staff, sufficient pain relief, satisfactory information about the gynaecological examination and contraceptive counselling, and easy access to the clinic. These factors were consistent with international studies among women (115-118) where the overall quality of abortion care was considered good (116, 118). Other studies have also confirmed dissatisfaction with the guidance and assistance received when having an induced termination of pregnancy is correlated with long waiting time between the first visit and the actual abortion procedure (117, 118), and with insufficient pain relief (115).

Pre-counselling is crucial (Paper III), as it was associated with the overall care satisfaction. Low satisfaction with information about the abortion procedure correlated with increased pain, as was found by Abdel-Aziz et al. (115). Therefore, it is essential that factors other than physical factors, such as gestational length, influence the experience of pain; for example, more educated women appear to recognise less pain, whereas, a woman’s fear of pelvic examinations and longer abortion procedures tend to increase a woman’s perception of pain during the abortion (119). Such circumstances need to be understood, as it helps to inform counselling strategies aimed at reducing the experience of pain in relation to an induced abortion.

Male partner’s experiences and needs

For both men and women, empathic attention from the health care staff, was strongly associated with high overall care satisfaction (Paper III). In addition, adequate information about the abortion procedure was associated with high care satisfaction among the men. This meant men reflected upon the staff’s personal attention and their communication skills. However, nearly half of the male partners involved in an induced abortion were not fully satisfied with the overall care. Addressing male partners empathically and providing information adapted to their needs might increase men’s satisfaction with abortion care. Although this is seldom considered, a previous Swedish study also found male partners sometimes feel neglected within abortion care (120) and this is recognised by YHC staff (79).

The men were emotionally involved during the abortion process, and their living conditions and experiences appeared to influence the women’s choices and experiences related to the abortion process (Paper V). For example, a woman’s socioeconomic situation is affected by a partner’s unemployment
as life circumstances are shared within a relationship. This may interfere with both women’s and men’s intentions and desires to carry a pregnancy to full term; although this appears obvious, it emphasises the need for addressing men in abortion care and the prevention of unintended pregnancies.

The clinical relevance of addressing men in woman-centred care could be questioned. However, a higher proportion of women in a stable relationship were less satisfied with the overall abortion care than single women were (Paper III). This indicated men’s experience of the care influenced women’s care satisfaction. Men have the right to be recognised in abortion care (21); but there is a need for increased commitment from healthcare professionals in supporting male partners, and with regard to future family planning. Abortion procedures are well regulated (21), but the additional care related to the human side is not specifically regulated in guidelines. In particular, there is limited knowledge and lack of guidelines or consensus on the role of the man in abortion care.

Neglecting the men involved in an abortion may reinforce and maintain attitudes an unintended pregnancy is a woman’s issue and responsibility, (16, 43). Even in 2012, there is still no proper terminology for describing the male partner causing an unintended pregnancy. In intended pregnancies, it is common to use “father”-to-be, but this is not suitable in the context of an unwanted pregnancy.

Therefore, preventive efforts and attention targeting men may affect both men and women, as they both have the potential and responsibility for preventing future unintended pregnancies.

The abortion process evokes existential feelings

The abortion process evoked existential thoughts and feelings in many women (Paper IV). These aspects could be considered universal, as there were no differences regarding age, educational level, parity, or relationship with partner. Sixty-one percent of the women had existential thoughts in connection with the abortion process, and almost half of women expressed a need or a wish for symbolic expressions related to the abortion. This result was in line with a previous qualitative study of Swedish women where there was a wide variety in maternal-foetal attachment in women choosing to abort (13), with some women describing the foetus as a human being and having inner pictures of the foetus as a child. Women are more likely to justify the decision to abort in a social context, whereas, they find it more complicated in an ethical context (6).

Induced abortion is a voluntary termination of a pregnancy, but considerable ambiguity surrounds the interpretations of the meaning of this reproductive outcome (Paper IV). Some women viewed abortion as the termination of an immature human life and more than just the removal or destruction of a
cluster of cells, which carry the potential to develop into a human being, whereas, others considered abortion in strictly medical terms, such as the process of a late menstruation (Paper IV). Each conceptualisation embraces individual attitudes regarding an abortion. For example, if abortion is viewed primarily as a simple medical procedure, the choice to abort would be accompanied with mostly positive feelings, such as relief and satisfaction. However, if abortion is viewed as ending a human life, one would probably anticipate more negative feelings of guilt, remorse, and grief.

From this perspective, the existential needs of each patient are important to address (13), if not, women can be disappointed with the personnel’s ability to respond to their thoughts and feelings (13). Although healthcare staff are generally positive towards providing abortion assistance (121), some gynaecologists have doubts about performing an induced abortion (122). As existential needs in relation to an abortion often remain invisible and unspoken (13), this may be further complicated as abortion is often considered a private issue surrounded by social taboo and not included in the social and ritual contexts where life-events are normally shared and manifested (13). As a result, existential thoughts and needs in context of an abortion are often neglected in research and in public health policies. Most likely, this neglect does not contribute to increase the awareness and skills among health care providers to handle existential aspects of care (13).

As a high degree of existential components correlated to the difficulty in making the decision on abortion and to psychological wellbeing (Paper IV), this suggests it is possible to identify those women with certain needs related to existential dimensions. An existentially supporting environment may help women and men to interpret the abortion experience in a meaningful way: such support might also enable them to be better prepared for making preventive and reproductive choices in the future (13).

Routines in abortion care should be continuously evaluated to ensure both safety and security and that care satisfaction includes the human and existential parts of care. This might be a challenge for abortion personnel, as the situation involves complex aspects over and above medical procedures and routines. According to the VIPS model, commonly used in Swedish health care, existential dimensions should be considered in the nursing process (32).
Home abortion

Home abortion increased the individual’s autonomy (Paper V). Women are able to administer the final medical procedure at home and the procedure is appreciated among both women and their male partners (25, 124, 125). The home environment encouraged privacy and control during the abortion procedure, and self-care ability was demonstrated. However, this autonomy was partly related to dependence. In particular, dependence related to the human side of the care provided prior to the abortion.

Nevertheless, care provided prior to a home abortion may be challenging for health care providers. Women and their partners conveyed a need to be treated with empathy and respect on equal terms, to have choices on alternative procedures/methods, and to receive adequate information tailored to individual self-care needs (Paper V). This was in accordance with another Swedish study emphasising home abortion implies a radical change in empowerment for women, if they choose this method themselves and are well informed (24). This may challenge the staff’s counselling and communication skills more than when the abortion is provided in hospital: staff must anticipate different scenarios to cover all possible upcoming needs. When an abortion is carried out in hospital, the staff may continuously adapt the care to individual needs as they arise.

There is always a risk that sensitivity and empathy by staff may be marginalised in favour of technical aspects. Although home abortion increases autonomy, the woman and her partner may need to discuss thoughts and feelings before the abortion, and to have these thoughts and feelings confirmed by a trained professional. For example, one woman explained she did not expect the staff to make the decision for them, but she (staff) could have contributed with some perspective to the conversation. It was unusual for women and men to have shared their experiences of the abortion with someone else before the interview. Even though women and men felt the decision on abortion evoked resilient existential thoughts, they did not talk about it with anyone. At the end of the interview, they described their participation in the study in positive terms, as a relief to share their story about the decision to abort, the home-procedure, and the future.

In a Swedish one-year follow-up study (126), a majority of the women (n=58) did not experience any emotional distress post-abortion and almost all the women reported they had coped well; however, 12 women had had severe emotional distress directly post-abortion. At follow-up, more than half of these 58 women reported only positive experiences, such as mental growth and maturity over the abortion process (126). If an abortion experience contributes to deeper maturity and growth, this could be reflected in relation to relevant outcomes, for example contraceptive use.

For those who experience emotional distress related to an abortion, Cullberg’s crisis theory (106) could be applicable. This theory provides a model...
for adaptation to crisis after four phases: shock, phase of reaction, phase of processing the experience, and a phase of re-orientation. To attain recovery and future well-being, each phase has to be accurately dissolved, if not, problems may appear later in life, if one or more phases have not been sufficient dissolved (106). It could be speculated whether stigma and taboos surrounding abortion hampers proper dissolution, as thoughts and feelings are suppressed instead of being processed.

Orem’s Theory of Self-Care Deficit may be relevant in relation to the findings in Paper V. This model appears well structured and useful in relation to home abortion, as the model focuses on identifying needs and deficits in individuals. This is applicable in relation to home abortion, as health care staff have to anticipate different scenarios and needs that may occur outside the hospital environment and the actions required by the individual. Such “caring in advance” provided in relation to a home abortion might place higher demands on health care staff, as it differs from having the abortion in a hospital, where care can be adapted in accordance to the progress of the abortion procedure. Caring aspects such as empathic and sensitive attention from health care staff was highly valued among both women and men in relation to an abortion (Papers III and V). However, Orem’s theory of Self-Care Deficits focuses on physical care with less emphasis on psychological care, which is more addressed in Jean Watson’s Theory of Caring (107).

Developing the human side of care related to an induced abortion could be considered a low priority in comparison to other health care issues and rising healthcare costs, which have become a problem both nationally and globally. However, this stresses the importance of developing new effective care/methods of high quality at low cost (5). Home abortion is an effective method at low cost compared to having the abortion in hospital, but assuring high quality also justifies developing additional care beyond the medical procedures.

The crisis theory of Cullberg (106) and the Self-Care Deficit Theory by Orem (127) might be valuable for health care staff for investigating, understanding, and addressing physical, psychological, sociological and existential needs in both women and men in relation to an induced abortion.

In a broader context, Paper V adds perspectives on experiences and needs related to an induced abortion with the final treatment at home. However, participants also commented on perspectives beyond their own needs as individuals and beyond the health services providing the care, as suggested in Figure 5.
Decision making and reasons for abortion need to be addressed in abortion care and counselling

Decision on abortion was considered difficult among half of both women and their male partners (Paper III). For men, no comparative data have been identified, but the proportion among women who reported a difficult decision was considerably higher in a study by Larsson et al from 2000 (4), where only 19% of the women considered the abortion decision easy (4). This finding (Paper III) suggests the abortion decision may have become easier over time. Changes in how an abortion decision is perceived could reflect changes in societal norms. The current legalisation on abortion dates from 1975 and may be an integral fundamental right for those in fertile age today. Decision on abortion may have been embraced with more taboos and ethical dilemmas in earlier generations, who were aware abortion was surrounded by ethical and moral grounds before legalisation. In addition, new procedures has developed and abortions are generally now performed much earlier in the pregnancy (56).

Experiences and needs in relation to an induced abortion should be analysed and understood from a holistic view, and with regard to the individual’s reasons behind the decision on abortion. A woman’s free choice to decide on abortion is sometimes influenced by life circumstances that to varying degrees drive her to decide to undergo an abortion (Paper V). A woman’s ambivalence in the decision to abort is associated with socioeconomic factors, on-going studies, and/or partner’s involvement in the abortion decision (4, 128). These aspects require attention, as current and anticipated emotions play an influential role in a patient’s medical decision making and choice (129). Patients usually need to manage both the cognitive and emotional aspects of the health threat and the cognitive and emotional elements of the decision itself.

In a setting such as Sweden, an induced abortion cannot be considered a medical health threat. However, choosing to carry a pregnancy to term and give birth to a child is undoubtedly one of the most significant decisions a person will ever take. In addition, pregnancy is a state many women hope to experience, although under circumstances other than those that make them request an abortion. This dilemma can account for ambivalence and diverse emotional reactions in both women and men, such as pride, gratefulness and relief, grief, shame, guilt, existential thoughts on life, meaning and morality, and regret (6, 13, 14, 120, 126, 128, 130).

The reasons behind a decision on abortion should also be considered in contraceptive counselling. The intention to adopt or to change a specific behaviour is partially based on the subjective perception of the benefits and barriers related to that behaviour (131). For example, barriers to using contraception may be insufficient knowledge, hesitant attitudes among self or partner, side effects, high cost, or an inner desire to have a child that has
been pushed aside for various reasons. This thesis emphasises the importance of identifying and reflecting on these complex aspects in family planning counselling.

Although, various emotional and social aspects and needs related to induced abortion have underlying reasons, these reasons are rarely discussed. The reason for this avoidance might be human rights in Sweden are firm and clear concerning abortion decision. The Abortion Act states the woman should make the decision about abortion without either veto or force upon her (8). However, the consideration of the underlying reasons for decisions on abortion does not need to infringe on a woman’s right to abortion; allowing women and men to disclose and reflect on reasons and choices may increase the quality of care, and may contribute to processing their experiences in a meaningful way. Such an approach may also promote discussion on the prevention of a subsequent unwanted pregnancy and abortion. The attitude and approach of the caregiver is crucial when providing counselling in lifestyle behaviours related to sexual and reproductive health (65, 132-134).

Both women (34%) and men (27%) reported a negative development of their psychological well-being 2-6 weeks after the abortion (Papers I and II), suggesting psychological distress was common among both women and men in a short-term perspective. In addition, women who found it difficult to decide on abortion were more likely to report existential components post-abortion than women who did not find the decision on abortion as difficult (Paper IV). A Swedish study shows that, even if women report distress related to the abortion decision, most women are able to make the complex decision to have an abortion without suffering any lasting negative effects or regret (126). Satisfactory coping in the short-term perspective could be important in a long-term perspective (135).

Therefore, a holistic view including “causes behind the causes”, i.e. motives behind a decision to abort are important considerations in abortion care, even though it is something health care staff are not allowed to interfere with, according to the Abortion Act (8). If the reason(s) for the decision concerns the abortion seeking women and/or their partners, they need the opportunity to discuss this, and health care staff should pay attention to these issues.
Limitations

This thesis has limitations. The samples in the studies (Papers I-V) were not randomly selected nor were control groups (women and men without experience of abortion) or data on non-participants included. These limitations hamper the possibility of generalising the results to the general population. Although there are limitations, these findings were similar with regard to mean and median ages, and distribution between different abortion methods to statistics from the annual national report from NBHW (38). Statistics from NBHW also confirms repeat abortion is common: 40% of all abortions in Sweden during 2009 were repeat abortions (38). There are no comparative data for men with experience of repeat abortions in their female partners. The response rate for the male sample could not be determined, as it is unknown how many women actually gave the questionnaire to their male partners. The response rate among women was only about 50%. Although this could be considered a low response rate, it is common for this type of study. For example, in a Norwegian study (136), 47% of eligible women participated, and only 43% completed the study. Waiting-room questionnaires often provide a higher response-rate, but this approach was considered inappropriate for a study focusing on post abortion experiences and reflections with regard to existential dimensions. Although a Swedish study that used waiting room questionnaires with similar background questions had a response-rate of 88% (4), existential dimensions were not included.

The experience of repeat abortion between women and men was the same irrespective of origin, in contrast to previous studies (among women) (51, 108); however, this result should be interpreted with caution, as only women who understood Swedish were asked to participate, which resulted in a high proportion of those with an origin from Scandinavia (88% in both groups). In 2009, 18% of men and 19% of women aged 20-64 years living in Sweden were born outside the country (137).

The majority of respondents (87% among women and 90% among men) lived in an on-going relationship, and women in a stable relationship were probably more likely to deliver the questionnaire to their partner than women without a stable relationship were. Introduced bias cannot be excluded: women and men with previous experience of abortion might be either more willing to participate in the study or more unwilling, as they considered the experience of repeat of abortion a personal failure.

It is also important to consider the retrospective design of the studies (Papers I-IV). Most women and men completed the questionnaire within a period of one to four weeks after the abortion. This implied recall bias could not be excluded, particularly for questions concerning the abortion decision and the women’s wellbeing before the pregnancy. Nevertheless, the reasons for having an abortion were similar to the reasons presented in other studies (4, 12, 112). Only a one-item question was used to measure psychological well-
being, but as this was not a primary outcome of the study, the results related to psychological wellbeing should be interpreted with caution.

The questionnaires were study-specific (Papers I-IV), however, they were developed by the authors in collaboration with researchers, gynaecologists, midwives, and social workers working in abortion care. Specific questions were based on findings from previous studies (4, 13), and the questionnaires were pre-tested and adjusted. A similar procedure was adopted when developing the interview guide in Paper V. These procedures and the mixed-method design of the project (141, 142) strengthened the validity and the reliability of the results.

Public health implications

In accordance to the reasons for the abortion (Papers I and V) and associated risk factors for repeat abortion (Papers I and II), some women and men considered work opportunities and economic support might have enabled them to continue the pregnancy. In addition, increased SRE, easy/free access to high-quality contraceptives and counselling were interventions suggested for preventing unintended pregnancies. In a European context, sexual education and provision of access to reliable and affordable contraception are essential for achieving low rates of induced termination of pregnancy (36). In Finland, teenage pregnancy and abortion rates began to increase in the mid-1990s (140). The increase in abortions started first among adolescents, and gradually spread to teenagers. This trend was related to a change to less effective use of contraceptive methods among teenagers and an earlier age of teenage sexual activity. The most likely explanation for less effective contraceptive use were cutbacks in healthcare and family planning services in the 1990s and the reduction of sex education in schools (140). Swedish investigations show routines for contraceptive prescriptions, conditions for YHC, and the quality of SRE in school vary greatly between different providers and counties (39, 64, 87). This is relevant in a public health perspective, as society should contribute with supporting environments and health services suitable for both men and women (47).

The Social Model of Health (Figure 4) can be a potential explanatory model for understanding the impact of societal efforts on an individual’s health and behaviour. The model highlights the importance of broader interventions directed towards interpersonal, organisational, community, and public policy factors, in order to prevent undesired behaviours/outcomes in individuals (101). In addition, norms and attitudes with regard to subcultures need to be considered for understanding and addressing sexual behaviour (99).

Accurate guidelines, subsidisations, and routines for contraceptive follow-ups may improve the quality of counselling and enhance contraceptive ad-
herence, as suggested in Papers I and V. Further efforts, other than a single individual counselling session on contraceptive use, may be required. As low emotional support among the women was associated with repeat abortion (Paper I), long-term behavioural change or adherence to contraceptive use may require social and psychological support based on the experiences of the woman (109, 111). In addition, men should be considered important in family planning, as they influence women’s contraceptive choices and use (79-81, 104). These aspects require attention both within public health policies and in local abortion care, as the overall public health objective in Sweden states the importance of creating societal conditions that ensure good health for the entire population, regardless of sex or socio-demographics (34). Thus, health is not only defined in physical terms, but also in terms of psychological and social well-being.

Future studies

Existing research mainly focuses on problems related to sexual behaviour, such as unintended pregnancy and abortion. The Swedish indicators that are used to follow the development of the public health objective “sexuality and reproductive health” measure undesirable outcomes, such as abortion rates, Chlamydia, and sexual crimes (39). A discourse of desire and pleasure, as a power promoting health, is entirely missing.

To shift the discourse of sexuality from a problem-oriented to a health and pleasure-oriented discourse requires more understanding about how people perceive, define, experience, and express their sexuality and pregnancy intentions. In this context, men are important, as their attitudes, behaviour, and life circumstances interact with their partners. Thus, existential dimensions evoked by an induced abortion should be systematically investigated and analysed. Continuing professional development and guidance for professionals involved in abortions is considered important by most gynaecologists in Sweden (122).

Future studies need to focus on all these aspects; indicators promoting sexual and reproductive health, men’s role and impact on women’s reproductive choices, and men’s needs related to sexual and reproductive health. In addition, further research on the influence of women and men’s pregnancy intentions and existential dimensions on reproductive choices, satisfaction with abortion care, contraceptive usage and adherence are suggested. These aspects may contribute to understanding the reasons behind the decision on abortion and how to adapt sufficient preventive efforts and care related to an induced abortion.
The Swedish abortion register needs to be extended

Within the European Union the reporting of abortions needs to be more consistent and coherent (36). The large variation in abortion rates between countries suggests abortion rates may be reduced in some countries without restricting women’s access to abortion (36). In the Swedish abortion register, only age, abortion method, gestation week, parity, residence, and number of previous abortions are available (38). The documentation of the woman’s personal identification number (PIN) would connect data from the abortion register to other registry data with several levels of information relevant for innovation studies, such as field and level of education, income, ethnicity, household and family, and health outcome.

As 40,000 abortions are performed per year in Sweden, abortion is a common intervention in women’s healthcare and can be compared with the number of births (90,000/year), and new cases of breast (7,000/year) and prostate cancer (10,000/year). Research in these areas has been enabled by data recorded in patient registers based on the PIN. Abortion care should not be an exception, as assessment of complications associated with abortion can be difficult to investigate. This must be viewed as serious from a women’s health perspective,

In Finland and Denmark, extended reproductive registers exist, and both countries have lower abortion rates than Sweden (37, 141). For example, Denmark has three population-based registers, namely the Fertility Database, the Register of Legally Induced Abortions, and the In Vitro Fertilisation register, aimed at providing data for surveying reproductive outcome (142). These registers include information on births, abortions, assisted reproduction, and selected characteristics of the women (and men) involved. Researchers can apply for permission to use the register data. These registers have high validity and coverage and provide, individually and in combination, unique opportunities for undertaking detailed and comprehensive research in the field of reproduction (142).

The most important purpose of implementing the Register of Legally Induced Abortions in Denmark was to ensure a safe procedure by monitoring the occurrence of complications, both directly related to the abortion and later complications, and to follow the development and provide data for the regional public health planning (142). This is not possible in Sweden, due to the limited registry data.

The Swedish NBHW’s records are safe and extending the abortion register should not be considered as intruding on a women’s integrity. On the contrary; there is much to be gained by providing opportunities for research, for example on how to tailor effective prevention programs for reducing the number of unintended pregnancies in different groups (142).
Conclusions

In a country such as Sweden, where a woman’s right to abortion is well established and accepted, experiences and needs in relation to an induced abortion can still be complex in both the women’s and their male partner’s life.

More than one-third of women and men in this study had experience of repeat abortion and appeared more socioeconomically disadvantaged than those who experienced their first abortion. When addressing unequal disparities between different groups, the social determinants of health need to be considered. This implies prevention of unintended pregnancies is not merely the responsibility of the health sector.

Men commonly participate and support their partner during the whole abortion procedure, and are emotionally involved. Consequently, men reflect upon the care provided in relation to an induced abortion. However, some men felt neglected by health care staff. Most women were satisfied with the overall care provided in relation to the abortion. The human side of care, such as empathy and sensitivity, were the most valued factors for high care satisfaction among both women and their male partners.

Another notable finding is that an abortion often evokes existential thoughts and feelings in women, which sometimes need to be expressed in a symbolic way. Two-thirds of the women thought of the pregnancy in terms of a child. These existential dimensions are rarely addressed in research or in guidelines related to care during an early, induced abortion. This may partly explain why some women find the decision on abortion is difficult. For some women, the decision on abortion is influenced by the life circumstances surrounding her or her partner. Therefore, the reasons behind the decision to abort are essential for understanding and adapting proper care to the unique situation of each woman and her male partner.

Home abortion increases autonomy among women and their male partners. Yet, the human side of care prior to the final treatment at home is crucial for their experiences of the procedure. Both women and their male partners desire to be treated with empathy and respect on equal terms and to receive adequate information tailored to their self-care needs, but with the emotional aspects also being considered. Women and men in a relationship share life circumstances and influence each other with regard to decision making on abortion and experience of care satisfaction. Therefore, men are important in both abortion care and preventive work.

Unintended pregnancy and abortion are important issues, not merely a question of women or the health care; it is larger than that, an issue for the entire society.
Recommendations

The quality of the human side of care needs to be systematically highlighted in national guidelines and local programs for abortion care. In these issues, caring and nursing theory and sciences are valuable resources for putting theory into practice.

When applying these findings to a broader public health perspective, welfare systems and labour policies designed to narrow the gap between different socioeconomic groups become important. In addition, SRE, effective contraceptives with few side effects at low prices, and easy access to high-quality contraception counselling with follow-up visits are important.

More knowledge is required in public health efforts for identifying robust indicators for promoting SRHR, reducing unintended pregnancies, and predicting risk behaviour. This advocates up-dated national indicators within sexuality and reproductive health, according to international recommendations, in combination with an extended abortion register. Better data sources could diminish the existing knowledge gap about group differences in women seeking an induced abortion and help increase the quality of abortion care.

If men are expected to participate as responsible partners in improving their own and others’ sexual health, and preventing unintended pregnancies, the role of male partners involved in an induced abortion, and the support they need, should be established.
Sammanfattning på svenska (Summary in Swedish)

De senaste åren har kvinnor fått ökade möjligheter att välja mellan olika abortprocedurer, vilket medfört att andelen medicinska aborten har ökat och utgör 89% av alla inducerade aborter före utgången av graviditetsvecka 9. Den medicinska aborten kan avslutas i hemmet om kvinnan så önskar och inga hinder finns. Generellt finns begränsad kunskap om kvinnor och framför allt män som är involverade i en abort. Socialstyrelsens register ger endast information om; vilken vecka aborten avslutas i, abortmetod (medicinsk/kirurgisk), kvinnans ålder, kommun tillhörighet, antal barn och tidigare aborter. Det innebär att det finns begränsad möjlighet att undersöka eventuella skillnader mellan olika grupper. En relativt hög andel (40%) av de abortsökande kvinnorna har erfarenhet av att ha gjort minst en tidigare abort, men kunskap om den gruppen är begränsad. Det övergripande syftet med den här avhandlingen var att undersöka erfarenheterna och behov i samband med en abort och deras syn på förebyggande insatser.

Kvantitativa och kvalitativa metoder har använts i de olika delarbetena (I–V) samt teoretiska modeller som utgår från folkhälso- och omvårdnadsperspektiv. Samtliga studier är godkända av den regionala etikprövningsnämnden i Uppsala.


Resultatet i delarbete I och II visade att 35% av 798 kvinnor i åldern 14 – 49 hade erfarenhet av minst en tidigare abort och den andelen var högre i åldern 20 – 49; 41%. Upprepad abort var associerat med; att ha barn (Odds Ratio [OR] = 2.57), brist på emotionellt stöd (OR 2.09), att vara arbetslös eller sjukskriven (OR 1.65), rökning/snusning (OR 1.56), och låg utbildningsnivå (OR 1.5). För de 590 män i åldern 16 – 63 hade 32% erfarenhet av minst en tidigare abort. Upprepad abort var associerat med; att ha varit utsatt för våld eller tvång (OR 2.62), att vara arbetslös eller sjukskriven
(OR 2.58), och att ha barn (OR 2.0). Daglig tobaksanvändning var vanligt förekommande bland både kvinnor (33%) och män (50%), men vanligare bland dem med erfarenhet av upprepad abort (41%/57%).

Konkreta åtgärder som kvinnor och män med abort erfarenhet efterfrågar i det förbyggande arbetet är fler arbetstillfällen, mer och bättre kvalitet på sex- och samlevnadsundervisningen i skolan, hög tillgänglighet till billiga och effektiva preventivmedel samt kvalificerad rådgivning.

Slutsatserna i delarbete I och II är att kvinnor och män med erfarenhet av en abort löper hög risk för en upprepad abort. Personer med erfarenhet av upprepad abort är mer socioekonomiskt utsatta. Att minska skillnader mellan olika socioekonomiska grupper kan därför vara av betydelse i det förebyggande arbetet med önskade graviditeter.

Delarbete III syftade till att undersöka hur nöjda kvinnor och män upplevt vården i samband med en inducerad abort samt att identifiera faktorer som har samband med en hög grad av tillfredsställelse med vården. De flesta var nöjda med vården, men en fjärdedel (26%) av kvinnorna och nästan hälften av männen (48%) var inte helt nöjda. Den viktigaste faktorn för hög tillfredsställelse med vården var att ha fått ett gott bemötande bland både kvinnor (OR 11.78) och män (OR 5.32). Andra faktorer av betydelse var för kvinnorna att ha fått tillfredsställande; smärtlindring (OR 3.87), information om den gynnekologiska undersökningen (OR 2.25), och preventivmedelsrådgivning (OR 2.23), samt att det var lätt nå kliniken via telefon (OR 1.91). För männen var även information om abortproceduren en viktig faktor för deras totala tillfredsställelse med vården (2.64).

Slutsatserna i delarbete III är att en fjärdedel av kvinnorna och varannan man inte var helt nöjda, vilket indikerar att abortvården kan förbättras, speciellt avseende männens. Bland både kvinnor och män, är ett positivt bemötande från personalen den viktigaste faktorn för en tillfredsställande upplevelse av vården i samband med abort.


Slutsatserna i delarbete IV är att existentiella känslor, tankar och handlingar i samband med abort är vanligt förekommande. Detta är för vården personalen en utmanande aspekt som inte självlklart inkluderas i abortvården och dess styrdokument.

Syftet med delarbete V, som var en kvalitativ studie, var att undersöka kvinnors och mäns upplevelser och behov i samband med hemabort. Syftet var även att belysa deras syn på samhälleliga åtgärder för att förebygga
oönskade graviditeter. Kvinnorna rekryterades från fem olika kvinnokliniker och männen tillfrågades om att delta i studien genom kvinnorna. Tjugofyra kvinnor och 13 män intervjuades via telefon.

Innehållsanalysen mynnande ut i två övergripande teman; *autonomi* som beskriver att beslutet om abort och valet av metod var väl genomtänkt av kvinnan, men oftast med stöd av partner. Hemmiljön ökade deras integritet och kontroll, vilket också underlättrade deras möjligheter att fritt uttrycka och dela känslor; *beroende* som beskriver kvinnors och mäns önskan att bli behandlade med värdighet och respekt och att få tillfredsställande information som är individuellt anpassad för deras behov. Resultatet indikerar att hemabort ställer höga krav på vårdpersonalens kommunikationsförmåga. Kvinnor och män var motiverade att förebygga en ny oönskad graviditet men ett planerat återbesök var ovanligt. I det förebyggande arbetet av oönskade graviditeter ansågs fast arbete, förbättrad kommunikation/utbildning och subventionerade preventivmedel som viktigt.

Slutsatserna i delarbete V är att hemabort ökar kvinnors och mäns *autonomi*, men samtidigt finns ett uttalat *beroende* av att vårdpersonalen utförmer vården individuellt och med respekt för olika livssituationer. Rutiner och uppföljning bör därför kontinuerligt utvärderas för att säkerställa både kvaliteten av abortvården men också följsamheten i användningen av preventivmedel.

Oönskade graviditeter och aborter är inte frågor som endast berör kvinnor eller hälso- och sjukvården, det är större än så, ett delat ansvar som berör både individer och samhället.
This thesis is the end of my journey in obtaining my PhD. I have spiritually travelled to many places and learned a lot. Without doubt, these years have been greatly challenging, however, some of the best in my life. This journey has brought me to dark and cold places, but always ended in light and brightness. Some of the dark sides have been the loss of both my parents during this period. I wish they were here today, but hope their souls rest in peace and solace in heaven. They are my guardian angels. On the bright side, are all the loved ones who supported me along the way and all the new fantastic friendships this journey brought into my life.

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