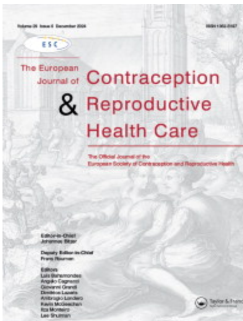

The European Journal of Contraception & Reproductive Health Care

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/iejc20

Medical termination of pregnancy: people's expectations and experiences in the Netherlands

Daphne C. Latour-Oldenhof, Sandra M.A. Dijkstra-Kersten, Eline W. Dalmijn, Jildau Tuinhof & Sophie H. Bolt

To cite this article: Daphne C. Latour-Oldenhof, Sandra M.A. Dijkstra-Kersten, Eline W. Dalmijn, Jildau Tuinhof & Sophie H. Bolt (2024) Medical termination of pregnancy: people's expectations and experiences in the Netherlands, The European Journal of Contraception & Reproductive Health Care, 29:6, 287-293, DOI: 10.1080/13625187.2024.2385533

To link to this article: https://doi.org/10.1080/13625187.2024.2385533

© 2024 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group.

Published online: 21 Aug 2024.

Submit your article to this journal

Article views: 593

View related articles

View Crossmark data

Full Terms & Conditions of access and use can be found at
https://www.tandfonline.com/action/journalInformation?journalCode=iejc20

THE EUROPEAN JOURNAL OF CONTRACEPTION & REPRODUCTIVE HEALTH CARE
2024, VOL. 29, NO. 6, 287–293
https://doi.org/10.1080/13625187.2024.2385533

RESEARCH ARTICLE

OPEN ACCESS

Medical termination of pregnancy: people's expectations and experiences in the Netherlands

Daphne C. Latour-Oldenhof[a,b], Sandra M.A. Dijkstra-Kersten[a], Eline W. Dalmijn[a], Jildau Tuinhof[a] and Sophie H. Bolt[a]

[a]Fiom, 's-Hertogenbosch, the Netherlands; [b]Utrecht University, Utrecht, the Netherlands

ABSTRACT

Purpose: Annually, approximately 31,000 people experience a termination of pregnancy (TOP) in the Netherlands. In 2021, about one-third of them chose medical termination of pregnancy (MTOP). We explored experiences with MTOP and to what extent expectations, pain, and counselling in the clinic are associated with satisfaction with MTOP.

Materials and methods: A retrospective cross-sectional study was conducted using an online questionnaire. We included 138 respondents, ≥16 years, who chose MTOP (September 2020–March 2022).

Results: The majority of respondents experienced MTOP more positively than expected or as expected (67%). For 24%, the experience was more negative than expected. In the event of another TOP, half of these respondents would hesitate to choose or would not choose MTOP, mainly due to physical side effects. The majority of respondents (73%) would choose MTOP again. Their main motivation was self-determination during treatment. Respondents cited four key elements: pain, intensity of experience during and after treatment, blood loss, and duration. Correspondence between MTOP expectations and experiences was associated with satisfaction with MTOP, while pain and satisfaction with counselling were not.

Conclusions: The majority of respondents were satisfied with MTOP and would choose the treatment again. Non-correspondence between expectations and experiences negatively affected satisfaction with MTOP. This highlights the importance of managing expectations by providing accessible information about the variety in expectations and experiences to patients with a focus on key elements of the experience.

SHORT CONDENSATION

The majority experienced the abortion pill more positively than expected or as expected. Four experience elements are key: pain, intensity during and after treatment, blood loss, duration. Information about these elements is crucial since non-correspondence of expectation and experience negatively affects satisfaction.

ARTICLE HISTORY
Received 11 April 2024
Revised 21 June 2024
Accepted 22 July 2024

KEYWORDS
Abortion; medication abortion; expectation; satisfaction; information; counselling

Introduction

Annually in the Netherlands, approximately 31,000 pregnant people[1] opt to have a termination of pregnancy (TOP) [1]. Before ≤63 days amenorrhoea, they can choose either a medical or surgical termination of pregnancy. Over the years, medical termination of pregnancy (MTOP), also known as abortion pill treatment, has become more popular in the Netherlands. In 2015, 22% of the people who had an abortion chose MTOP. In 2021, this percentage increased to 34% [1].

International studies on patient satisfaction with MTOP show contradictory outcomes. Several studies show that people are generally satisfied with their choice of MTOP: from 53% to 97% of respondents report being satisfied with abortion pill treatment [2–5]. But the studies of Di Carlo, Savoia [6] and Slade, Heke [7] report 39% and 47% of dissatisfaction regarding MTOP in Italy and Great Britain. Factors of (dis)satisfaction are among others pain, bleeding severity and the (dis)satisfaction with care or the procedure [2–7].

However, none of these results are easy to translate to other countries due to large medical, legal and cultural contextual differences. In the Netherlands, MTOP is provided in a hospital or an abortion clinic that meets the requirements specified by the Termination of Pregnancy Act of 1984.[2] With MTOP, 200 mg of mifepristone is ingested followed by 800 mcg of misoprostol in the next 24 to 72 h. People receive counselling before and after abortion pill treatment. Furthermore, in recent years Fiom, the Dutch expertise centre on unwanted pregnancies, received increasing signals that people experience MTOP as unpleasant. These observations were recorded by Fiom, abortion clinics and counsellors.

This retrospective cross-sectional study therefore aimed to provide insight into how pregnant people in the Netherlands experience MTOP. As shown in our model (Figure 1), and as based on results from previous research, we hypothesise that satisfaction with abortion treatment is

CONTACT Daphne C. Latour-Oldenhof dlatour@fiom.nl; d.c.latour@uu.nl Fiom, Kruisstraat 1, 5211 DT 's-Hertogenbosch, the Netherlands.
© 2024 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group.
This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (http://creativecommons.org/licenses/by-nc-nd/4.0/), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited, and is not altered, transformed, or built upon in any way. The terms on which this article has been published allow the posting of the Accepted Manuscript in a repository by the author(s) or with their consent.

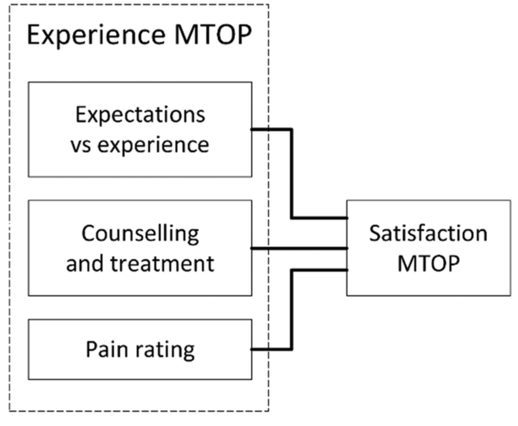

Figure 1. Study model.

influenced by three key elements of the experience: 1) the correspondence between expectations and experience [2,5–8], 2) experience with counselling in the clinic [2,3,9,10] and 3) the amount of pain experienced during treatment [3,11]. In this study, we examine to what extent these elements determine satisfaction with MTOP.

Materials and methods

A retrospective cross-sectional study was conducted using an online questionnaire with both closed- and open-ended questions. The Medical Ethics Committee of the University Medical Centre Groningen confirmed that the study complies with ethical guidelines (research register number: 202000276).

Pregnant people aged at least 16 years, ≤63 days amenorrhoea, who chose MTOP in the Netherlands, were recruited from September 2020 till March 2022.[3] In the Netherlands, the COVID-19 pandemic has not resulted in severely restricted access to abortion care. The clinics remained open and also provided care to people who were symptomatic for COVID-19. However, access to abortion care was hampered by some logistical barriers, therefore clinics shifted to telehealth (phone or video) for initial screenings. Another change was that partners and companions were prohibited from accompanying patients to the clinic.

All abortion clinics in the Netherlands and the two hospitals who perform TOP on social indication, participated in the recruitment process. Medical staff received printed instructions regarding informing clients about the study and the exclusion criteria, so that the recruitment process was similar everywhere. Illiterate and non-Dutch speaking people, those pregnant as a result of sexual assault, and those seeking MTOP for medical reasons (foetal abnormality or risks to the pregnant person's health) were excluded from the study.

People who met the requirements were given a leaflet containing information about the study by medical staff. This leaflet contained two options: 1) registering and receiving a link to the survey by email six weeks after taking mifepristone, or 2) a direct link to the survey without a reminder after six weeks. The information leaflet also provided the option of contacting a Fiom counsellor (free of charge) if a respondent experienced emotional distress following the questionnaire. None of the respondents used this option. Participation was on a voluntary and anonymous basis, and respondents could withdraw from the study at any point in time, without any data being saved. Two respondents were excluded due to a similarity in their answers that suggested duplication.

Our web-based survey was cross-sectional, self-administered and available in Dutch. It included a consent statement, followed by survey sections exploring respondents' demographics, pregnancy history and perception, personal characteristics using NEO-FFI-3 Neuroticism and Extraversion [12], social support by using the Isolation Scale from the Individual Level Abortion Stigma Scale [13], the abortion experience using the Numeric Pain Rating Scale [14], and Short Assessment of Patient Satisfaction (SAPS) scale [15]. Open-ended questions asked respondents about their motivation to choose, not choose, or hesitate to choose MTOP again in the event of another TOP, and their expectations and experiences with MTOP. The questionnaire took on average 25 min per respondent to complete.

Despite the preference of participating six weeks post-TOP, the survey was available for people between three to eight weeks after taking mifepristone. We used complex skip pattern logic so respondents only saw relevant questions, and we made certain questions mandatory to answer if they were key for skip pattern logic or analysis. The data from two different questions of two respondents were pairwise deleted, as one respondent gave contradicting answers and one respondent filled in an amenorrhoea deviating from the MTOP legislation.

Statistical analysis of the quantitative data was carried out using SPSS (version 27). First, the characteristics of the study sample were displayed using frequencies for categorical variables and means plus standard deviations (sd) for numerical variables. The study sample characteristics were stratified by MTOP satisfaction and tested for statistically significant differences using chi-squared test (categorical variables), independent samples t-test (normally distributed numerical variables) or Mann-Whitney U test (non- normally distributed numerical variables).

Second, the descriptives (frequencies or mean + sd) of the correspondence between MTOP expectations and experience, satisfaction with counselling at the abortion clinic, and the amount of pain respondents experienced were stratified by MTOP satisfaction and tested for statistical significance using chi-squared test and independent samples t-test. Third, we used logistic regression analyses to determine to what extent these elements were related to MTOP satisfaction. Satisfaction was operationalised as whether respondents would choose MTOP again. The response options 'not choose MTOP again' and 'hesitate to choose MTOP again' were combined due to low numbers, resulting in a dichotomous variable. We added age in years, amenorrhoea at MTOP in weeks, educational level (lower and medium vs. higher educational level) to the model as potential confounders. A p-value of <.05 was considered statistically significant.

For the qualitative analysis, NVivo 12 Pro software was used to code and categorise the various motivations given in the open-ended questions. Multiple response analysis was used to analyse the frequency as there was more than one response per respondent to the survey question [16]. Coding was performed per open-ended question independently by three authors (DL, SB, JT). In case of disagreement, an open discussion took place among them until consensus was reached.

Results

Study sample

A total of 6,555 leaflets were requested by clinics during the recruitment period. It is unsure how many leaflets were exactly handed out by clinics. The online survey was completed by 138 respondents (2.1%). The characteristics of the study sample are displayed in Table 1. For the majority of respondents, this was their first pregnancy (51.4%) and first MTOP (79.1%). Mean amenorrhoea at MTOP was 5.2 (SD = 1.5) weeks with a minimum of 1 and maximum of 9 weeks. The mean age was 31 (SD = 7) years, and two-thirds of the respondents were highly educated (n=91/138). Of the respondents, 17% were migrants or children of migrants. Respondents that would choose MTOP again were more likely to be higher educated (71%) than those that would hesitate or not choose MTOP again (51%). No other statistically significant differences were found.

Key elements of the experience of MTOP

Expectations versus experience

Respondents were asked about their expectations of the treatment in an open-ended question. Of the 138 respondents, 132 filled in one or more answers, in total describing 221 expectations. Three-quarters (73%) of their answers have a negative connotation, and 12% a positive connotation; for instance, some respondents expected to experience a lot of pain while others expected to experience no (excessive) pain. In a further 12%, we could not deduce whether there was a positive or negative expectation. For example, respondents indicated that it resembled a previous miscarriage without mentioning how they had experienced this.

Respondents were also asked a closed-ended question about whether their experience was different than expected. Eighty-four respondents (62%) indicated that the experience was different than expected. The majority of respondents experienced MTOP more positively than expected or as expected (Table 2: n=93/138, 67%). For 33 respondents (23.9%), the experience with MTOP was more negative than expected. Still, half of these respondents would choose MTOP again in the event of another TOP.

The respondents who indicated that their experience was different than expected were asked *via* an open-ended question to explain what was different. They gave 134 reasons, of which were 56% positive and 44% negative. Figure 2 shows the percentage of respondents (n=84) who either positively or negatively described why the treatment was different than expected. What this figure shows is that the factors on which they rated their experience were both better than expected and worse than expected. Take pain as an example: some experienced less pain than expected (40%) while others experienced more pain (21%).

Information and counselling

Overall, respondents were satisfied with the information and counselling they received from the abortion clinic. The lowest score was given for the extent to which the information given corresponded to their experience (mean = 3.9, SD = 1.0). Satisfaction with information and counselling did not differ statistically between 1) respondents who would choose MTOP again and 2) respondents who would not choose or were hesitant to choose MTOP again.

Table 1. Descriptives of the study sample.

Respondent's characteristics	All participants	Would choose MTOP again	Would not/ hesitant to choose MTOP again	*P* value
	N=138	n=101	n=37	
Age, M (SD)	30.9 (7.1)	30.8 (7.1)	31.1 (7.2)	.837
Education level (%)				.047
lower	5 (3.6%)	2 (2%)	3 (8.1%)	
medium	42 (30.4%)	27 (26.7%)	15 (40.5%)	
high	91 (65.9%)	72 (71.3%)	19 (51.4%)	
Amenorrhoea at MTOP: weeks, M (SD)	5.2 (1.5)	5.3 (1.5)	4.8 (1.6)	.071
First pregnancy: yes (%)	71 (51.4%)	53 (52.5%)	18 (48.6%)	.690
First MTOP: yes (%, n=67*)	53 (79.1%)	36 (75.0%)	17 (89.5%)	.189
Migrants or children of migrants: yes (%)	24 (17.4%)	19 (18.8%)	5 (13.5%)	.467
Neuroticism (NEO-FFI-3): 5-60, M (SD)	32.4 (6.8)	32.3 (7.0)	32.5 (6.4)	.876
Psychological symptoms prior to MTOP: yes (%, n=137)	22 (16.3%)	17 (17.0%)	5 (13.5%)	.622
Number of weeks post abortion (n=136)	4.8 (2.1)	4.8 (1.9)	4.9 (2.5)	.768

*Based on the 67 respondents for whom it was not the first pregnancy.
Information on the educational level of respondents is converted to the International Standard Classification of Education (ISCED) of 2011 [17]; 'high education' corresponds to ISCED level 6-8 (bachelor/master/doctoral degree or equivalent), 'medium education' corresponds to ISCED level 3-5 (upper secondary, post-secondary non-tertiary, short-cycle tertiary), 'lower education' corresponds to ISCED level 1-2 (primary/lower secondary).

Table 2. Elements of MTOP experience.

	All participants	Would choose MTOP again	Would not/ hesitant to choose MTOP again	*P* value
	N=138	n=101	n=37	
Expectations vs experience (%)				<.001
Positive/as expected	93	74 (79.6%)	19 (20.4%)	
Positive and negative aspects	12	11 (91.7%)	1 (8.3%)	
Negative	33	16 (51.5%)	17 (48.5%)	
Patient satisfaction with information and counselling on scale 1–5: *M (SD)*	4.3 (0.6)	4.3 (0.6)	4.3 (0.6)	.715
Enough information in advance	4.3 (0.9)	4.3 (0.9)	4.4 (0.8)	.658
Information corresponding with experience	3.9 (1.0)	4.0 (1.0)	3.8 (1.0)	.209
Satisfaction with counselling prior to treatment	4.4 (0.6)	4.4 (0.6)	4.5 (0.7)	.612
Satisfaction with care	4.5 (0.7)	4.5 (0.8)	4.4 (0.6)	.557
Pain rating on scale 0-10: *M (SD)*	5.4 (2.8)	5.2 (2.8)	5.8 (2.6)	.341

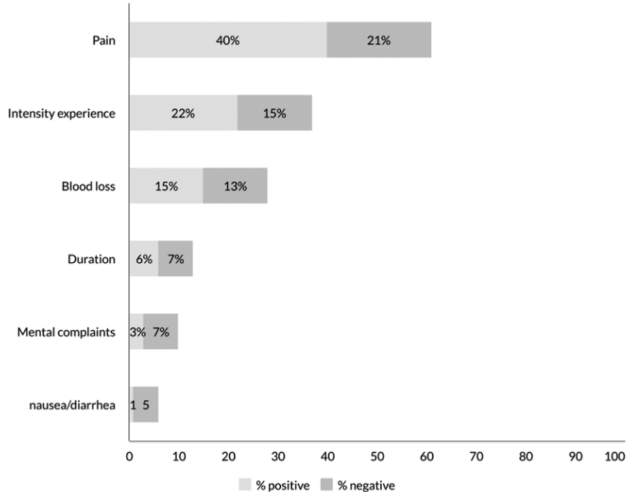

Figure 2. Percentage of respondents ($n=84$) who positively or negatively described why MTOP was different than expected.

Pain

Respondents experienced moderate pain during the treatment: the mean pain score was 5.4 (SD = 0.7). Pain scores did not differ statistically between respondents who would and would not/were hesitant to choose MTOP again.

Satisfaction with MTOP

Motivations whether to choose MTOP again or not

The majority of respondents (73.2%) would choose MTOP again if they found themselves again in a situation where they would want to terminate a pregnancy, while only 9.4% would not choose the treatment again and 17.4% would hesitate. Table 3 shows the categorised and coded responses for why the respondent would or would not choose MTOP again. Some respondents gave only one reason while others gave more. Therefore, the second column presents the percentages of the number of respondents and the third column the percentages of the number of responses. The main motivation why respondents (35.6%) would opt for MTOP again is that it gave them self-determination during the treatment. They themselves had control over the location, person(s) present and time. The main motivation why respondents would not choose the MTOP again (46.2%) or why they hesitated to choose MTOP (41.7%) again were physical side effects.

Relation between experience and satisfaction

The regression model (Table 4) showed that the correspondence between the expectations and experience of MTOP was statistically significantly associated with patients' satisfaction with MTOP. Respondents that reported that some aspects were more negative and some aspects were more positive than expected, and respondents who described their experience as more positive or as expected were, respectively, 17.6 times (p=.014) and 5.7 times (p=<.001), more likely to choose MTOP again than respondents who described their experience with MTOP as more negative than expected. Patients' satisfaction with information and counselling and the experienced pain were not associated with MTOP satisfaction.

Discussion

Findings and interpretation

This study finds that around three-quarters of respondents would choose MTOP again in the event of another termination of pregnancy. The majority of respondents (67%) experienced MTOP more positively than expected or as expected. The main reason respondents would choose MTOP again was self-determination during treatment, being able to control the location, person(s) present and/or time. However, for almost one-quarter of respondents, the experience with MTOP was more negative than expected. Half of these respondents would hesitate to choose MTOP again or would not choose it again, mainly due to physical side effects. Our results show that non-correspondence between expectations and experiences negatively affects satisfaction with MTOP. Looking at patient satisfaction, the element 'information given in the clinic corresponding with experience' has the lowest satisfaction.

Results in the context of what is known

In the literature so far satisfaction with the abortion pill treatment ranges from 53% to 97% [2–5]. Based on this outcome, it seems that the majority of our respondents did not have the negative experiences with MTOP that were shared in recent years with Fiom and healthcare professionals in the Netherlands.

The information pregnant people receive before treatment is crucial in their experience and satisfaction with treatment. This finding is consistent with results from previous research, which found that women who feel well-informed are more likely to have a positive experience [9,10]. More specifically, in this study we find four key elements of the experience that overlap with previous research. Firstly, studies showed that women who were well prepared for pain and bleeding were more satisfied with abortion pill treatment [2,3]. Secondly, the remaining two elements (intensity of experience during and after treatment and duration) relate more to the emotional experience of treatment. An aspect in counselling that was already identified by Donnelly et al. [8] as relevant alongside medical information. Attention to the medical and emotional elements prior to treatment only works if the importance of understandable, practical information is also recognised by the caregiver [8].

Clinical implications

These results point to the importance of accessible information provided in the clinics to manage expectations. There also lies a significant challenge, because our results showed that the factors on which respondents rated their experience can be both better than expected or worse than expected. The experiences varied widely. Outlining a variety of possible experiences may be helpful. This seems more appropriate than preparing pregnant people for a 'worst-case scenario'.

The results also indicate that there are a few elements in the experience that people remember most or found most important when they recounted their experience afterwards, regardless of positive or negative connotations.

Table 3. Motivations for whether or not to choose treatment with the abortion pill again.

Motivations to choose treatment again			
		% based on the total number of	
	Responses	Respondents ($n = 101$)	Responses ($n = 169$)
Autonomy	36	35.6	21.3
Where	28		
With whom	6		
When	2		
Preference over surgical treatment	28	27.7	16.6
More natural way	20	19.8	11.8
Positive experience	19	18.8	11.2
(Physical) side effects were not too bad	19	18.8	11.2
Mild treatment	14	13.9	8.3
Fast/effective treatment	10	9.9	5.9
Safe treatment	6	5.9	3.6
Good treatment in early pregnancy	6	5.9	3.6
Accessible treatment	5	5.0	3.0
No traumatic experience	4	4.0	2.4
Know what to expect from previous MTOP experience	2	2.0	1.2
Total	169		100

Motivations not to choose the treatment again			
		% based on the total number of	
	Responses	Respondents ($n = 13$)	Responses ($n = 17$)
Severe physical side effects	6	46.2	35.3
Thinks they would not choose TOP again in general	4	30.8	23.5
Intense experience	3	23.1	17.6
Treatment failed	2	15.4	11.8
Emotionally heavy	1	7.7	5.9
Uncertainty whether treatment is effective	1	7.7	5.9
Total	17		100

Motivations to hesitate to choose the treatment again			
		% based on the total number of	
Negative connotation	Responses	Respondents ($n = 24$)	Responses ($n = 36$)
Physical side effects were greater than expected	10	41.7	27.8
Thinks they would not choose TOP again in general	4	16.7	11.1
MTOP is a long process	4	16.7	11.1
Thinks they might better choose instrumental treatment	4	16.7	11.1
Uncertainty whether treatment is effective	3	12.5	8.3
Intense experience	3	12.5	8.3
Treatment failed	2	8.3	5.6
I do not know	2	8.3	5.6
Both treatments (medical and surgical) are not pleasant	1	4.2	2.8
Great impact on daily life	1	4.2	2.8
Feels like murdering your own child	1	4.2	2.8
Seeing the expelled product is intense	1	4.2	2.8
Total	36		100
		% based on the total number of	
Positive connotation	Responses	Respondents ($n = 24$)	Responses ($n = 4$)
Mild treatment	1	4.2	25.0
Positive experience	1	4.2	25.0
Autonomy (where)	1	4.2	25.0
More natural way	1	4.2	25.0
Total	4		100

Table 4. Regression analyses was performed with adjustment for confounding factors (age in years, amenorrhoea at MTOP in weeks, educational level [lower and medium vs. higher educational level]).

Elements of experience	Satisfaction: would choose MTOP again		
	OR	95% CI	*p* value*
Expectations vs. experience			
Negative	Reference category		
Positive and negative aspects	17.6	(1.81–171)	.014
Positive / as expected	5.68	(2.10–15.4)	<.001
Patient satisfaction with information and counselling (1–5)	1.20	(0.61–2.36)	.605
Pain rating (0–10)	1.00	(0.85–1.19)	.969

*A *p*-value of <.05 was considered statistically significant.

These elements are pain, intensity of experience during treatment, intensity of experience after treatment, blood loss, and duration. Given the large amount of information pregnant people receive prior to MTOP, focusing on these elements in counselling and aftercare could provide targeted preparation that in most cases matches people's key experiences. This is in line with Berendsen, et al. [18] who argue for tailored information, because a large amount of health care information can have negative effects on patients' well-being.

Research implications

Further research into the possible relationship between respondents' background characteristics and the elements of satisfaction could contribute to further improvement of tailored care in MTOP.

Strengths and limitations

The findings of this study should be interpreted in the context of several limitations. First, the response was lower than expected. We cannot give an exact response rate because it is unclear how many persons who met the requirements were given a study information leaflet by the medical staff. The sample represents 1.4% of the total number of MTOPs during the study period. But again, it is unknown how many people of this group met the inclusion criteria of this study. Termination of pregnancy can be experienced as a very intense life event [19], and it might be that people do not want to recall their feelings and emotions by answering this questionnaire. Other reasons for the low response rate may be the length of the questionnaire and the fact that people could only fill in the questionnaire three to eight weeks post-MTOP. Second, a direct comparison between medical and surgical termination of pregnancy was not possible due to the study design. Future research could focus on comparing satisfaction with these methods and their associated factors. Third, highly educated people are overrepresented in our study sample compared to the Dutch population as a whole and the population accessing abortion clinics [20]. Although not statistically significant, highly educated people were more inclined to choose MTOP again, which may have resulted in a slight overestimation of persons who would choose MTOP again. Migrants and children of migrants were underrepresented in our study compared to the general population. However, this proportion was comparable to the population that chooses MTOP in abortion clinics.

A strength of our study is that we combined a quantitative and qualitative approach, using questions from existing, validated questionnaires as well as self-developed, open-ended, in-depth questions. Also, the design of the online questionnaire resulted in few missing data.

Conclusions

The majority of respondents were satisfied with MTOP and would choose the treatment again. Non-correspondence between expectations and experiences negatively affected satisfaction with MTOP. We recommend focusing on the key elements of the experience in clinic-based MTOP counselling and using visual elements to make the information more widely accessible.

Notes

1. We use 'pregnant people' to include women and transgender and non-binary people who can become pregnant.
2. Dutch translation: Wet Afbreking Zwangerschap (Wafz): https://wetten.overheid.nl/BWBR0003396/2023-01-01.
3. Within the study's timeframe, there were 28,532 TOP patients, 31% of whom chose MTOP.

Acknowledgements

The authors are grateful to the respondents for taking part in the study. They would like to thank the Dutch Association of Abortion Doctors (NGvA) for their support, and they extend special thanks to the abortion clinics and two hospitals for their assistance in recruiting respondents.

Disclosure statement

The authors report there are no competing interests to declare.

Funding

The research programme of Fiom is funded by the Dutch Ministry of Health, Welfare and Sports. They had no involvement in the study design, the collection, analysis and interpretation of data, in the writing of the report and in the decision to submit the article for publication.

ORCID

Daphne C. Latour-Oldenhof http://orcid.org/0009-0007-9538-7672
Sandra M.A. Dijkstra-Kersten http://orcid.org/0000-0002-9014-2779
Eline W. Dalmijn http://orcid.org/0009-0004-7077-6944
Sophie H. Bolt http://orcid.org/0000-0002-4807-1778

Data availability statement

The data that support the findings of this study are available from the corresponding author, [DL], upon reasonable request.

References

[1] Health and Youth Care Inspectorate. Jaarrapportage Wet Afbreking Zwangerschap 2017 [Annual report Termination of pregnancy act 2017]. Utrecht Health and Youth Care Inspectorate - Ministry of Health, Welfare and Sport. Dutch; 2019 [cited 2023 Apr 17]. Available from: https://www.igj.nl/publicaties/rapporten/2019/02/07/jaarrapportage-wet-afbreking-zwangerschap-wafz-2017.

[2] McKay RJ, Rutherford L. Women's satisfaction with early home medical abortion with telephone follow-up: a questionnaire-based study in the U.K. J Obstet Gynaecol. 2013;33(6):601–604. doi: 10.3109/01443615.2013.782276.

[3] Abdel-Aziz E, Hassan IM, Al-Taher H. Assessment of women's satisfaction with medical termination of pregnancy. J Obstet Gynaecol. 2004;24(4):429–433. doi: 10.1080/01443610410001685592.

[4] Jones RK, Henshaw SK. Mifepristone for early medical abortion: experiences in France, Great Britain and Sweden. Perspect Sex Reprod Health. 2002;34(3):154–161. doi: 10.2307/3097714.

[5] Harvey SM, Beckman LJ, Satre SJ. Choice of and satisfaction with methods of medical and surgical abortion among US clinic patients. Int Fam Plan Perspect. 2001;33(5):212–216. doi: 10.2307/2673784.

[6] Di Carlo C, Savoia F, Ferrara C, et al. "In patient" medical abortion versus surgical abortion: patient's satisfaction. Gynecol Endocrinol. 2016;32(8):650–654.

[7] Slade P, Heke S, Fletcher J, et al. A comparison of medical and surgical termination of pregnancy: choice, emotional impact and satisfaction with care. Br J Obstet Gynaecol. 1998;105(12):1288–1295. doi: 10.1111/j.1471-0528.1998.tb10007.x.

[8] Donnelly KZ, Elwyn G, Theiler R, et al. Promoting or undermining quality decision making? A qualitative content analysis of patient decision aids comparing surgical and medication abortion. Womens Health Issues. 2019;29(5):414–423. doi: 10.1016/j.whi.2019.05.007.

[9] Lie ML, Robson SC, May CR. Experiences of abortion: a narrative review of qualitative studies. BMC Health Serv Res. 2008;8(1):150. doi: 10.1186/1472-6963-8-150.

[10] Breitbart V. Counseling for medical abortion. Am J Obstet Gynecol. 2000;183(2 Suppl):S26–S33. doi: 10.1067/mob.2000.107947.

[11] Bélanger E, Melzack R, Lauzon P. Pain of first-trimester abortion: a study of psychosocial and medical predictors. Pain. 1989;36(3):339–350. doi: 10.1016/0304-3959(89)90094-8.

[12] McCrae RR, Costa PT, Jr, Martin TA. The NEO-PI-3: a more readable revised NEO personality inventory. J Pers Assess. 2005;84(3):261–270. doi: 10.1207/s15327752jpa8403_05.

[13] Cockrill K, Upadhyay UD, Turan J, et al. The stigma of having an abortion: development of a scale and characteristics of women experiencing abortion stigma. Perspect Sex Reprod Health. 2013;45(2):79–88. doi: 10.1363/4507913.

[14] Ferreira-Valente MA, Pais-Ribeiro JL, Jensen MP. Validity of four pain intensity rating scales. Pain. 2011;152(10):2399–2404. doi: 10.1016/j.pain.2011.07.005.

[15] Hawthorne G, Sansoni J, Hayes L, et al. Measuring patient satisfaction with health care treatment using the Short Assessment of Patient Satisfaction measure delivered superior and robust satisfaction estimates. J Clin Epidemiol. 2014;67(5):527–537. doi: 10.1016/j.jclinepi.2013.12.010.

[16] Grotenhuis M, Matthijssen A. Multiple response. In: Grotenhuis M, Matthijssen A, editor. Basiscursus SPSS. Assen: Van Gorcum; 2005. p. 1–16.

[17] UNESCO Institute for Statistics: International Standard Classification of Education ISCED 2011, Montréal, 2012.

[18] Berendsen AJ, de Jong GM, Schuling J, et al. Patient's need for choice and information across the interface between primary and secondary care: a survey. Patient Educ Couns. 2010;79(1):100–105. doi: 10.1016/j.pec.2009.07.032.

[19] van Ditzhuijzen J, Ten Have M, de Graaf R, et al. The impact of psychiatric history on women's pre- and postabortion experiences. Contraception. 2015;92(3):246–253. doi: 10.1016/j.contraception.2015.05.003.

[20] Dutch Central Bureau of Statistics: Open data StatLine. Bevolking: onderwijsniveau en migratieachtergrond 2003-2021 [Population: educational attainment and migration background 2003-2021], Dutch; 2021 [cited 2023 Apr 17]. https://opendata.cbs.nl/statline/#/CBS/nl/dataset/82275NED/table?fromstatweb.