The Sociology of Women's Abortion Experiences: Recent Research and Future Directions

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Abstract

Abortion is a common and essential reproductive healthcare procedure experienced by approximately one third of women at some time in their life. Abortion is also commonly politicised and presented in public discourse as inherently contentious or controversial. However, recent sociological research on women's experiences of abortion is relatively thin on the ground. The body of qualitative research on abortion experiences, which does exist, varies in scope and focus on a relatively limited range of themes.

Building on an earlier review of qualitative research on women's abortion experiences, this paper explores the recent literature and identifies three key thematic areas: the context of abortion; reasons and decision-making; and abortion stigma. It then goes on to identify gaps in the literature, to explore what shape a sociology of women's abortion experiences might take and to suggest future directions for sociological research.

Introduction

Abortion is a common medical procedure: as commonly performed in the United States as, for example, caesarean section (Cockrill and Weitz 2010). Approximately one in three women of reproductive age will undergo an abortion at some point in their lifetime (Stone and Ingham 2011). Despite its presence as an event in so many women's reproductive lives, abortion is also politicised and is often framed in public discourse in more abstract terms and debated as a moral or ethical issue that is removed from women's lived experiences. Abortion also tends to be under- or mis-represented or over-associated with negative outcomes in the media and popular culture (Sisson and Kimport 2014; Purcell, Hilton et al. 2014). Abortion receives ongoing media attention, and recent media interest in the United Kingdom has focused on the increasing visibility of US-style anti-abortion (or 'pro-life') groups outside independent sector abortion clinics in England, and on so-called 'sex selective' abortion. While some of these stories may

be grounded in concrete examples of why women seek abortions, news media representations overall tend to present abortion in a way that is highly stigmatising, sensationalist (Evans and O'Brien 2014) and from which the voices of women who have experienced abortion are largely absent (Purcell, Hilton et al 2014).

In reality, attitudes to abortion differ substantially by context, and it is normalised to varying degrees in countries such as Cuba, Sweden and the United Kingdom (with the exception of Northern Ireland).[1] It remains highly politicised in others such as the United States, where access has become increasingly restricted (Gold and Nash 2012). A recent poll suggested the majority of people living in England, Wales and Scotland are not against abortion, with 46 percent favouring keeping or raising current gestational limits on provision and only 7 percent favouring a ban (YouGov 2013).[2]

Abortion rates, laws and access to services also vary worldwide (see Guttmacher Institute 2012; Sedgh et al 2007). There continue to be approximately 47,000 deaths each year related to abortions being unsafely provided (World Health Organization 2011). Where procedures are carried out according to current guidelines, abortion is a low-risk procedure (WHO 2012), which is safer than childbirth (Raymond and Grimes 2012). The emergence of the 'abortion pill' (mifepristone or RU486) has seen abortion treatment change over the last two decades in the United Kingdom and elsewhere (see Schaff 2010), with an increasing trend toward medical rather than surgical procedures.[3] This has implications for what and how women actually experience the process of abortion.

There are a number of directions from which abortion might be approached, and this paper reviews one area of scholarship: namely existing research on women's experiences of seeking, arranging and undergoing abortions. It builds on an earlier review of qualitative research on abortion experiences (Lie et al 2008) and thus focuses on qualitative research published between 2008 and 2014. My aim here is to present an up-to-date review of recent research on women's abortion experiences. I take a broadly sociological perspective, although there is of course interdisciplinary overlap, reflecting the scope of the existing research. The review draws on scholarship published worldwide in English in a range of disciplines including sociology, anthropology, public health, nursing studies, medical humanities and feminist scholarship. Papers are also drawn from a range of cultural and socio-economic settings including South and East Asia, Africa, Latin America, the United States, Europe and Scandinavia. Hence, they address a range of resource-rich and poor settings, in which abortion ranges from being free

and legally available to illegal and highly restricted. Since socio-cultural context has significant implications for how abortion is provided and perceived, the contextual diversity of the various contributions discussed in this review means that they should be read with the caveat that their generalisability is limited where they address locally specific factors.

I do not offer a systematic review of the literature: while relevant databases were searched to establish the full array of perspectives, the aim here is to highlight key debates and points of interest, rather than to present an exhaustive survey. Included are papers addressing 'unwanted' pregnancies and experiences of contraceptive use, where women may have sought and considered abortion but then decided against it. I exclude papers that did not look directly at women's experiences (such as those focusing on providers) and those taking an exclusively quantitative approach. Research focusing expressly on experiences of abortion due to foetal abnormality is also bracketed here as the complex attendant ethical, legal and medical debates require significant space to adequately address, and since a recent review of recent qualitative research in this field is available elsewhere (Lafarge et al 2014). I focus specifically on women's experiences as a means of concretising the debate, rather than taking a more abstract view of the rights and wrongs of abortion. I do so in the view that women's lived experiences of abortion offer the most obvious starting point for understanding abortion as a social phenomenon. Before moving on to address the literature, the next section offers a brief sketch of what abortion treatment involves.

What does abortion involve?

For the purposes of this paper, 'abortion' signifies 'induced' rather than 'spontaneous' abortion (the term sometimes applied to miscarriage). While access, methods and experiences vary worldwide, what is common is that what abortion actually involves is often socially silenced.
In contexts where abortion is legally available, a woman might present first at a primary care service such as a general practitioner (GP), or at a non-profit service such as Planned Parenthood in the United States, the British Pregnancy Advisory Service (BPAS) in the United Kingdom or Marie Stopes International. Where access is restricted, women might access online help services like Women on Web (www.womenonweb.org) or illegal providers. Taking the United Kingdom as an example, the majority of women present first at their GP and are referred to an abortion assessment clinic at a hospital or specialist service (Finnie et al 2006). There, she has an ultrasound to determine the gestational age of the pregnancy; has various routine blood and STI tests carried out; and speaks with a doctor (and possibly also a nurse) about her eligibility for different methods. It is

recommended that women are given a choice between surgical and medical abortion procedures (UK Royal College Obstetricians and Gynaecologists 2011), though this is constrained by service availability and gestation. In current World Health Organization (2012) guidelines, the recommended medical abortion regime comprises two drugs to be taken 24–48h apart, which cause the uterine lining to break down and be passed along with the yolk sac, embryo or foetus (depending on gestation). The same guidelines recommend the surgical abortion methods of vacuum aspiration or dilation and evacuation (D&E), with the most appropriate method varying by gestation and context.

Of the literature reviewed here, the majority addresses settings where abortion is available in one or other of the above methods, although some papers also address the issue of women seeking illegal and unsafe abortions by other methods when the former cannot be obtained. The next section begins with a brief outline of the earlier review of qualitative abortion research upon which this article builds, before moving on to review the literature from 2008 onwards, drawing out key points of interest and identifying gaps that warrant further sociological attention.

Existing insights on abortion experiences

Lie et al.'s (2008) review identified 18 qualitative studies of women's experiences of abortion in a range of countries published between 1998 and 2007. This review spanned a time period in which medical (as opposed to surgical) abortion was becoming established practice. Papers reviewed addressed either medical abortion specifically or abortion experiences more generally, including experiences of the procedure and recollections of abortion later in life. Lie et al. highlighted three main thematic areas broadly relating to issues around choice; experiences of seeking and undergoing abortion; and the impact of the environment in which it takes place.

With regard to the 'choices' women make around abortion, Lie et al. found moral considerations to be present but to be outweighed by practical concerns relating to the woman's life circumstances and relationships. Women's decision to have an abortion was typically found to have been made prior to presentation at health services, although their choices were also constrained by those services and what was (or was perceived to be) available to them. The review found that medical abortion may mitigate negative feelings in that the process is experienced as more 'natural' vis-à-vis surgical intervention, although for others, the medical process was found to be just as invasive. Women were also found to experience a broad and

complex range of emotions around abortion, and to have increased 'reservations' regarding later procedures, except in the case of foetal abnormality. With regard to environmental factors, the contexts in which women sought and had abortion were found to have a significant impact on experiences. UK studies in particular were found to focus on accessibility of abortion services and quality of care; and issues identified as negatively impacting on women's experiences included negative attitudes of healthcare professionals and unclear processes for referral, which can lead to delays in treatment.

Having touched on these issues, this earlier review nevertheless found the existing research on women's experiences to be 'limited in scope and detail' (Lie et al 2008:7). Showing significant overlap with Lie et al.'s three categories of 'choices', 'experiences' and 'environment', the more recent articles identified for the present review fell predominantly into categories of 'context and access' and 'reasons and decision-making', while a further theme of 'stigma' has also emerged. Perspectives on these often intertwined thematic areas are presented in turn.

Context of abortion

The broader social context in which abortion takes place, and the impact this has on access, features as significant themes in the literature across a range of settings. Contextual factors interact with and shape women's decisions around abortion, and pregnancies have been found to be deemed unwanted when they 'occur in contexts that [do] not reinforce socially-sanctioned notions of motherhood and "proper" procreation and/or revealed women's use of their sexuality in ways deemed culturally-inappropriate' (Izugbara et al 2011:1038). Cultural settings in which sexual activity and childbearing outside marriage are not sanctioned make it difficult for unmarried women to negotiate condom use with partners (as this might imply promiscuity) while also making access to abortion more fraught (Izugbara et al 2011).

Restrictive laws create tangible barriers to access which endanger women's lives and freedom (Schuster 2010). Even where abortion is legally provided, constraints on access such as parental consent laws, cost (which increases with gestation) or simply a wish not to disclose the procedure drives women to seek illegal treatment (Hung 2010). Where normalised to a greater degree – as in Cuba, for example – abortion is disclosed, seen as an 'everyday' occurrence that can be talked about openly in concrete terms and is viewed as a form of fertility control, which is complementary to contraception, rather than last resort when it has failed (Belanger and Flynn, 2009).

The need to travel substantial distances where local services are not provided can act as a barrier to obtaining abortion (Doran and Hornibrook, 2014). This is exacerbated by issues such as childcare and the financial and emotional costs of travel, including the additional emotional strain created by travelling to an unfamiliar place at an already potentially difficult time (Purcell, Cameron et al 2014). Barriers to access are experienced in 'deeply intertwined and synergistic ways that tended to complicate each other' (Ostrach and Cheney 2014: 1009). Women who are already disadvantaged by poverty are more likely to struggle to overcome subsequent barriers to access and are 'more vulnerable to the barrier of inadequate social support' (Ostrach and Cheney 2014:1014).

Considering context at a more immediate local level, women's experiences of abortion clinics can be negatively impacted by anti-abortion 'hostilities', by the presence of security measures for which the former create need, particularly in politically charged contexts such as the United States (Kimport et al 2012). Kimport and colleagues suggest that the tenacity of 'social myths' that dominate broader-level abortion narratives (clinics as places of suffering, unpleasant staff) indicates that at least some women find these myths to be true. The location from which abortion is offered – specifically whether this is a specialist or general medical service – impacts experiences in different ways, and women's preferences differ in this regard (Weitz and Cockrill 2010). However, the exceptionalism with which is it organised in the United States in particular, and potentially elsewhere, results in women viewing it as of its nature necessitating specialist care (Weitz and Cockrill 2010). In settings where women may complete the abortion at home, experiences of passing the foetus are impacted by attendant practical difficulties of resource-poor settings, such as shared living spaces and communal toilets (Ganatra et al 2010).

What these examples foreground is that, to some degree irrespective of context, women's experiences of abortion continue to be broadly framed by conventions of femininity (including motherhood); however, these may be locally formulated. A key means of reducing barriers to access requires digging down into the inequalities that underpin these framings.

Women's decision-making and reasons for seeking abortion

Much of the recent literature addresses women's reasons for seeking abortion. The most commonly cited reasons include the following: partner or relationship factors; financial

concerns; not being ready for parenthood; age; concerns for existing children; a wish to continue with future plans (completing education and establishing a career); a wish to increase spacing between pregnancies; and the stigma of pregnancy outside socially sanctioned contexts (Belanger and Flynn, 2009; Chibber et al., 2014; Ganatra et al 2010; Juarez and Bayer, 2011; Omideyi et al 2011). Such reasons are similarly relevant for women undergoing abortions at relatively 'later' gestations, although notable additional issues have been identified in this context, including slow referral and other 'service-related' barriers that create delay (Ingham et al 2008). Other common factors in women presenting later for abortion include their not expecting to be or realising that they were pregnant, and changes in life circumstances such as the end of relationships and withdrawal of partner support (Ingham et al 2008; Lee and Ingham 2010; Purcell, Cameron et al 2014).

When considering abortion, women are found to value information and support that facilitates their decision-making (Mukkavaara et al 2012). Women who feel that they have played an active part in the decision-making process when facing an unintended pregnancy are argued to experience the most positive outcomes following abortion (Cappiello et al., 2014). Conversely, those who do not feel the decision was theirs or who do not have subsequent support may be more likely to experience emotional difficulty following an abortion (Kimport et al 2011). Kimport et al. suggest that, despite anti-abortion claims to the contrary, it is not the fact of undergoing an abortion per se but the social context of abortion – namely one which stigmatises the experience and discredits those who have it, and in which women may not be fully empowered to make their own reproductive decisions – which creates space for women to experience difficulties. Those who feel most supported are those who have been listened to in the course of decision-making by someone who was able to 'affirm their decisional authority while also recognizing the many factors they must weigh to make a decision' (Kimport et al 2011:108). Following the procedure, women tend not to express doubt in their decision (van Dijk et al 2011). Moreover, it is mooted that the politicisation of women's feelings following abortion – be it by groups propounding to be either in favour or against abortion – need to be put aside in order to facilitate a more nuanced and contextualised understanding of these emotional responses (Kimport 2012).

Where abortion is severely stigmatised and a potential child is perceived as belonging not only to the would-be parents, but to the wider family and social group, women's accounts of abortion decisions convey a reclaiming of bodily autonomy and control (Oduro and

Otsin 2014). Autonomy is also significant specifically in young women's reproductive decision-making. The impact of the broader assumption that teen pregnancy is negative can be contrasted with values that normalise early motherhood, and in which abortion is less morally acceptable (Hoggart 2012). Young women are found to talk about pregnancy decisions in terms of 'responsibility' and 'readiness', and to particularly value autonomous decision-making when their own values are felt to be at odds with others related to that process (in this context parents or guardians). Where some young women may initially have felt they had come to a decision by themselves, reliance on help from significant others to realise that decision may result in a loss of autonomy as parents take over the decision-making role (Tatum et al 2012).

The focus on reasons and decisions thus brings to the fore the part played by significant others in the decision-making process and the ways in which women are likely to situate their abortion decision in the broader context of their lives and relationships (Chibber et al 2014). Women seeking abortion are commonly reported to cite relationship factors including partners who do not wish to support the pregnancy and resultant child; partners who are not viewed as suitable to have a baby with; or relationships that have subsequently ended (Chibber et al 2014; Purcell, Cameron et al 2014). Taking a discourse analytic approach to women's accounts, Kirkman et al. (2011) find abortion to be presented as 'a difficult solution to a problem', which has broad implications for the woman, significant others and her life as a whole.

Women's accounts of decisions around more specific aspects of the abortion process highlight the ways in which their options may be constrained. For example, regarding whether or not they preferred to view the ultrasound image (used to confirm and date the pregnancy), some women feel 'uncomfortable' asking to view the screen, while others feel discouraged from doing so by their healthcare professional (Cappiello et al., 2014). Reasons for viewing include curiosity, the wish to confirm their own health and fertility and that it might assist in their decision-making about the abortion. For those who want to be actively involved in the decision-making process around abortion, the added aspects of choice and control around viewing the scan are f lagged as an advantage (Cappiello et al., 2014).

Interestingly, some women who have experienced abortion are found to characterise their own reasoning and decision and that of others in distinct ways: presenting their own as considered, but regarding others' as in need of greater regulatory control (Cockrill and Weitz 2010). This is echoed in the adoption or rejection of the identity of 'a woman who's had an abortion', and the ways in which women construct their accounts as exceptional

(Cockrill and Nack 2013; also Nickerson et al 2014). In so doing, the common cultural binary of 'good' and 'bad' abortion is perpetuated.

Stigma

One particularly common hook in the recent literature is that of stigma. Drawing on Goffman (1963), by way of Kumar et al.'s influential (2009) conceptualisation, abortion stigma is presented as comprising three variations, namely 'felt', 'enacted' and 'internalised' stigma (Cockrill and Nack 2013). Women are found to manage abortion stigma with both 'intrapersonal' and 'interpersonal' strategies involving 'managing the damaged self', 'maintaining a good reputation' and 'managing a damaged reputation' (Cockrill and Nack 2013). Non-disclosure is highlighted as not only taking work to maintain but also as depriving women of the therapeutic impact of disclosure, and preventing abortion from becoming further normalised. Felt most acutely at the time of the procedure, stigma is experienced as decreasing over time as its significance abated and the woman's skills in managing it become more adept (Cockrill and Nack 2013). Othering is a significant means by which stigma is enacted, and the differentiation from other women undergoing abortions noted above exemplifies a key way in which women manage or resist abortion stigma for themselves, and at the same time perpetuate it more broadly (Nickerson et al 2014; Shellenberg et al 2011).

Stigma shapes women's expectations and experiences of treatment – by leading them to anticipate judgement from healthcare professional – and limits the extent to which they feel able to disclose and discuss their abortion experiences subsequently, as they similarly anticipate negative responses from friends and family (Astbury-Ward et al 2012). Where stigma is 'internalised', women's perceptions of the process of seeking and undergoing abortion may be negatively impacted, to the point where some prefer to avoid face-to-face with a healthcare professional: developments in telemedicine offer advantages here including enhanced 'privacy' (Grindlay et al 2013). Where measures are in place to protect women from anti-abortion groups, these can compound 'feelings of stigma, secrecy and isolation, consistent with the mythic construct of the clinic' as a negative space (Kimport et al 2012:208). While there are some opportunities for providers to mitigate this – for example, with small gestures of caring – significant shifts are only likely to come about with shifts in larger-scale public abortion narratives (Kimport et al 2012).

As with the issues around decision-making noted earlier, abortion stigma is intertwined with

constructions of appropriate femininity in a way which encourages women not to discuss or disclose abortion. Women are found to reflect on their experiences as 'moments where they have failed to live up to the expectations of others and to their own moral code' (Cockrill and Nash 2013:987). This may be particularly so when local norms of femininity are shaped by conservative religious discourse (Sorhaindo et al 2014).

The part played by stigma in shaping women's abortion experiences, including how and if they are able to talk about it, is no doubt a significant one, since the socio-political context of abortion leads to stigma playing out in a range of ways and to varying degrees worldwide. It has been suggested more recently, however, that there may be a danger inherent in allowing the concept of abortion stigma to become too all-encompassing, to the detriment of addressing the inequities that underpin women's abortion experiences (Kumar 2013). The remainder of this paper attends to the potential sociological directions that this field might take.

Developing a sociology of women's experiences of abortion: knowledge gaps and future directions

As outlined above, key themes that were found to dominate the recent literature were contextual factors, women's reasons for seeking abortion and the impact of stigma. To a degree, these echo findings of the earlier review by Lie et al. (2008) and illustrate the tenacity of certain factors in shaping women's experiences, as well as their persistence in what might loosely be considered an 'abortion research agenda'. This persistence across time further underscores the relatively limited scope of this recent research, as well as f lagging a range of gaps that would benefit from sustained sociological attention. While the shape that this attention might take is of course open to debate, I suggest a few options here that could prove fruitful directions for investigation. In broad-brush terms, a sociology of women's experiences of abortion could examine the ways in which social context sets the stage for these experiences; address competing framings of what abortion is, who has it and why it is necessary; problematise the assumptions underpinning these framings; and address the inequalities perpetuated therein.

Take, for example, the issue of women's decision-making. While the benefit of understanding women's reasons and decisions around abortion is not in doubt, the prevalence of this focus in the recent research primarily reflects dominant framings of abortion as a public health or healthcare provision issue, which (as with any framing) places limitations on the kinds of questions that can be asked. From a healthcare perspective, the focus tends to be on understanding

women's reasons with a view to improving access, evaluating experiences of care and (with varying degrees of explicitness) reducing incidence of abortion. However, this approach leaves other interesting sociological questions unaddressed, and questions such as these benefit from more critical unpacking.

While a focus on improving access of course has potential benefits (and should be maintained), so too does interrogation of the language used around women's experiences of abortion. Despite the powerful role of language in constructing experiences of abortion and perpetuating stigma around it, this analytic approach is largely absent from the literature reviewed. Drawing on narrative or discursive methodologies, in-depth consideration of the linguistic resources women utilise to account for and make sense of their experiences – on the lines of the work of Kirkman et al. (2011) – could offer sound phenomenological grounding for future work. Building on such grounding, this work might in turn question and disrupt dominant and entrenched ways of knowing and talking about abortion. For example, as well as being f lagged as a key theme in Lie et al.'s 2008 review, the issue of choice (and also control) is implicit throughout much of the recent research, yet how choice is constructed is not its central focus. Where reproductive 'choice' is an abortion watchword and a driving factor in safe legal provision, the reviewed research suggests that how choice is understood by women seeking abortion, and what their choices amount to, varies significantly by context. Where the concept of choice has been more thoroughly interrogated elsewhere in healthcare (for example, Mol 2008), in-depth analysis of women's constructions of choice in the context of abortion for the moment remain absent. Where language is taken as constituting everyday lifeworlds – as is the case in phenomenological sociology – understanding the language of abortion facilitates understanding the lived experiences of women seeking abortion. Thus, doing so has the potential to contribute to greater understanding of barriers to access and other constraints on reproductive control, to create space in which to explore intersections of gender, ethnicity and class. Doing so, in turn, would allow not only for further exploration of the ways in which these factors interrelate to compound abortion stigma but also to dig down into the foundations of the deep-seated inequalities on which abortion stigma is predicated.

Likewise, evaluating care experiences has significant potential to improve experiences of what, for some, can be a stressful or difficult time. But where much of the research stops short is in giving accounts of the embodied physicality of the abortion process – touched on briefly by

Ganatra et al. 2010, and in some of the inclusions in Lie et al.'s review– and how this relates to women's experiences of their lived bodies, reproductive or otherwise. This absence may reflect a broader squeamishness in academic research, or a reluctance to address frankly issues that may be deemed to somehow degrade participants (Twigg 2006). While the dignity of research participants should of course be of the utmost concern, it can conversely be argued that not addressing this aspect of women's reproductive experiences contributes to the shroud of silence over abortion and thus to further stigmatisation and understanding. Sociological research addressing the complexities of what women actually experience when dealing with an unwanted pregnancy, and with the embodied transformation from pregnant to not pregnant which abortion comprises, would be a welcome addition to the field as a means of explicating what it means to undergo an abortion in a given social context. Building on the phenomenologically influenced sociology of embodiment – stemming from the work of Williams and Bendelow (1998) and also Young (2005) – could offer the opportunity to address questions of meaning-making around the physical process of abortion treatment, as well as its broader social location as something that happens to the bodies of women.

Refocusing attention on women's embodied experiences of the different abortion methods could likewise prove fruitful, particularly around the distinction of women being un/conscious for the procedure. In contrast to surgical methods carried out under local or general anaesthesia, women undergoing medical abortion must by its nature play a conscious and active role in the procedure. This process is often messy and potentially distressing, since the woman would usually experience pain and vaginal bleeding accompanied by nausea, vomiting, fever and diarrhoea (side-effects of the medication), which can last anything between 4 and 24h, until the embryo/foetus is expelled. Second trimester medical abortions can more closely resemble an induced labour as the woman has to actively push to pass the foetus. Sociological interrogation of the different forms of agency required of women undergoing these procedures and the implications of this for how abortion is experienced would also shed light on abortion as a social phenomenon.

The public health drive toward reducing the incidence of abortion makes sense in the logic of pressurised healthcare services, and from the perspective that abortion requires medical intervention that might be considered 'avoidable'. However, a more explicitly sociological perspective here might question the focus on reducing incidence, and the associate implication that the ideal rate of abortion is either very low or none at all (see Weitz 2010). A sociological

perspective might also draw out that the focus on women's reasons for seeking abortion also reflects an assumption that abortion is something that ultimately requires justification. In this respect, it may be more useful to look beyond reasons and decision-making on an individual basis, and to dig down into notions of 'responsibility' and 'deservedness' in this context, and to draw on the wealth of feminist scholarship on reproductive health experiences. That the gendering of responsibility for contraception is a conceptual theme that has already received substantial sociological attention (for example, Brown 2015; Beynon-Jones 2013) makes it all the more notable (and indeed peculiar) that women's experiences of abortion have not, of late, been subject to similar analytical attention.

Addressing women's experiences in greater depth, and with more theoretical grounding than has been the case in recent research, would also offer a means of addressing the inequalities underpinning many issues around abortion, in relation to stigma and in terms of gender, ethnicity and socio-economic status. Thinking sociologically about women's abortion experiences would have the potential to produce knowledge of abortion, which is dominated to a lesser degree by abstract political, medical or legal viewpoints and instead informed by perspectives of those who have experienced it.

Conclusions

This article presents a review of recent qualitative literature on women's experiences of abortion, building on an earlier review, and identifying key themes in the research. Abortion is a common healthcare procedure and a common feature of women's reproductive experiences worldwide. Nevertheless, abortion continues to be stigmatised and only partially represented at the level of public discourse, such as in the news media. Women continue to face a range of barriers to accessing abortion, and silence and misunderstandings persist around what they procedure actually involves. This review shows that recent qualitative literature tends to focus around the themes of context, reasons and decision-making and stigma. While these are significant factors, there is scope for more sustained sociological analysis of the ways in which women account for their abortion experiences. That much of the literature is not of an explicitly sociological focus points to this being a rich area as yet under-explored, and questions remain regarding women's experiences of abortion, which are not explicitly addressed in existing contributions. Developing a sociology of women's experiences of abortion – which might address the social location and competing framings of abortion, as well as problematising assumptions and addressing inequalities underpinning current constructions of abortion – would

allow for a richer understanding of a common but all-too-often silenced experience.

Short Biography

Carrie Purcell is a qualitative health sociologist based at the MRC/CSO Social and Public Health Sciences Unit, University of Glasgow. Carrie began her research career in sociology at the University of Edinburgh, where her PhD research involved a phenomenological narrative inquiry on holistic massage practice. Since then, her research interests have focused around sexual and reproductive health, and she has undertaken a range of projects at both the MRC/CSO SPHSU and the Centre for Research on Families and Relationships, University of Edinburgh. She has published and presented widely on experiences of abortion, abortion care provision and media representations of abortion. More generally, Carrie has an interest in emotions, stigma, embodiment and the socio-political contexts of healthcare provision, as well as phenomenological sociology and narrative methodologies.

Notes

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[1]Although part of the United Kingdom, where abortion is available on a range of grounds to 24 weeks of gestation, abortion in Northern Ireland continues to be illegal in all but the rarest circumstances, with access highly restricted, and women being required to travel to other parts of the United Kingdom for treatment.

[2] I give a number of UK-based examples in this review as this is where I have carried out my research to date.

[3] In Scotland, for example, just under 80 percent of abortions are carried out using medication rather that surgical methods, and in England and Wales, the proportion is around half (Information Services Division Scotland 2014, UK Department of Health 2014).

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