

THE UNIVERSITY OF HULL

Ending a pregnancy: Young Women's stories and future health care
professionals' perspectives

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Overview

This portfolio thesis consists of three parts:

Part one- Systematic Literature Review

The systematic literature review integrates the findings of future health care professionals' attitudes towards terminations. A systematic search of the literature generated fifteen studies and a narrative synthesis was conducted. The methodological quality of the studies was also assessed. Subsequent conclusions are discussed and suggestions for future research are made.

Part two-Empirical Paper

The empirical paper explored the narratives constructed and contextual factors involved in young women's decisions to end a pregnancy. A qualitative narrative approach was used to analyse the stories. Holistic form analysis identified two plot themes and categorical content analysis identified four major and eight minor categories. The findings and implications of the research are subsequently discussed and future research is explored.

Part three- Appendices

The appendices provide additional information supporting the systematic literature review and empirical paper. Included is an epistemological and reflective statement.

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Part one: Systematic Literature Review

**The attitudes of future health care professionals towards terminating a pregnancy:
a systematic literature review**

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(see Appendix A for submission guidelines)

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Abstract

Background: Previous research has highlighted certain factors that can influence future health care professionals' attitudes towards terminations. The review aimed to integrate and summarise research findings with the view of understanding the attitudes of future health care professionals towards clients terminating a pregnancy.

Method: A systematic search of the literature using electronic data bases was conducted to identify appropriate studies using inclusion and exclusion criteria. A total of fifteen international quantitative studies were identified, a quality assessment of the included studies was carried out and narrative synthesis conducted.

Results: The main factors included personal characteristics, the quality of education and experiences found within training, future intentions to provide care and attitudes relating to policy and criteria for terminations.

Conclusions: The findings support previous research in highlighting how certain demographic characteristics are associated with negative attitudes. The review also highlighted the need to incorporate more comprehensive termination training into health curricula, as well as differences in willingness to provide care. Future research should explore how training could be changed and adapted to ensure professionals competency and confidence in providing quality care.

Key words: termination; attitudes; future health care professionals; students

Introduction

Terminating a pregnancy is a common and low risk procedure in reproductive health yet still remain of the most controversial interventions (La Vecchia, 2018). In the UK, the Abortion Act (1967) has provided women with the legal and medical means of ending a pregnancy for example, if the woman's mental or physical health is at risk or the baby will be born with severe disabilities. Furthermore, women can end a pregnancy up to 24 weeks although medical and surgical methods are dependent on gestation within this period. Approximately 200,000 women yearly end a pregnancy in England and Wales (Department of Health, 2018) seeking support from nurses, physicians and allied health care professionals (Miles, Penny, Mercey & Power, 2002). Understanding terminations from a global perspective remains difficult as many countries with restrictive laws are likely to under-report the prevalence of terminations. Therefore, most valid reports come from countries with more liberal policies (La Vecchia, 2018). Health care providers are likely to experience termination care during training or on clinical placement. The health care provider's view of terminations may impact the quality of care they provide; if health care providers reinforce a negative view this may cause distress (Pryce-Miller & Vernel, 2014). This raises questions around the way student health providers' view terminations in relation to their training, policy and intentions to provide care once qualified.

Attitudes are beliefs which can influence the behaviour of the individual (Fishbein & Ajzen, 1975). Attitudes are important in self-identity and personal development; individuals with certain attitudes identify with specific social groups (Price, 2015). The formation of attitudes can be understood as conditioning and reinforcement, for example, positive stories of women's experiences ending a pregnancy may lead to more

supportive views (Bracken, 1973). Furthermore, exposure is likely to increase positive attributions. Exposure includes active participation as well as education, media and political exposure (Zajonc, 1968). Cognitively, attitudes can be regarded as a set of beliefs or cognitive schemas, with people's understanding of the world influenced by experience (Fiske & Taylor, 1991). Additionally, attitudes may develop due to an individual's value base as a result of upbringing or life experience (Harris & Mills, 1985).

Past research into attitudes towards terminations has identified important demographic factors. For example, higher levels of education have been associated with more permissive attitudes, which is thought to be due to individuals obtaining additional knowledge around values and social norms (Wang & Buffalo, 2004). Age on the other hand, has not consistently been found to influence attitudes, particularly within a student population, as many studies have reported mixed results (Begun & Walls, 2015). This may however be due to student populations having wide age ranges. Gender has yielded varied results, with some studies reporting male health care professionals holding more supportive views than female professionals (Carlton et al. 2000). However, in student populations, female students were likely to hold more extreme views around terminations compared to males (Carlton et al. 2000). For some health care providers, religion was significant in influencing attitudes. Church attendance was generally associated with negative attitudes amongst nurses and social workers, though there was no difference between liberal and conservative branches of Christianity (Marek, 2004). This suggests that active participation in religion is a strong predictor of negative termination attitudes. Pryce-Miller and Vernel (2014) identified the need for emotional intelligence within nursing professions to provide a high standard of health care and clinical practice. Nurses need to be aware of attitudes in respect of their profession and in relationships with their patients. Attitudes can have a

negative impact on access to services, terminations and quality of care. For example, research investigating stress in health care professionals working in termination services has shown that those exhibiting critical attitudes towards women accessing termination care did not always provide comprehensive person-centred care (Lipp & Fothergill, 2009). There are however, instances when health care professionals demonstrated insight in understanding that their patients had received insufficient levels of care and that the quality of the practitioner-patient relationship was weak (Lipp & Fothergill, 2009). Furthermore, in extreme cases where negative attitudes have compromised clinical practice, physicians have conscientiously objected to performing termination procedures, objected to providing education to students and even provided deceptive information resulting in women being unable to access legal care (Fink, Stanhope, RoCHAT & Bernal, 2016).

A past review on qualified health care professionals has noted that those involved in termination care are likely to experience difficulties in separating their own attitudes towards termination from the care they provide (Lipp, 2008), potentially having a profound impact on the quality of care women receive. The nationality of health care professionals was also highlighted; medical professionals from the USA were more likely to have negative attitudes and more likely to decline care (Fischer, Schaeffer & Hunter, 2005). This was attributed to increased stigma and disapproval towards termination services. The review also highlighted that the longer health care providers spend in reproductive health, the more likely they are to develop supportive attitudes; experience rather than age was found to affect attitudes, as more experienced professionals had more liberal attitudes (Lipp, 2008). Professionals who had personal experience in having a termination or knew of a friend who had, were more likely to have supportive attitudes (Lipp, 2008). Furthermore, attitudes appeared to be dependent

upon the baby's gestational age, with late term terminations viewed more negatively. Also, medical reasons were more likely to be supported than socioeconomic reasons (Lipp, 2008).

Influential factors in attitudes of health care professionals from sub-Saharan African and Southeast Asian populations have also been reviewed (Loi, Gemzell-Danielsson, Faxelid & Klingberg-Allvin, 2015). This included supportive attitudes around the human rights of both the foetus and the woman, as well as more supportive attitudes around traumatic reasons for terminations such as rape (Harries, Lince, Constant, Hargey & Grossman, 2012). Traditional gender stereotypes were predictors of attitudes, with providers viewing women seeking a termination as rejecting their identity of what it means to be a woman and going against the will of God (Cooper et al, 2005). Additionally, feelings of uncertainty in performing termination procedures once qualified and a lack of guidance also brought feelings of negativity; many nurses spoke about entering the profession to save lives and to provide emotional support whilst working in clinics that provide termination care (Harrison, Montgomery, Lurie & Wilkinson, 2000). Additionally, themes emerged around access to the right care. Nurses' opposition to termination proved to be an important barrier for women attempting to access care (Cooper et al, 2005).

Past research found that health care providers in training receive inadequate education and training, with termination teaching only being covered when discussing ethical issues (Steinauer et al, 2009). If attitudes are formed from exposure, learning and experience, then understanding the attitudes of those still undertaking their training within the medical, nursing or social work profession provides a unique understanding of the attitudes of the next generation of providers and their potential clinical practice.

Understanding attitudes is also important from a clinical practice perspective as the role of health care professionals is to provide collaborative, compassionate and person centred care ensuring that clients have the best possible care. This review may additionally aid the development of training programmes, policy and how to better support those accessing termination care. Previous reviews have consolidated research on the attitudes of qualified health care professionals and not exclusively future health care professionals. This would therefore be the first review to examine literature from a new generation of future health care providers. This review aims to integrate and summarise the findings with the view of understanding the attitudes of future health care providers towards terminating a pregnancy and the factors influencing positive and negative attitudes towards terminations.

Method

Search Strategy

A systematic search of the literature was conducted from December 2018 to February 2019 using EBSCOhost literature search service. The electronic databases searched included: PsychINFO, PsychARTICLES, CINAHL, Medline and Academic Search Premier for relevant articles. The search data bases used were to ensure a comprehensive search of the literature, identifying any literature from a medical, nursing, social work perspectives.

The search terms that were applied to title and abstracts included:

(abort* OR terminat* OR "ended a pregnancy")

AND

(student* OR postgrad* OR undergrad*)

AND

(attitude* OR perception* OR opinion* OR thought* OR feeling* OR belief* OR view)

Study screening

Articles were included if they fitted the following criteria:

1. Students studying medicine, nursing, social work / allied health professionals in training where they may come into direct contact with women seeking terminations;
2. Countries where elective terminations are legal; this includes elective terminations and for socioeconomic reasons;
3. Papers reporting quantitative or qualitative methodologies;
4. Studies investigating attitudes or beliefs towards terminating a pregnancy.

Studies were excluded based on the following exclusion criteria:

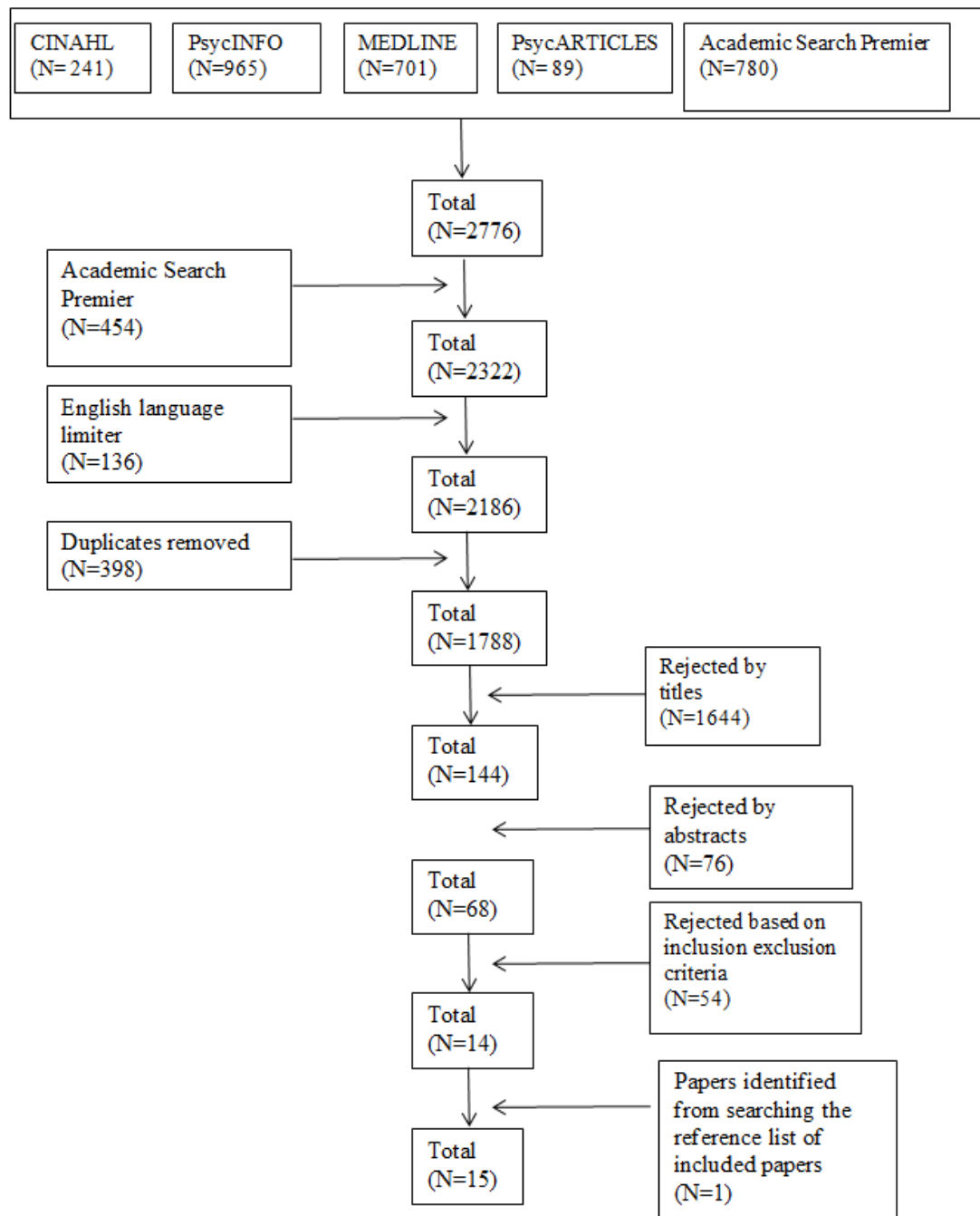
1. Not published in the English language;

2. Studies that were not peer reviewed;
3. Papers not explicitly focused on terminations (i.e. contraception or reproductive health);
4. Students with professional qualifications (i.e. completing post-qualification training).

Article Selection

The search produced 2776 papers, of these 398 were duplicates. The article titles and abstracts were then read, excluding 1644 and 76 searches respectively. The remaining articles were then read against the inclusion and exclusion criteria which excluded 54 articles; one article was added after searching the reference list of identified papers leaving fifteen included in the review. Figure 1 shows the PRISMA diagram outlining this process. A worked example and data extraction form is outlined in Appendix B and C respectively.

Figure 1: Search strategy employed to produce articles included in the review



Synthesis

Narrative synthesis was used to summarise the outcomes of the studies. Narrative analysis involves the procedure suggested by Popay et al, 2006, where findings are extracted and collated in order to explore themes and relationships between them and finally, assessing the robustness of the synthesised findings through methodological quality checking (Appendix D).

Quality Assessment

Despite a broad inclusion criteria, only quantitative papers were identified therefore the National Institute for Health and Care Excellence (NICE) checklist for quantitative papers (Jackson et al, 2006) was used to assess quality. This checklist is based on 'Graphical appraisal tool for epidemiological studies' (GATE) (Jackson et al, 2006) assessing the internal and external validity of studies reporting correlational data. The checklist is split into five sections whereby questions are assigned with a score of '++' in cases when the criterion is fulfilled, '+' when the criterion is partially fulfilled. When the criterion is not met this is indicated by '-'; there are also additional scores such as 'not reported' and 'not applicable'. All articles were included in the review. Other quality measures were considered such as Downs and Black (1998) but because this measure primarily assesses intervention studies it was not employed here. Seven of the articles were quality checked by another independent peer reviewer with a 71% agreement rate; cases of disagreement were discussed with a final decision agreed upon.

Results

Study Characteristics

Fifteen studies (n= 8503 participants) were included in the review, all of which employed cross-sectional quantitative methodologies. Samples ranged from 43-89% female and 11-57% male participants, with a mean age of 25.7 years.

Opportunity sampling techniques (n=14) and repeated measures design (n=1) were used in the studies. The data was collected using self-report questionnaires: fifteen were self-developed and one was already established. Additionally, the studies took place across eight different countries with a majority coming from the USA (n=8), South Africa (n=2), UK (n=1), Turkey (n=1), Spain (n=1), India (n=1), Sweden and Italy (n=1).

Quality Assessment

Most of the studies described their source population well and participants were representative of the target area. The studies however scored poorly for controlling the effects of confounding variables. Only two studies scored the maximum score of ‘++’ for both internal (IV) and external validity (EV) and on the whole, the scores were higher for EV compared to IV, indicating that the studies were generalisable to the source population. Although there was only a marginal difference in scores between EV and IV, the influence of bias may still be present. For example, all of the studies used self-reported measures potentially leading to response bias. The data was largely correlational and descriptive and consequently cause and effect cannot be inferred. Additionally, a majority of measures were developed by the researchers but not all of the self-developed studies reported on the validity and reliability of their measures. Though studies spanned across seven countries, they were all comparable to the UK due to training being conducted in university settings but none the less, not all of the items

used in the checklist were necessarily applicable particularly those that inquired about interventions. All studies asked for demographic information such as gender, religion and age. Studies investigated termination knowledge including policy, attitude to termination and policy or willingness to provide care; see Table 1 for overview of studies.

Table 1: Overview of studies included in the review

Author(s) and year	Location	Study aims	Participant characteristics	Methodology	Measures used	Key findings	Quality score
Agostino & Wahlberg (1991)	Sweden and Italy	To investigate the attitudes and knowledge of nursing students towards termination and family planning	229 nursing students: 105 from Sweden Female 89% Male 11% 124 from Italy Female 85% Male 15%	Design: cross- sectional Method: self- administered questionnaire Analysis: Comparison of means and correlational	Self-developed questionnaire 1. Attitudes of termination 2. Knowledge of sexual health services	Religion and sexual experiences were predictors of negative attitudes	+
Begun et al (2016)	USA	To investigate termination knowledge and attitudes in student social workers	504 Social work students Female 85.9% Male 14.1% Age range= 19-60 Mean age= 28.6 SD= 6.1	Design: cross- sectional Method: self- administered questionnaire Analysis: Correlation	Self-developed questionnaire assessing, 1. Demographic data 2. Prior knowledge 3. Termination attitudes	Majority supported terminations. Religion was a significant predictor of negative attitudes	+

Begun, Kattari, McKay, Winter & O'Neill (2017)	USA	To explore the relationship between sexual and termination attitudes in social work students	504 Social Workers Female 85.9% Male 14.1% Age range= 19-60 Mean Age= 28.6 <i>SD</i> = 6.1	Design: cross-sectional Method: self-administered questionnaire Analysis: Regression	Self-developed questionnaire assessing 1. Demographic data 2. Sexual attitudes 3. Termination knowledge 4. Termination attitudes	Students who had permissive attitudes around sex, were likely to support terminations. Religion was also a significant predictor of negative attitudes	++
Bennett, McDonald, Finch, Rennie & Morse (2018)	USA	To examine the views of medical students towards terminations at difference stages of training and assess the current training curriculum	315 medical students Female 52.4% Male 47.6% Mean age= 25.4	Design: cross-sectional Method: self-administered quest Analysis: Correlation	Self-developed questionnaire 1. Demographic data 2. Views on terminations	Students were supportive of terminations regardless of stage of training. Final year students found late stage terminations more acceptable than first year students.	+
Buga (2002)	South Africa	To assess the views of medical students towards terminations	300 medical students Female 55.3% Male 44.7% Age range= 15-36 Mean age= 21.8 <i>SD</i> = 3.4	Design: Cross-sectional Method: self-administered questionnaires Analysis: Correlation	Self-developed questionnaire including, 1. Demographic data 2. Sexual practices 3. Termination attitudes	Majority of the students thought that terminations were murder but would still carry out the procedure.	++

Dans (1992)	USA	To investigate the criteria in which medical students would perform terminations	811 first year medical students	Design: repeated measures Method: self-administered questionnaires Analysis: Correlation	Self-developed questionnaire 1. Religion 2. Involvement in ethics lectures 3. Termination attitudes	Attitudes did not significantly change over the course of medical training. More supportive attitudes were present when the mother's or baby's life was a risk.	-
Ely, Flaherty, Akers & Noland (2012)	USA	To investigate student social workers attitudes towards termination and views around future care	115 social work students Female 88% Male 12% Age mean= 30 <i>SD</i> = 9.7	Design: cross sectional Method: self-administered online questionnaire via email invitation Analysis: Comparison of means and correlation	Abortion Attitudes Scale (Davis et al, 1998)	Religion was a significant predictor of negative attitudes Half of the students would make referrals but over a third reported low policy knowledge.	++
Espey, Ogburn & Dorman (2004)	USA	To examine whether attitudes towards termination were influenced by clinical experience	86 medical students Female 51% Male 34% Mean age= 28.8	Design: cross sectional Method: self-administered questionnaire Analysis: Comparison of means and correlation	Self- developed questionnaire assessing 1. demographic information 2. clinical experience 3. termination attitudes	Students rated the clinical experience highly though only minority reported changes in the attitudes towards terminations to more supportive	++

Gleeson et al (2008)	UK	To assess the attitudes of medical students towards terminations	470 medical students Female 63% Male 37% Age range= 17-31 Mean age= 19.2 SD= 1.3	Design: cross sectional Method: self-administered questionnaire to students prior to lectures Analysis: Correlation	Self-developed questionnaire assessing; 1. Demographic 2. View of UK policy 3. Intention to provide termination care	Majority of the students supported terminations, minority intended to provide care, this decreased depending upon involvement	++
Rosenblatt, Robinson, Larson & Dobie (1999)	USA	To investigate the attitudes of medical students at different stages of training	219 medical students Female 54.8% Male 45.2% Age range= 19-38	Design: Cross sectional Method: self-administered questionnaire Analysis: Correlation	Self-developed questionnaire including, 1. Demographic information 2. Future practice intentions 3. Attitudes towards terminations	Students felt terminations should be available and expected to incorporate terminations into their future practice	++
Rodríguez-Calvo et al (2012)	Spain	To investigate the attitudes, knowledge and future intentions of medical, nursing and law students towards terminations	245 Medical Nursing Law (not included in the review) Female 73% Male 27% Age range= 19-55 Mean age = 22.6	Design: Cross-sectional Method: self-administered questionnaire Analysis: Comparison of means and correlation	Self-developed questionnaire 1. Demographic information 2. Attitudes towards terminations 3. Knowledge of terminations and policy	Students had good policy knowledge. Intention to provide care was rated as high for traumatic or health reasons but less so for elective terminations	++

			<i>SD</i> = 4.2				
					4. Future intentions to provide care		
Shotorbani, Zimmermann, Bell, Ward & Assefi (2004)	USA	To assess attitudes of health care students and their intentions to provide care	312 first and second year students including physician assistants 137, medical 147 and nursing students 28	Design: Cross-sectional Method: self-administered questionnaire Analysis: Correlation and regression	Self-development 1. Demographic information 2. termination attitudes 3. Training provision 4. Intention to provide	Majority supported terminations but only a minority intended to provide this service once qualified.	++
Sjöström, Essén, Sydén, Gemzell-Danielsson & Klingberg-Allvin (2014)	India	To explore the attitudes of medical students from India including the impact of sociodemographic variables	1996 medical students Female: 43% Male: 57%	Design: cross sectional Method: self-administered questionnaire Analysis: Comparison of means	Self-developed questionnaire assessing; 1. Demographic data 2. Perception of education and training 3. Termination attitudes	Majority were supportive of terminations. Few students had clinical experience	++
Wheeler, Zullig, Reeve, Buga & Morroni (2012)	South Africa	To explore the attitudes of medical students and their future intentions to provide termination care	1308 medical students from 2 different Universities, University of Cape Town = 882 Walter Sisulu University = 426	Design: Cross-sectional Method: self-administered Analysis: Regression	Self-developed questionnaire 1. Demographic data 2. Knowledge of policy 3. Attitudes around termination	Majority of students supported elective terminations but only a quarter intended to provide care once qualified. Students further	++

					4. Attitudes towards education	into their training were likely to support termination care	
					5. Future intentions to provide care		
Yanikkere m, Ustgörül, Karakus, Baydar, Esmeray & Ertem (2018)	Turkey	To investigate student nurses attitudes towards elective terminations	1089 Nursing students Female: 79.5% Male: 20.5% Age range= 17-36 Mean age= 20.7	Design: Cross-sectional Method: self-administered questionnaire Analysis: Comparison of means	Self-developed questionnaire 1. Demographic information 2. Termination knowledge 3. Termination attitudes	Moderate support for terminations was found. Those with more sexual experiences were also more supportive of terminations	+

Key

++	Study has minimised potential bias
+	Unclear whether the study has minimised potential bias
-	Significant sources of bias
NR	Not reported
NA	Not applicable

Synthesis of Findings

The findings of the studies can be summarised into four groups:

1. Personal attributes
2. Education and training
3. Future intentions to provide termination care
4. Policy and criteria.

Personal Attributes

Age

Most studies reported the age of the participants. Rosenblatt, Robinson, Laron & Dobie (1999) found a correlation between medical students over 30 years old and more lenient termination views. Older medical students were also more likely to support first and second trimester terminations compared to younger medical students less than 24 years. It might be that older students have more life experience influencing their attitudes or there might merely have been a chance difference in the participant sample between older and younger students. In contrast, Begun et al (2016) found that higher age in social work students was associated with declining to work with clients; this may be because older students have more confidence to decline work compared to younger students. Other studies reported that age was not a significant predictor in termination attitudes for medical or nursing students (Gleeson et al, 2008; Rodríguez-Calvo, Martínez-Silva, Soto, Concheiro & Muñoz-Barús, 2012). Begun et al (2016) and Bennett, McDonald, Finch, Rennie and Morse (2018) suggested that the stage of training is more likely to be associated with negative attitudes. In sum, there is mixed evidence on the relationship between age and termination attitudes.

Religion

Many studies suggested that students with higher self-reported religiosity or those who hold conservative religious beliefs such as Catholic, Evangelical Christian or Mormon faiths have significantly higher negative termination attitudes (Ely, Flaherty, Akers, & Noland, 2012; Begun et al, 2016; Begun, Kattari, McKay, Winter & O'Neill, 2017; Bennett, McDonald, Finch, Rennie and Morse, 2018). Furthermore, Ely, Flaherty, Akers and Noland (2012) reported that social work students with moderate to high participation in their religion were more likely to hold negative termination attitudes, however, the quality of this study is questionable as it reported a very low response rate for the questionnaires (17%). Similarly, Gleeson et al (2008) found that medical students who actively practised their faith held more pro-life attitudes. Religion was also found to be the reason given for medical students declining experiences in termination care (Espey, Ogburn & Dorman, 2004; Agostino & Wahlberg, 1991). Additionally, Rosenblatt, Robinson, Laron and Dobie (1999) found that the 10 commandments were the foundation in forming personal beliefs around termination care in the USA (Agostino & Wahlberg, 1991; Buga, 2002). Therefore, studies suggest that both conservative Christian religions and active participation in the religion are likely to contribute to negative attitudes.

Gender

For studies that reported the influence of gender, most concluded that there were minimal to no significant differences between men and women in their termination attitudes (Espey, Ogburn & Dorman, 2004; Buga, 2002; Dans, 1992; Bennett, McDonald, Finch, Rennie & Morse, 2018; Begun et al, 2016; Rodríguez-Calvo, Martínez-Silva, Soto, Concheiro & Muñoz-Barús, 2012). However, small

significant differences have been reported. For example, female student medics were more likely to consider providing terminations over their male colleagues (Shotorbani, Zimmerman, Bell, Ward & Assefi, 2004; Rosenblatt, Robinson, Larson, & Dobie, 1999). Similarly, female student social workers were more supportive of reproductive services over male students. Historically, research has suggested that there is a general development of women being more supportive (Dans, 1992).

Sexual experiences and sexual orientation

Some studies investigated sexual experiences, relationships and sexual orientation of students. Begun et al (2016) found that students who identified as LGBTQ+ held more supportive termination attitudes than heterosexual students. Buga (2002) reported no relationship between the sexual experiences of medical students and their personal or professional attitudes towards terminations. On the other hand, Begun, Kattari, McKay, Winter and O'Neill (2017) investigated the relationship between terminations and sexual attitudes with student social workers. Students who held more supportive views around sex generally held permissive views of termination, especially students with more sexual experience.

Training and Education

Stage of training

Studies that reported stage of training showed a general trend of those in later stages of training having more supportive views than those in their first year (Buga, 2002; Bennett, McDonald, Finch, Rennie & Morse, 2018; Gleeson et al, 2008; Yanikkerem et al, 2018). Wheeler, Zullig, Reeve, Buga and Morroni (2012) found that within the first year of medical school, students had little intention of

providing termination care. However, this changed throughout training with final year medical students being less likely to oppose providing care. Gleeson et al (2008) and Dans (1992) found similar results, with second year medical students having more permissive views than first year students. Bennett, McDonald, Finch, Rennie and Morse (2018) reported that medical students viewed terminations as morally acceptable regardless of their stage of training. Instead, negative attitudes towards second trimester terminations were more likely to be present further into training. However, the researchers posited that the lack of differences in attitudes between years of study is likely due to a high acceptance of terminations at baseline level. Alternatively, Buga (2002) reported that the year of study had no significant influence on personal values but did affect professional values; with a higher proportion of first year medical students not intending to provide care or refer women to services when compared to other years.

Clinical experiences

Clinical experience and exposure to terminations was highlighted in various studies (Shotorbani, Zimmerman, Bell, Ward & Assefi, 2004; Espey, Ogburn & Dorman, 2004; Begun et al, 2016). Clinical experiences were defined as placement or training opportunities. For example, social work students reported not having sufficient placement experience which resulted in a lack of knowledge and feelings of uncertainty around terminations (Begun et al, 2016). Similar findings arose in work by Begun, Kattari, McKay, Winter and O'Neill (2017); social work students lacked training and clinical experience both academically and on placement. Other studies have found that comparatively, medical students experienced more clinical opportunities compared to student nurses and physician assistants (Shotorbani, Zimmerman, Bell, Ward & Assefi, 2004). However, in

some cases, medical students reported a lack of clinical experience (Sjöström, Essén, Sydén, Gemzell-Danielsson & Klingberg-Allvin, 2014). Additionally, Espey, Ogburn and Dorman (2004) investigated whether medical students' attitudes towards termination changed following exposure through clinical experience. After the experience, students placed greater value on psychological support within services and were more likely to consider working in termination services. However, clinical experience did not significantly influence student attitudes regarding terminations, with only a minority becoming more supportive of terminations (Espey, Ogburn & Dorman, 2004). Authors suggested that students may have felt pressure to participate in the study and rate the experience highly, thus affecting the study's validity. Similarly, exposure to terminations increased the likelihood of students considering working in reproductive services but was not related to an increase in acceptability towards terminations (Bennett, McDonald, Finch, Rennie and Morse, 2018; Buga, 2002; Rosenblatt, Robinson, Larson, & Dobie, 1999).

The Curriculum

Espey, Ogburn and Dorman (2004) identified that medical students supported incorporating termination care into the mandatory training curriculum. Likewise, Shotorbani, Zimmerman, Bell, Ward and Assefi (2004) reported student medics', nurses' and physician assistants' support for the inclusion of termination teaching throughout training, with a majority of students considering taking elective courses in termination to advance their knowledge and skills base. However, medical students felt that they had received adequate training from the university and reported their knowledge as good. It was also highlighted that both physician assistants and nurses felt they should be trained to provide terminations as part of

their professional role; however, this view was not supported by medical students (Shotorbani, Zimmerman, Bell, Ward & Assefi, 2004). Sjöström, Essén, Sydén, Gemzell-Danielsson and Klingberg-Allvin (2014) found that medical students reported that reproductive health was well covered throughout training and subsequently cited good knowledge in this area. Furthermore, medical students identified the importance of incorporating medical ethics training to appreciate the emotional impact of clinical practice (Rodríguez-Calvo, Martínez-Silva, Soto, Concheiro & Muñoz-Barús, 2012). Social work students on the other hand, reported a lack of training throughout placements and lectures to the point where they felt unable to work with a woman seeking termination care due to inadequate knowledge (Begun, Kattari, McKay, Winter & O'Neill, 2017; Begun et al, 2016).

Future intention to provide care

Referrals

Dans (1992) reported that most medical students would make referrals if there was a threat to the woman's life or medical risk but intended referral rates decreased when the reason for the termination was around the mental health of the woman. Student social workers, were less likely to make a referral for women seeking termination care (Ely, Flaherty, Akers and Noland 2012). When students perceived themselves as unable to perform terminations due to feelings of incompetence or due to personal reasons, medical and nursing students were still willing to make a referral to another professional ensuring the future care of the woman (Shotorbani, Zimmerman, Bell, Ward & Assefi, 2004; Wheeler, Zullig, Reeve, Buga, & Morroni, 2012). There were circumstances in which medical students would not refer for elective terminations. However, support for referrals

increased when the mother's life or mental health was at risk, or in cases of rape, or if foetal development was at risk (Buga, 2002).

Willingness to provide care

Most medical students identified that performing terminations was a core part of their future clinical practice and they intended to provide such care in the future (Rosenblatt, Robinson, Laron & Dobie, 1999; (Wheeler, Zullig, Reeve, Buga & Morroni, 2012). Gleeson et al (2008) found that intention to provide future care was profoundly influenced by the level of participation in the procedure. Students were more willing to sign paperwork in the early stages of the pregnancy and when the woman's life was at risk, with an overall decline in willingness when level of participation increased. Therefore, the circumstances and stage of the pregnancy affected the overall willingness of the medical students to provide care. Furthermore, the study found that a majority of medical students would complete the relevant documentation for terminations, but only a minority of the students would perform the procedure. Similarly, Rodríguez-Calvo, Martínez-Silva, Soto, Concheiro and Muñoz-Barús (2012) identified that both medical and nursing students intended to provide termination care once qualified, however, this was dependent upon the level of perceived participation in the procedure. Wheeler, Zullig, Reeve, Buga and Morroni (2012) reported that a minority of medical students would discourage a woman from having a termination. Lastly, those who declined to provide care objected on the grounds of the woman being in her second trimester or due to beliefs that the foetus was a person (Rosenblatt, Robinson, Laron & Dobie, 1999; Dans, 1992). There was also a difference between medical and surgical terminations; Shotorbani, Zimmerman, Bell, Ward and Assefi (2004) found that students' intentions to provide termination care was

low for medical terminations but significantly lower for surgical terminations, due to personal values, religious beliefs and lack of training. Shotorbani, Zimmerman, Bell, Ward and Assefi (2004) identified that due to frequently changing policies it may be difficult to predict intentions to provide care. Furthermore, as studies here investigated perceived willingness to provide termination care, this may not reflect the student's actual attitudes once qualified.

Policy

Criteria

Most medical students demonstrated permissive beliefs and were supportive of elective terminations (Gleeson et al, 2008; Sjöström, Essén, Sydén, Gemzell-Danielsson & Klingberg-Allvin, 2014; Dans, 1992). For example, medical, physician assistants and nursing students supported legal and widely accessible terminations regardless of the reason to end the pregnancy (Shotorbani, Zimmerman, Bell, Ward & Assefi, 2004). However, Wheeler, Zullig, Reeve, Buga and Morroni (2012) found that medical students were equally split between supporting and opposing elective terminations. Medical students were more supportive of terminations if there was potential for significant harm to the woman or in criminal circumstances, such a rape or incest (Wheeler, Zullig, Reeve, Buga & Morroni, 2012). In an older study, a difference in acceptability was identified between medical reasons for termination and the mental health of the woman, with the latter being less acceptable (Dans, 1992). More recently however, Bennett, McDonald, Finch, Rennie and Morse (2018) found that for pregnancies resulting from more traumatic reasons or physical and mental health concerns then, there was no difference in the acceptability of terminations. In a Turkish study, nursing students supported elective terminations without spousal consent or need to be

married (Yanikkerem et al, 2018). Social work students viewed late term terminations as illegal (Begun et al, 2016).

Policy knowledge

Begun, Kattari, McKay, Winter and O'Neill (2017) found that student social workers supported current termination policy, however, they did not feel confident in their knowledge of policy and medical procedures, ultimately viewing themselves as unable to work with a woman seeking termination care. Equally, Ely, Flaherty, Akers and Noland (2012) reported that student social workers also shared a similar belief around their inability to work with a client due to a perceived lack of policy knowledge. Despite a reported lack of policy knowledge, procedure and lack of discussions within their cohort around terminations, student social workers still felt they were able to support clients seeking care. From a medical perspective, Agostino and Wahlberg (1991) discussed how medical students underestimated the number of terminations annually including having little personal and policy awareness. However more recently Rodríguez-Calvo, Martínez-Silva, Soto, Concheiro and Muñoz-Barús (2012) reported that medical and nursing students had good policy awareness and legal knowledge. Yanikkerem et al (2018) also reported that Turkish student nurses were confident in their knowledge of relevant and up to date policy.

Discussion

This review aimed to integrate research findings to understand the attitudes of future health care professionals towards terminating a pregnancy. All fifteen international studies explicitly reported the attitudes of students towards terminations. Findings suggest that there are different factors involved in the way future health care providers view terminations. The main factors identified included certain personal characteristics, the quality of education and experiences found within training, future intentions to provide care and attitudes relating to policy and criteria for terminations. The findings support previous research highlighting the importance of certain demographic characteristics, such as religion, impacting negative termination attitudes over factors such as age and gender. Additionally, studies reported that future health care professionals with more clinical experience are more likely to hold permissive attitudes. However, the current findings have also highlighted differences around future intentions to provide care, with the need for potential changes to be made to training curricula.

The review indicated that most future health care professionals were supportive of elective terminations. Recent literature suggests that future health care professionals are becoming more supportive of second and third trimester terminations as well as preserving the mental health of the women (Bennett, McDonald, Finch, Rennie & Morse, 2018). Unlike previous research, no difference in supportive attitudes was found between different professionals; student social workers were equally supportive in their attitudes as medics and nurses. However, there was a difference between professional groups in their knowledge of policy. For example, medical and nursing students perceived themselves as more confident in their knowledge of policy (Rodríguez-Calvo, Martínez-Silva, Soto, Concheiro & Muñoz-Barús, 2012; Yanikkerem et al, 2018) than student social workers who reported poorer policy

knowledge and felt less confident in their ability to work with clients (Begun, Kattari, McKay, Winter & O'Neill, 2017; Ely, Flaherty, Akers & Noland, 2012). The impact of inadequate policy knowledge could affect professionals' ability to make referrals. Previous research has highlighted the importance of social workers increasing their knowledge base around the impact of policies and barriers to accessing care (Wright, Bird & Frost, 2015).

The outcome of the current review indicates the need for improvements in the way training courses teach termination care across professional groups. There was a reported lack of conversations within training and social groups around terminations, an absence of termination experiences both in lectures and on clinical placement as well as poor teaching around policy (Shotorbani, Zimmerman, Bell, Ward & Assefi, 2004; Begun, Kattari, McKay, Winter & O'Neill, 2017; Espey, Ogburn & Dorman, 2004). This is supported by previous research, with health care professionals indicating feelings of unpreparedness in providing care once qualified, predominantly due to a lack of training or experience (Paul, Gemzell-Danielsson, Kiggundu, Namugenyi, & Klingberg-Allvin, 2014). Furthermore, additional research has highlighted the importance of comprehensive education throughout training and post-qualification experience for health care providers to be competent (Harries, Stinson & Orner, 2009). Yet, this may not suffice, as the current review highlighted that clinical experiences do not necessarily lead to a change in attitude towards terminations (Bennett, McDonald, Finch, Rennie and Morse, 2018; Buga, 2002; Rosenblatt, Robinson, Larson, & Dobie, 1999). This is supported by previous research by Steinauer, Drey, Lewis, Landy and Learman (2005) who found that medical residents' or registrars' attitudes to terminations did not change following experience at a family medicine clinic.

Espey, Ogburn, Leeman, Nguyen and Gill (2008) investigated attitudes surrounding the inclusion of termination care into core medical training; this was met with support by students with suggestions that termination teaching should become compulsory. It was also highlighted that there are several difficulties in integrating termination care into medical school on a national level such as the political context of the country, hence why termination care is largely covered within medical ethics training. Espey, Ogburn, Leeman, Nguyen and Gill (2008) further added that since termination services are under threat politically and financially, this may also be why termination training is marginalised within medical and nursing schools. If services are under threat from political or funding pressures this may also influence what the university can offer in terms of clinical experiences.

Furthermore, the review has highlighted the importance of medical ethics throughout training (Rodríguez-Calvo, Martínez-Silva, Soto, Concheiro & Muñoz-Barús, 2012). Hanson (2005) emphasised the importance of medical ethics teaching throughout training to support students to develop skills in managing moral conflicts in their clinical training and career. Medical ethics training should ideally be facilitated alongside other health care students such as nurses to encourage inter-professional collaboration and to provide a high quality of patient care. This is supported by previous research which indicated the need for reflective practice for qualified professionals to discuss their attitudes towards practice and monitor burnout (Lipp, 2008). Furthermore, multidisciplinary team (MDT) meetings are effective in promoting professionals to work together to ensure joined up care for the woman, monitor clinical effectiveness and facilitate the sharing of information between services (Taylor et al, 2010). Schwartz rounds may also provide opportunities for different professionals to

develop skills such as communication, therapeutic relationships, teamwork and increased peer support (Lown & Manning, 2010).

The review highlighted differences in willingness to provide future termination care by student social workers, medics and nurses. Social work students were less likely to support women seeking termination care due to perceived lack of training and clinical experience. On the other hand, medical students reported more clinical experience and exposure to termination care over the course of their training with final year students being more permissive in their views. However, some studies found that with increased participation in providing care, medical students were less likely to perform the procedure (Bennett, McDonald, Finch, Rennie, Morse, 2018). This is important as it was highlighted that in the USA there was a decrease in the number of health care professionals willing to provide such services as termination policy is under frequent threat from the government (Foster et al, 2006; Stulberg, Dude, Dahlquist & Curlin, 2011). Additionally, this potentially indicates a more complex relationship in attitude formation than just through exposure and active participation (Fishbein & Ajzen, 1975; Zajonc, 1968). The theory of planned behaviour (Ajzen, 1985) provides a helpful framework predicting an individual's behaviour like providing termination care, which is heavily influenced by the intention to provide the procedure (see figure 2). Intentions to provide care are in turn influenced by attitudes, social norms and acceptability of the behaviour as well as the individual's perceived behavioural control.

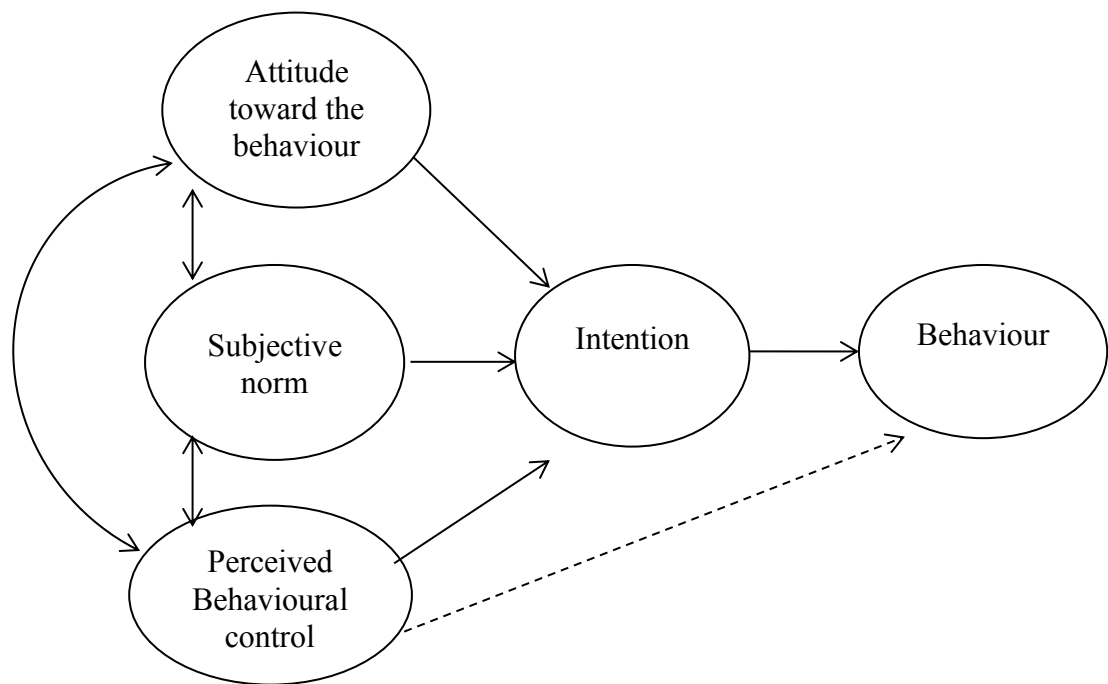


Figure 2: Model of the theory of planned behaviour (Ajzen, 1985)

Applying this to the current review, most studies indicated permissive attitudes towards terminations, with policies and cultural climates of an equally supportive nature. A lack of behavioural control however was highlighted by inadequate training and lack of clinical experiences resulting in diminished intentions to provide care. Improvements in training and more clinical experience could subsequently increase perceived behavioural control, potentially impacting attitudes in becoming more supportive, thus increasing the likelihood of providing care.

Intention to provide care has been researched in other challenging situations such as in palliative care (Wang, Wang & Dong, 2017). Similarly, future health care professionals with more supportive attitudes around death and dying were more likely to provide care once qualified. Other influential factors included perceptions around receiving a good education as well as having personal experience around palliative care.

Strengths and limitations

The methodological quality of the papers included within the review were relatively high. The studies provided good descriptions of participants, sampling, location and outcome measures used. However, the quality measure was slightly adapted for this review, for example, the questions regarding intervention and comparison groups were excluded. There are methodological limitations of the studies used within this review. Most studies used self-developed measures developed specifically for each university, the reliability of said measures are therefore questionable as they are only applicable to the institution they were developed in. There is also a lack of consistency between the studies included and questions asked. However, Yanikkerem et al (2018) proposed that previously established questionnaires are only applicable to the country that they were developed in, so the strength of this approach is that each measure was designed for use in its own cultural context. The majority of the participants in the studies were female. Whilst this did not produce a homogenous sample, it is likely representative of the health sector with a majority of working professionals female (Rodríguez-Calvo, Martínez-Silva, Soto, Concheiro & Muñoz-Barús, 2012).

Furthermore, the studies included within the review spanned 28 years. It is highly likely that training curricula and views around terminations have changed, more so in recent years (Patev, Hood & Hall, 2019). However, similar findings were found across the studies which suggest that little has changed over this period. A clear majority of the studies originate from the USA across a variety of states with different termination policies. If the researchers came from a 'pro-choice stance' this may have influenced their approach to the research. Therefore, considering the international nature of the studies, there may be challenges in applying the results to UK based health care settings, especially as professional roles and responsibilities are likely to be different.

Clinical Implications and Conclusions

The implications of the current review suggest potential changes to the way current training courses deliver termination teaching. For example, courses could ensure that termination training includes relevant policy and procedure. Clinical experience is also important to reduce feelings of uncertainty upon qualification so future health care professionals can feel prepared and competent enough to provide care. Additionally, training programmes could incorporate integrative reflective practice with different health care professionals to encourage self-reflexivity and self-awareness, to consider personal impact on clinical practice (Mann, Gordon & MacLeod, 2009). In palliative care settings, reflective practice has encouraged group working and increased understanding of the impact of a supportive environment to reflect on experience (Bailey & Graham, 2007). The reflection aids practice development and learning to allow the individual to apply what they have learnt into practice (Kolb, 1984). Additionally, reflection can increase professional development and self-awareness (Jayatilleke & Mackie, 2013).

Future research should explore how training can be changed and adapted to ensure that future health care professionals gain the necessary training to provide high quality termination care. Additionally, as research has predominately focused on quantitative data, future research should focus on more qualitative approaches to understand more in depth attitudes and experience of future health care professionals. Theoretical frameworks such as theory of planned behaviour (Ajzen, 1985) would help focus research questions beyond correlations and towards meaningful behaviour change.

The current review conceptualises and integrates current literature on the attitudes of future health care professional towards terminations. The review highlighted factors

that can impact attitudes such as personal characteristics and the influence of policy as well as differences in professional groups. The findings additionally highlight the influence of quality of training, clinical experience and level of perceived participation when providing care in attitude formation. Subsequently, the review highlights directions for future research, such as making changes to the education of future health care professionals, which ultimately ensures women receive a high quality of care.

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Part Two: Empirical Paper

Exploring young women's stories in their decision to end a pregnancy

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Abstract

Background: Previous research has identified some of the factors associated with women's decisions to end a pregnancy, such as moral values and pragmatic reasons. An ecological model framework has been used to identify relevant factors in different areas of the system. This study aims to investigate the narratives that young women construct in their decision to end a pregnancy and identify contextual factors involved in decision making.

Method: The study used a narrative approach to analyse the narratives of six young women at university in their decision making to end a pregnancy. A holistic-form approach was used to analyse the structure of storytelling and a categorical-content approach was adopted to analyse the content of the narratives.

Results: Two different plot themes were found from holistic-form analysis, '*Letting go and moving on*' in which participants emerged from a challenging experience positively, whereas for the '*Making meaning of the fantasy*' theme, participants were overcome by the experience. Four major themes were identified from categorical-content analysis around decision making such as life stage, relationships, perceptions of raising a child and the decision being already made.

Conclusions: The perceived impact of factors such as life stage, relationships and attitudes around being a young mother appear to be more important than the decision to terminate a pregnancy. Future research provides scope to investigate narratives in other contexts, such as the partner and family.

Key words: termination, narrative research, ecological, young women, decision making

Introduction

Since the Abortion Act (1967) approximately 200,000 women a year end a pregnancy in England and Wales (Department of Health, 2019); this Act has provided the legal and medical means of ending a pregnancy. Dramatised stories from Hollywood and mainstream media portray shame, secrecy and political dissonance on the subject of terminations, leaving little encouragement for women to share their personal accounts (Hallgarten, 2018). For some women, while terminating a pregnancy can undeniably be complicated, sharing experiences has proved to be a powerful way to increase public knowledge and awareness in addition to providing a means for women to reflect on their own personal experience (Aléx and Hammarström, 2004).

Many studies investigating decision making in terminating a pregnancy focused on experience. Lie, Robson and May (2008) reviewed qualitative studies and found that the decision to end a pregnancy was predominately a moral choice which was influenced by the perceived impact of pregnancy, raising a child, personal and familial situations. Furthermore, the values of society and the community were influential in the decision making process. The review identified social factors as important facilitators, such as the role of male partners (Elul, Pearlman, Sorhaindo, Simonds & Westhoff, 2000) and talking to female friends (Fielding & Schaff, 2004).

Previous models of health decision making such as Andersen's behavioural model to accessing health care (Andersen, 1995) may not necessarily be appropriate when applied to termination related care, as terminations are accompanied by legal restrictions such as gestational age as well as being a highly stigmatised procedure. Coast, Norris, Moore and Freeman (2018) presented a framework exploring access to termination

services for those seeking care. The framework considers three domains: termination specific experiences, the individual context and the wider context at international and subnational levels. Termination specific experiences relate to the awareness and feelings around the pregnancy as well as disclosure and access to services. Individual context details the woman's characteristics, knowledge and beliefs around termination care. The final domain is the wider context such as the structural and institutional environment (regulatory body or government) and the influence of society or faith institutions in decision making. Whilst this framework provides a comprehensive understanding of factors influencing decision making, it has been constructed based on past literature findings and not developed through interviews with women who have ended a pregnancy.

Purcell (2015) identified wider contextual factors that could influence decision making. For instance, the role of the media in promoting negative undertones about terminations can be stigmatising with a focus on separating society into two groups: pro-life and pro-choice. Similar to Lie, Robson and May (2008), Purcell (2015) found that the decision to end pregnancy is usually influenced but not changed by practical reasons. Moreover, it was posited that research has predominately focused on improving service provision and clinical and cost effectiveness. Whilst this is beneficial, this removes the lived experience and voice of the women who chose to end a pregnancy.

Research has additionally shown the impact of individual characteristics in influencing decision making. Despite government statistics showing an overall gradual decline in numbers of terminations for women under 25, the highest age has remained within the age bracket at approximately 21 years (Department of Health, 2019). From the ages 18-25 years' women face many challenges such as potential independence, seeking a home,

education or employment. This links well with Erikson's (1968) psychosocial development theory from infancy to adulthood characterised by staged crises. From ages 13-21 years young people face the identity vs role confusion crisis and between 21-39 years adults deal with an intimacy vs isolation crisis.

Harden and Ogden (1999) reported that young women aged 16-24 experienced a loss of control following the termination but the decision itself elicited feelings of control and status, despite restrictions and delays from services. The experiences of the termination were mainly positive, with women expressing relief. For women under 21 years old, factors such as perceived maturity, parental views on termination and being a young mother, education and career prospects all greatly influenced decision making process (Lee, Clements, Ingham & Stone, 2004).

Evidently, both moral values and pragmatic reasons such as economic strains and career prospects influence decision making. A common theme is that women are not influenced by one factor. In Ghana, Oduro and Ostin (2014) conducted narrative research with women aged 15-30 years about influences on their termination decisions. To frame their research, Bronfenbrenner's ecological model (1979) was used; this model has been used previously in research around public health and child development (Krug, Dalhberg, Mercy, Zwi & Lozano, 2002).

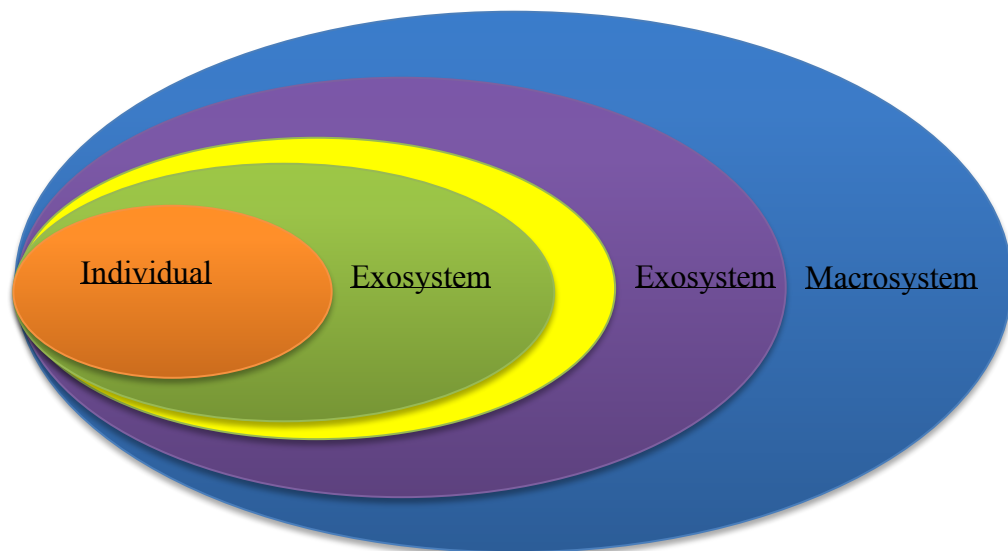


Figure 1: Example of ecological model Bronfenbrenner, (1979)

Bronfenbrenner's ecological model consists of four systems around the individual that interact with, and influence the individual. This model considers both the individual, the microsystem (family and friends), mesosystem (provides a connection between the systems), exosystem (larger social systems) and finally the macrosystem (cultural values, policy and law).

Oduro and Ostin's study (2014) identified the following themes: lack of knowledge around termination law, economic reasons, empowerment and defending moral integrity. Additionally, there were some implied factors such as the views of male partners potentially influencing or controlling the decision of the women. However, a considerable limitation was that recruitment for the study was hindered by societal stigma and shame surrounding terminations within Ghanaian society. This additionally highlights the influence of the societies' and the wider systems' view of terminations, which may subsequently impact the woman's inclination to talk about their decision to end the pregnancy. This may be different for cultures which have a more open view of terminations such as the UK. Finally, the Ghanaian study shows how Bronfenbrenner's ecological model has a good basis within termination research.

Aims and rationale for proposed study

The principal aim of this study is to investigate the narratives constructed in young women's decision to end a pregnancy. In addition to identifying factors involved in young women's decision making process of ending a pregnancy, drawing on Bronfenbrenner's ecological model to highlight contextual factors in an individual's system. Existing research has highlighted some of the factors associated with decision making, such as the influence of both moral values and pragmatic reasons. An ecological model can be used to frame the research, providing a visual representation of influential factors that is easily accessible to not only professionals but also to women who are either in the process of considering a termination or who already ended a pregnancy. This study is the first to explore the narratives of young women in their decision to end a pregnancy drawing upon an ecological perspective in the UK, considering contextual factors and wider systems around the woman. A narrative approach provides a platform for women to give voice to their stories within a confidential, non-judgemental setting in addition to providing insight to the way in which narratives are told as well as their content. From a clinical perspective, the findings may also encourage sexual health services and clinicians to gain a deeper understanding and appreciation around factors involved in decision making in turn influencing their clinical practice. Additionally, the findings of this research will build upon the existing body of literature and research within this area. Therefore, the research questions are:

1. What narratives do young women construct concerning their decision to end a pregnancy?
2. What contextual factors influence the decision-making narrative?

Method

Design

A qualitative design with semi-structured interviews was used with young women between the ages of 18-25 years to explore stories constructed and factors involved in decision making when ending a pregnancy. From the interviews, participants identified as being aged between 21-25, the interviews occurred 2-5 years post-termination. However, in order to protect participant anonymity, demographic data was not collected.

Recruitment

After ethical approval was acquired from the University of Hull Faculty of Health Sciences (Appendix F), the study was advertised in the University through posters (Appendix G), email (Appendix H), student lectures (Appendix I), student societies (Appendix J) and by word of mouth. It was also advertised through social media Twitter page. Potential participants could access a website (Appendix K) via a link or a QR code which contained further information about the study, the participant information (Appendix L) sheet, contact details of services and charities (Appendix M) as well as the details of the research team. Multiple approaches to recruitment were used due to significant challenges in recruiting participants. Once potential participants identified themselves an email was sent containing more information about the study. The inclusion criteria consisted of:

- Women currently aged between 18-25 years, women within this age range due to the highest number of terminations occurring below 25 years and the challenges that young people face as an emerging adult. For example, potential homelessness, further education and employment.

- Women who had experienced a medical or surgical termination in this age range. It was important for the women still to be in this age range as stories are likely to change if told from a different life stage (Avalos, 1999)
- Women who were students in higher education, due to the emotive nature of the research, recruiting university students meant that if they wished to seek further support this could be facilitated by the University well-being service who were supporting the study.

The exclusion criteria included:

- Women who had ended a pregnancy after 24 weeks as terminations post 24 weeks can only be carried out if there is significant risk to the mother's life or the foetus's development is severely effected
- Women who have had a forced or illegal termination
- Women who did not speak English

In total, recruitment took place from December 2018 to July 2019. Nine potential participants contacted the researcher, however one participant did not meet the criteria and two others ceased contact. Overall, six young women who met the inclusion criteria took part in the study. One participant was recruited through email, two participants were recruited as a result of talking about the study in lectures and remaining participants were recruited from social media. The participants were all women aged between 18-25 years and were either undergraduate or postgraduate students from four different universities in England. The sample size of six was deemed sufficient and appropriate for narrative analysis as the richness and quality of the data is more important than quantity (Lieblich, Tuval-Mashiach & Zilber, 1998; Josselson, 2011).

Data collection

As the study used a narrative approach, a non-directive style was taken to interviews. This was to prevent closed questions from being asked that would affect the story. From a narrative perspective, stories can be influenced by the setting in which they were obtained as stories largely reflect the internal world of the individual including their social environment (Josselson, 2011). Therefore, a statement was read to each participant before they told their story:

“I’d like to ask you about your story of deciding to end a pregnancy. I’d like you to think of the entire experience as a story. Start where you wish. After you have told your story, I may pick up points for clarification.”

The purpose of the statement was to help participants orientate themselves to share their story of ending a pregnancy as past research has highlighted that participants may find it difficult to construct stories (De Casterlé, Gastmans, Bryon & Denier, 2012). Once the participant came to the end of their story, further explorative questions were asked to bring about any further information around their story or to clarify parts of the story.

Procedure

At the interview, the inclusion and exclusion criteria were read again to ensure participants were appropriate for the study. The purpose of the interview was again repeated and written consent for audio recording for the interview was obtained for all participants (Appendix N). The participants were given a copy of the information sheet as well as contact details of charities and services, should they require these after the interview. Interviews were either conducted on university campus or via Skype video call. Following the interviews, the primary researcher made notes detailing any emotive and prominent points in the story.

Analysis

Narrative analysis was conducted following a model comprised of a four cell design (figure 2) as suggested by Lieblich, Tuval-Mashiach and Zilber (1998). To answer research questions, it is suggested that a mixture of the cells are used (Lieblich, Tuval-Mashiach & Zilber, 1998). Therefore, a holistic-form approach was used to analyse the structure or telling of the stories (Gergen & Gergen, 1988; Lieblich, Tuval-Mashiach & Zilber, 1998) and a categorical-content approach to analyse the content of the narratives. All participants were assigned a pseudonym using a random name generator.

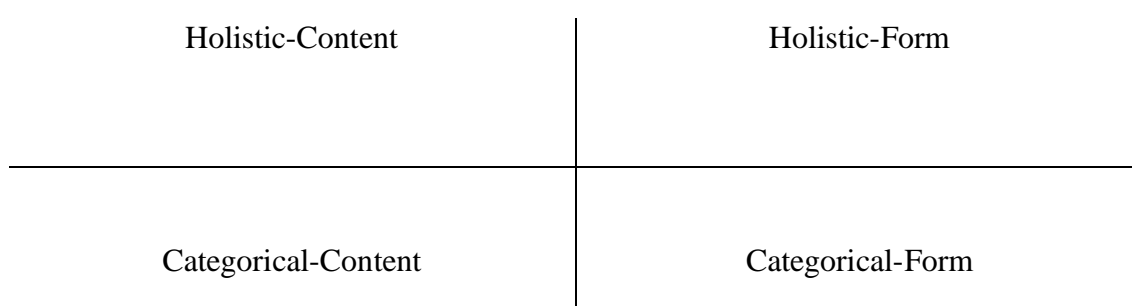


Figure 2: Lieblich, Tuval-Mashiach and Zilber (1998) analysis cell design

Holistic Form

Holistic form analysis was used following the Lieblich, Tuval-Mashiach and Zilber (1998) model to understand the structure of the narratives (how they were told). The recordings were transcribed verbatim then read and listened to numerous times to understand the emotion, tone, themes, events and general expression of the narrative, to develop the plot axis for each narrative. To develop the plot axis, a guide by Gergen and Gergen (1988) was used. This is characterised by several stages such as, understanding how the narrative develops from the beginning to the end point, choosing events that lead to the end point, re-writing events in chronological sequence, developing causal links and demarcation signs.

Furthermore, the next stage of analysis consists of identifying the form of the narratives through understanding the dynamics of the story. Frye (1957) identified four plot forms of stories; romance, tragedy, comedy and satire. Therefore, the plot forms could be given a plot theme (name) and individual graphs were constructed for each story. The construction of the graphs was also based on certain events and reflections from the interviews such as changes in emotion (Gergen & Gergen, 1988; Lieblich, Tuval-Mashiach & Zilber, 1998). Finally, the graphs for the six narratives were compared to assess any common themes between, the similar graphs subsequently combined together to create a prototypical graph (Lieblich, Tuval-Mashiach & Zilber, 1998).

Categorical content

Categorical content analysis was used to determine major and minor categories from the narrative around decision making. The categorical content analysis procedure from Lieblich, Tuval-Mashiach and Zilber (1998) was used to determine categories. Firstly, relevant text was selected from the transcripts however, as the interview question directly asked about the story of decision making when ending a pregnancy the entire transcript was included in the content analysis. Categories were then defined by selecting principal (meaningful) sentences from the transcripts, which were also read to determine minor categories which could label each primary sentence, using an inductive approach (Elo & Kyngäs, 2008). Additionally, the identified text was then sorted into major categories for example; the principle sentences were grouped together if they shared similar content with minor categories. Lastly, major categories were identified using the principle sentences, the frequency of principal sentences in each major theme to represent the content of the stories (Lieblich, Tuval-Mashiach & Zilber, 1998).

Researcher influence

The primary researcher (AKB) was a 25 year old White-British, female trainee clinical psychologist who had no experience in reproductive health but was, however, supportive of terminations. Due to the potential emotive nature of the research, the primary research had regular research supervision with two qualified clinical psychologists with extensive research experience and attended reflective practice group with fellow trainee clinical psychologists. Self-reflexivity is an important aspect of qualitative research, researchers are encouraged to become aware of their own biases and why they have chosen the research topic (Tracy, 2010)

Results

The duration of the interviews ranged from 10 to 22 minutes and all stories were told in a linear pattern with no fluctuations in the telling of the story. The total minutes of data collected was 91 minutes and average interview duration was 15.17 minutes.

Holistic analysis of form

Plot Axis

The narratives were first understood as a whole to create a prototypical phase for story progression, the events in the stories were in relation to the young women's decisions to end a pregnancy. In total, two Plot Themes were identified; '*moving on and letting go*', and '*making meaning of the fantasy*'.

Three of the stories presented with a plot axis of '*letting go and moving on*'. The events within these stories described participants starting positively but then progressing through difficulties yet emerging with a sense of moving on.

The remaining three stories presented with a plot axis of '*making meaning of the fantasy*'. The title of this plot axis was derived from one of the interviews meaning that the relationship with the partner did not live up to the perceived hopes of the participants ultimately, viewing their experience in the relationship as a fantasy. The events in these stories were initially similar however towards the end of the stories, events were centred around the young women feeling overcome by the decision and its impact on the relationship with her partner and family.

Comparing Plots

Letting go and moving on

Three plots were consistent with a narrative plot of ‘romance’ from Frye (1957), these narratives are characterised by the individual facing certain challenges and difficulties which they eventually overcome. There were a total of six phases, with phases being defined as particular events, emotions or acts which changes events throughout the narrative. Figure 3 shows the phases for *letting go and moving on*, see Appendix O for the phase table.

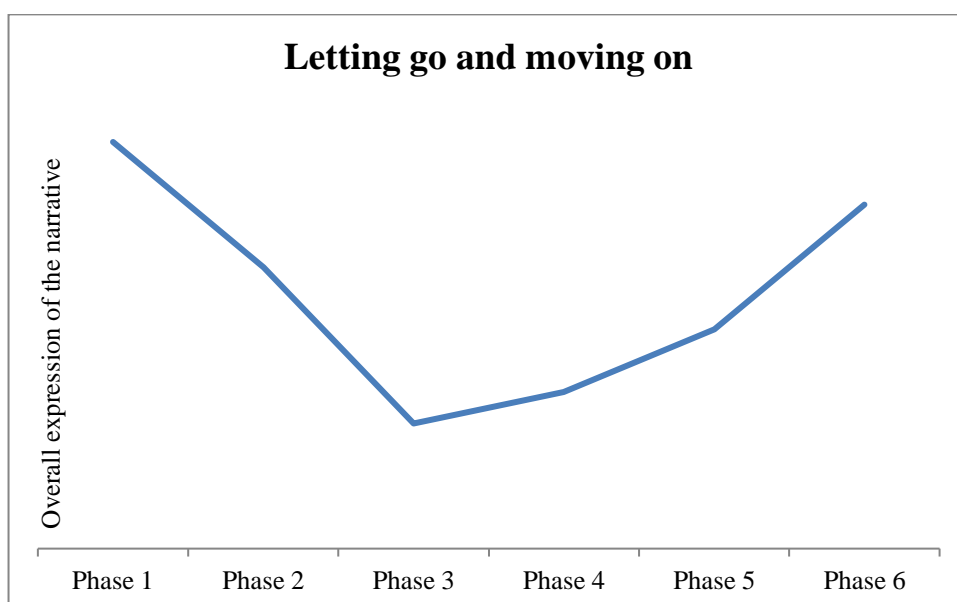


Figure 3: Phases of ‘*Letting go and moving on*’

Making meaning of the fantasy

The three remaining plots were consistent with the narrative plot of ‘tragedy’ (Frye, 1957), this is characterised by the individual facing challenges and difficulties which they do not overcome. Again, there were a total of six phases. Figure 4 shows the phases for ‘*making meaning of the fantasy*’, see Appendix P for the phase table.

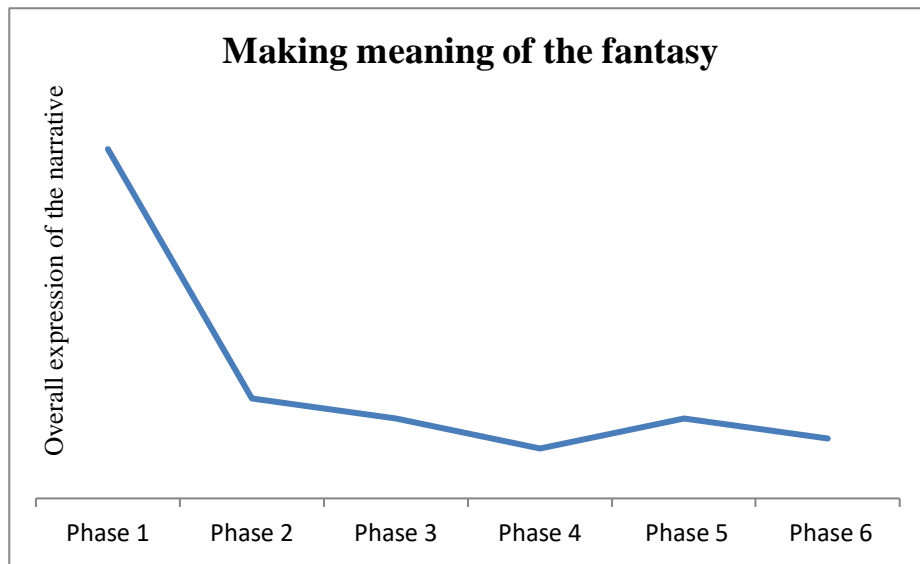


Figure 4: Phases of ‘*Making meaning of the fantasy*’

Phases of the decision

The initial phases for pre-decision (phases 1-3) were the same for both plot axes.

Pre-decision (phases 1-3)

Phase 1- The relationship

The first phase was characterised by the participants providing information around the context of their relationship with their partner or family. Both groups described these relationships as initially positive;

‘I was with my boyfriend um, who was my first boyfriend, it was like one of those intense, like I’m so in love sort of relationships’ (Naomi, page 1, 6-8)

Some of the participants talked about their hopes and dreams for the future that they had with their partner;

‘so umm I’ve been with my boyfriend for 2 years at the time and we had talked about silly things like when we would get married and like how many children we wanted and

what jobs we would have, just like umm utopian rainbow stuff you know' (Melissa page 1, 8-9)

Phase 2- Knowing

This second phase was characterised by the participants describing a feeling of knowing that they were pregnant which was later confirmed through a pregnancy test. Here, emotions changed, with the participants experiencing feelings of disbelief, and problems began to emerge.

'I remember that just one morning I started being sick, and I'm never sick like ever, I just felt awful. Umm then I just kind of knew and didn't want to believe it' (Victoria, page 2, 36-38)

One participant experienced a moment of realisation of knowing that she was pregnant. *'umm and I was at work one morning and I ended up throwing up after I'd eaten a banana or something and something clicked'* (Sophie, page 1, 14-15)

Phase 3- Telling

The telling phase detailed the participants telling or, in one case, not telling their partner about the pregnancy. This was a very challenging time for the participants with a distinct shift in emotion to more negative feelings such as shame and a responsibility to tell.

'Then I found out I was pregnant on Christmas eve umm went out for tea with him, didn't tell him, didn't tell him for days, must have been about a week before I told him' (Lorna, page 1, 10-12)

One participant described their experience of not telling anyone about their pregnancy, with an expectation that their partner's reaction to the pregnancy would be negative and associated telling their family with feelings of shame.

'The first thing I did was hide the test away from my family, I really didn't want them to know, I just really didn't, not even my sisters and I tell, I tell my sisters everything...I really wanted to tell him but part of me was so angry with him and just didn't even know how to tell him, I knew what his reaction would be'. (Victoria, page 2, 43-49)

The decision (phase 4)

Phase 4- The decision

The decision phase was characterised by the participants making the decision to end the pregnancy. For the participants in the '*Moving on and letting go*' plot axis, the decision felt more natural and less challenging than telling their partner.

'I felt like for me it was an easy decision to make at the time, I was just so focused on getting through my [subject] but it's like now since I've done my [subject] I reflect on it a lot but then still I now know it was the right decision'

(Lorna, page 2- 3, 63-65)

However, for some participants in the '*Making meaning of the fantasy*' plot axis, this was a very challenging and emotional time. One participant talked about experiencing feelings of loneliness in their decision, especially as they perceived their partner as lacking in the 'right' support.

'I found it a lot more lonely than I was expecting to because even though it was me and my boyfriend making this decision err decision together umm he umm he was very supportive and he you know was trying to do the right things and saying like it's your

body and it's your choice and all these things but it made me almost angry, it took both of us to make this happen but I'm the only one that experiencing all of these all of the guilt and all the negativity' (Sophie, page 2, 33-37)

Post-decision (5-6)

Phase 5- The clinic

The clinic phase was characterised by the participants going to the clinic to end the pregnancy. For people telling the '*moving on and letting go*' story, this was a more positive experience; services were supportive, and in one case, the participant's partner attended the clinic with them, resulting in an overall positive experience.

'the nurses were just so lovely, my umm my boyfriend came with me and they supported him just as much as me which I wasn't expecting, I was just so thankful you know for them [nurses] not being judgemental or anything' (Melissa, page 3, 67-68)

Women telling the '*making meaning of the fantasy*' story found clinical experiences difficult. For example, one participant described their experience at the clinic as if they did not belong there.

'I remember being sat there with um like people screaming people in handcuffs in this sex clinic it was just, I was like wow I don't belong here my college is across the road that's where I should be not here um I just remember feeling so guilty like I've done this to myself, I was on my own he did not come with me obviously because he didn't' (Naomi, page 5, 134-138)

Phase 6- Moving on and letting go

In this group, participants reflected on how they felt they had made the made right decision at the time. The participants then subsequently described how they were able to move on from the experience.

‘when I reflect on it I’m like oh god I could have had that now I want it but actually at the time and even now I look back on it and think it was genuinely the right decision for me’ (Maria page 3, 69-71)

Phase 6- Making meaning of the fantasy

For the ‘*Making meaning of the fantasy*’ group, there was a sense of loneliness and sadness with the participants overcome by the experience and its impact upon their relationship with their partner.

‘I still kept the pregnancy test because I wanted to prove that our relationship actually meant something, together we created this thing, it was our, just the two of us but then it was all down to me to end it, I was so alone. I still feel upset about everything around it’. (Victoria page 8, 191-199)

Categorical Content

Categorical content analysis was used to establish major and minor categories around the decision to end the pregnancy from the narratives. Table 1 outlines the major and minor categories.

Major Categories	Minor Categories	Number of primary sentences in major category
Life stage	Age	43
	It wasn't part of the plan	22
Relationships	Partner	52
	Family	28
	Community	7
Perceptions around raising a child	Being a young mum	16
	Providing perfect care	11
The decision	It was already made	39

Table 1: Major and minor categories

Life stage

Participants discussed elements of their life stage that were important factors in the decision to end their pregnancy.

Age

Many participants described their age as one of the predominant reasons for ending the pregnancy. For example, one participant said;

'I think my age was a really big one umm I didn't feel like I was an adult myself. I had so many aspirations of what I wanted to do with my life' (Maria, page 3, 73-74)

Age was also talked about in relation to their own perceptions about not having a child and not feeling like an adult;

'you know just massively freaking out I was 20 and not at all ready to be a mother umm I hadn't even, I still haven't decided if I ever want children' (Sophie, page 2, 48-49)

It wasn't part of the plan

This minor category detailed participants' plans and aspirations for the future in which having a child was not part of the plan, for example,

'I just sort of thought, I always had this plan to go to uni, originally I wanted to do [subject] and knew what I wanted to do that had always been my goal' (Maria, page 2, 35-37)

Some participants believed that having a child would mean that they would not be able to fulfil their dreams for the future and that having a child would set them back.

'I was going to go to uni and I was going to study [subject] and that was my dream and that this would have just cut my life in half I would have just had to start all over again' (Naomi, page 8, 220-222)

Relationships

Participants additionally talked about the relationship with their partner, family and community in relation to making the decision to end the pregnancy.

Partner

Some participants spoke about how their male partners were not supportive in the right way resulting in feelings of loneliness and anger throughout the decision.

'I found it a lot more lonely than I was expecting to because even though it was me and my boyfriend making this decision err decision together umm he umm he was very supportive and he you know was trying to do the right things and saying like it's your body and it's your choice and all these things but it made me almost angry, it took both of us to make this happen but I'm the only one that experiencing all of these all of the guilt and all the negativity and all these things' (Sophie, page 2, 33-37)

Another participant indicated that their partner was not supportive of continuing with the pregnancy and that he was invalidating of the participant's feelings around the pregnancy.

'what I do remember is [partner] being 'well you have to, you have to get rid of it, you have to have a termination because you have to have an abortion' I think he said 'because I can't deal with this, if I tell my dad I'm going to have to move out he's going to kick me out onto the street, this is what's going to happen to me' I was just like it's not, it's not really happening to you, you can walk away from this, I'm I'm stuck with this, its inside me, I'm, I can't run away from this and you can so it's not happening to you umm that argument must have lasted hours' (Naomi, page 4, 104-110)

However, some participants spoke about how their partner was involved and supportive throughout the decision process resulting in a calmer experience and healthier relationship.

'My boyfriend was so supportive, he was really great in being there for me and helping me with the err decision and going to the clinic. He just was there, we felt like a proper couple' (Melissa, page 1, 13-14)

Family

Participants described hiding the pregnancy and decision to end the pregnancy from their family because of the perceived fear, embarrassment and shame.

'I didn't want to have to tell my parents because I found it quite embarrassing that I'd been caught pregnant and didn't like want to have the conversations with my mum or dad or anybody or my sister about it so think it was more like embarrassment really, probably' (Lorna, page 2, 47- 49)

One participant talked about how her difficult relationship with her mum meant that she was unable to discuss the pregnancy and decision with her.

'I'm not very close with my mum so we didn't sort of have that conversation and to me it just never crossed my mind to speak to her about it, it's just not something I would ever do um' (Naomi, page 1, 14-16)

Community

There were additional factors from community groups that also influenced decision making. For example, one participant discussed how their university experience would have been affected if they had a child.

'my uni experience would not have been the same I feel like I might have been secluded from my friends a little bit' (Maria, page 3, 75-76)

Furthermore, one participant talked about perceived rejection from their religious community if they had the child or informed others of the termination.

'there was no way could of told anyone back home or even had the baby, it would have got back to my family then I would have been thrown out from my church and, and neighbourhood. I just find it really hard that they have these beliefs around abortions

and they umm don't even know that I've been in that position as their daughter, they would probably think I'm going to hell' (Victoria, page 9, 266-270)

Perceptions around raising a child

Many participants discussed their feelings on being a young mother in relation to previous interactions with young mothers as well as their perceived ability to provide care for a child.

Being a young mother

Some participants talked about the stigma of being a young mother in context of their own experiences.

'I didn't want to be one of those girls pushing a pram around with a baby and I know it sounds so harsh and judgey but I just wanted to make something of myself' (Victoria, page 2, 43-45)

One participant discussed her view that being a young mother would affect her future aspirations and that having a baby would hinder those aspirations.

'The, the kids that have babies at 18 were like, I'd hate to be so judgemental and stereotypical but they were like, the kids that never went to college and got grades or anything, it was those kind of people, that, that had babies at that age and I was, I was not like that I was, I was going to go to uni, I was going to do things' (Naomi, page 4, 123-126)

Being able to provide perfect care

Some participants talked about being unable to provide perceived perfect care for the child.

'just I would not be able to give this child what it needs, I was not ready like at all, I didn't have a steady income I didn't have somewhere to live and then there was another side of it you know me just panicking' (Melissa, page 2, 52-54)

One participant perceived that partly because they would not be able to provide the same upbringing for the child as they had for themselves they should end the pregnancy.

'I sort of in a weird way thought it was a selfish sort of decision because I just sort thought the circumstance that I am in right now is not fair to bring another human being into it because I had an amazing childhood and want to give that to my kids and I couldn't have done that at that it would have been really difficult for everybody involved' (Maria, page 4, 100-103)

The decision

It was already made

For some of the participants, the decision to end the pregnancy was already made and felt like an intrinsic decision, for example:

'it was just something I knew I would not be able to continue with the pregnancy it was just, I knew I couldn't do it so it wasn't really a struggle, the struggle with it, the decision was more having to inform my boyfriend of how I felt because he wasn't on the same page straight away so that was probably the hardest bit' (Lorna, page 2, 38- 41)

One participant felt that the decision to end the pregnancy was made outside her control by those in her system such as family members, partner and college.

'I felt like the decision was already made for me before I had to make it, by myself I would have never have had a baby, by my family, by what people at my college might think, by my boyfriend, I just feel like the decision was made, like like this is something

that I have dreamed of, having my partners baby and I really wanted that but I really wanted to get rid of it' (Naomi, page 7, 204-209)

Discussion

This study aimed to explore the narratives concerning young women's decision to end a pregnancy as well as the contextual factors influencing the decision making. The plot axes for the narratives reflected events both before and after the decision for all participants with the difference in the plots occurring in the post-telling phases for the two groups, resulting in plot themes of '*letting go and moving on*' and '*making meaning of the fantasy*'. The four major categories that emerged in the current study support previous research suggesting the impact of young women's life stage, relationships with their partner and family as well as being a young mother are integral factors regarding decision making in terminations. Furthermore, the use of Bronfenbrenner's ecological model provides visual representation of the categories in the participant's systems, demonstrating their interaction (see figure 5). Oduro and Ostin (2014) found that availability of services and poor knowledge impacted on decision making. Though the findings of the current study are different from Oduro and Ostin (2014), this is likely due to cultural and political differences around termination legality and societal acceptance in different countries. However, both studies found that feelings of embarrassment about becoming pregnant and fear of parental reactions influenced decision making.

The categories that emerged can be viewed in context with the ecological model (Bronfenbrenner, 1979). On an individual level, the life stage of the young woman such as age and aspirations, the decision being already made and perceptions around raising a child were the most influential factors. For the microsystem, relationships with the partner or family and community were the most significant factors. There were no factors identified for the exosystem by the participants. Finally, for society or the

macro system, perceptions around being a mother such as stereotypes of being a young mother and societal expectations of what a young person would be achieving.

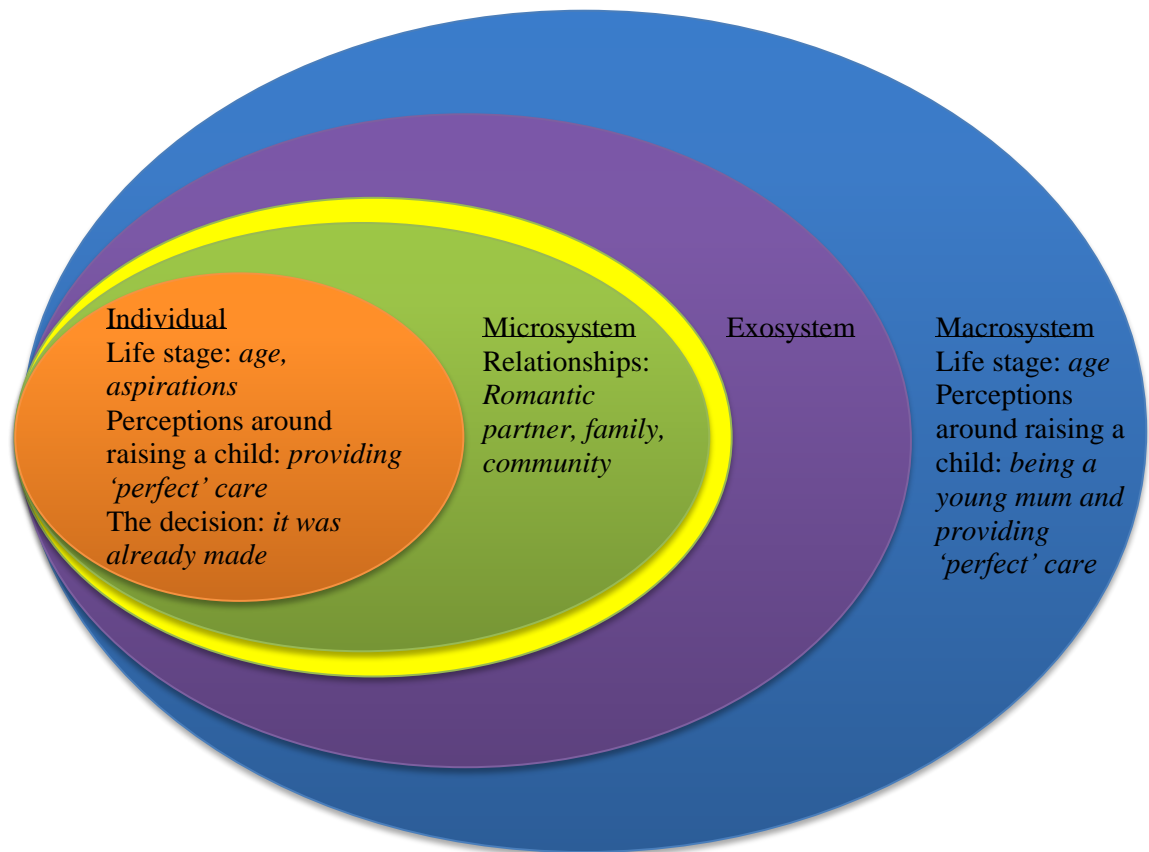


Figure 5: Major categories found in context of the ecological model (Bronfenbrenner, 1979)

The current study found that deciding to end a pregnancy is heavily influenced by the perceived impact on young women's current life stage, relationships and impact of being a young mother. Interestingly, this suggests that the woman intended to end the pregnancy once she knew that she was pregnant. The perception that the participant's life stage, specially their future dreams and aspirations, would be affected if the pregnancy was continued was a core finding of the study. This is similar to previous research investigating the experiences of adolescent mothers and terminations, suggesting that adolescent girls had established long term future goals based on education and career prospects prior to becoming pregnant (Halldén, Christensson &

Olsson, 2005; Brazzell & Acock, 1988). These long term goals ultimately became one of the reasons to end pregnancies as having a child would restrict these dreams.

Research investigating adolescent girls' decisions to continue or end a pregnancy found that those who chose to end the pregnancy did so to safeguard their aspirations, demonstrating more internal control (Bell, Glover & Alexander, 2014). However, the construction of future goals was only one aspect of decision making. Bell, Glover and Alexander (2014) additionally found that adolescent girls who ended their pregnancy were influenced by societal discourses around being a young mother and tended to distance themselves from similarly aged peers who were pregnant.

Negative perceptions around being a young mother were also reported by the participants as part of reason for ending the pregnancy. There are challenges of being a parent at any age, however, society widely portrays young mothers negatively, labelling women as irresponsible and immature (Smith Battle, 2013). As such, young mothers are susceptible to stigma and negative discourse as they have strayed from the model expectations of motherhood (Yardley, 2008). As a result of this stigma, young mothers are more likely to experience different treatment by the public and clinicians as well as perceiving themselves as unfit parents (Gregson, 2010; Fessler, 2008; Haynes-Lawrence, 2008). The perceived impact of being a young mother by the participants proved to be powerful in their decision to end the pregnancy which is likely due to societal discourses around being a young mother. This demonstrates again the utility of the Bronfenbrenner model (1979) in thinking about women considering pregnancy termination.

Furthermore, participants talked about the perceived impact of having a child on the relationship with their partner and family. Some participants reported feelings of

loneliness throughout the decision process due to their partners either not being supportive in the way they needed or reacting to women's feelings in invalidating ways. Research has indicated that young women are more likely to end a pregnancy if the future of the relationship with their partner was uncertain or if the relationship was in its early stages (Ekstrand, Tyden, Darj & Larsson, 2009). This is interesting because all participants discussed elements of the relationship with their partner and family throughout their stories; for some participants the decision to end the pregnancy led them to terminate the relationship. Additionally, the perceived influence of partners and family members in the women's decision to end the pregnancy is largely underestimated as older family members and male partners are likely to have more power in society and therefore influence within the decision (Ekstrand, Tyden, Darj & Larsson, 2009). Chiweshe, Mavuso and Mcleod (2017) identified a potential lack of autonomy by women in the decision to end a pregnancy. Some participants identified as being lonely in the decision as their partners were not supportive in ways that would facilitate a collaborative decision. Some of the male partners reportedly talked about the decision being their partner's choice as it was 'their body'; however generously this might have been intended, participants felt it served to put significant pressure on them to make the decision. This can be viewed as a reflection of traditional gender stereotypes rather than emancipation from them. For example, a women's role to carry a child versus the power that a male partner has. Male partners have a greater level of power within society, especially as they have the opportunity to not be involved in the decision or pregnancy (Chiweshe, Mavuso & Mcleod, 2017).

Additionally, there was a notable sense of shame and embarrassment from the participants in the telling and decision phases of their stories. Some participants talked about feelings of shame in becoming pregnant as well as having to end a pregnancy

(which in some cases, resulted in the participants not informing others of their decision), experiencing loneliness and fear of rejection from others. The presence of guilt and hiding the decision away from others has been reported before (Lie, Robson & May, 2008). Yet, the impact of stigma could be playing a crucial role. Goffman (1963) originally defined stigma as being labelled as different due to possessing an attribute which viewed as discrediting. Kumar, Hessini and Mitchell (2009) posited that women who ended a pregnancy challenge societal assumptions on being a woman thus eliciting potential feelings of shame. Further research identified social costs for women who have ended a pregnancy for example, being labelled as unmarried or considered incapable of being a mother (Tagoe-Darko, 2013). The acknowledgment of social stigma additionally led to feelings of fear, shame and embarrassment resulting in decreased communication with family members. This was due to perceptions around being rejected from parents resulting in increased concealment of the decision which increased the probability of the young woman ending the pregnancy (Tagoe-Darko, 2013).

Shame and embarrassment has also played a role in other areas of sexual health such as HIV and contraceptive research. Many individuals who had received a recent diagnosis of HIV or sexually transmitted infection experienced a fear of family and friends being informed about the diagnosis and were anxious about the perceived impact upon their religious community. Additionally, embarrassment was a barrier in accessing services (Thatte, Bingenheimer, Ndiaye & Rimal, 2016). This is significant as feelings of embarrassment and shame may prevent individuals such as women seeking termination care from accessing vital services and support.

Although research has suggested that the decision to conceal the pregnancy and termination are in part due to shame or perceived negative reaction from the partner or family. Alternative, research has suggested that women who decide not to share details of their pregnancy and termination may decide to do so to avoid being ‘othered’ by individuals in their social system. This however may be dependent on the culture’s acceptability of termination (Chiweshe, Mavuso and Mcleod (2017). Additionally, not all participants felt shame and embarrassment around their decision to end the pregnancy. Feminism provides an emancipatory perspective towards reproductive rights, aiming to increase awareness and knowledge to women who are disadvantaged or marginalised within society (Noel, 2016). The feminist movement emphasises the importance of women’s lived experiences (Ropers-Huilman, 2003), encouraging women to reflect and share their own stories to feel empowered (Aléx and Hammarström, 2004). This chimes with the current study as after the interviews many participants expressed their gratitude for the chance to share their story.

The duration of the interviews for all participants was relatively short, ranging between 10 and 21 minutes. Arguably, the nature of narrative interviews in sensitive research is such that the participant controls the information they wish to include and exclude as well as regulating the amount of detail to disclose (Corbin & Morse, 2003). However, participants are aware that although their personal details will remain anonymous, elements of their story will still be shared publically. Additionally, those who have not shared their story in full before may become nervous in the interview or may still be making sense of events themselves (Corbin & Morse, 2003). This may have therefore influenced the amount of information shared, affecting the interview times. As previously discussed, the role of stigma around this research topic may have contributed to short interview times and challenges within recruitment. Research suggests that as a

result of termination stigma women are expected to conceal the termination. For example, Shellenberg (2010) found that two thirds of women would not share information around their termination experience due to perceived expected stigma. Ultimately, termination stigma resulting in concealment perpetuates judgemental attitudes due to a lack of stories being shared to help change attitudes.

Limitations

There are several limitations of the current study. As the recruitment strategy required participants to contact the researcher following information about the study from a lecture, email, social media message or poster, this may have led to a potential bias as the study only captured the narratives of those willing to share their stories. This being said, the sample size of the study was also small thus questioning generalisability of the results. However, the intention of narrative analysis is not to necessarily create representative data (Josselson, 2011); in fact, all of the narratives collected had similar experiences between the participants. The impact of stigma and sharing potentially emotive stories may have affected recruitment and acted as a barrier in taking part in the research. Lastly, the qualitative approach taken may have also been a limitation of the research. Narrative research predominately uses unstructured interviews with limited follow up questions. This lack of structure may have led participants to withhold or overlook information (Corbin & Morse, 2003). A considerable strength of the research was its ability to provide a safe platform for women to share their stories, adding to an under researched area. Another strength was the use of social media to promote the research in a positive manner to facilitate recruitment, particularly as social media has served as an important platform for fourth wave feminism and the sharing of experiences (Munro, 2013).

Future Research, Clinical Implications and Conclusions

An important finding of the study is how the perceived impact of factors such as life stage, relationships and attitudes around being a young mother appear to more important than the decision itself. Future research could be important in determining whether these views are reinforced on a societal level or are perceptions of the age group of women at university. Furthermore, it may also be interesting to investigate the contextual factors involved in decision making from the perspective of a different age group and whether different contextual factors emerge from of a university and ageing perspective.

Furthermore, as partners and family members had an impact on the participant's decision to end the pregnancy, it would be beneficial to explore narratives constructed from their perspective. The length of the interviews and challenges throughout recruitment was another interesting part of the research and future studies should be aware of such difficulties. Additionally, there are implications for clinical services and practice. For example, it may be beneficial for specialist services during consultations or even reflective practice groups to be aware of the how challenging deciding to end a pregnancy can be for young women in addition to the influential factors involved in decision making. Especially, the underestimated role in which partners and family play within decision making. Within mental health settings, clinician may also be encouraged to ask about a client's termination experience if mentioned this during the assessments.

This study has highlighted the narratives that young women construct when ending a pregnancy. Contextual factors that influenced decision making included life stage, relationships and perceptions around becoming a mother. Relating this to the ecological framework, young women are likely to be affected by a variety of intrapersonal, interpersonal and societal factors. The young women were either able to move on from the experience or felt overcome by it. The limited role that decision making has when

ending pregnancy has also been uncovered. In fact, the research indicated that the women had more often than not decided they were going to end the pregnancy due to the perceived impact of factors such as life stage, relationships and being a young mother. Previous research has demonstrated the role of stigma around terminations and being a young mother in adolescent and young mothers. These findings have implications on future research in exploring narratives from different age groups as well as further investigated the extent of family and friends impact on a women's decision to end a pregnancy.

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Part three: Appendices

Appendix A: Author guidelines for journal of Sexual and Reproductive Health Matters

Instructions for authors

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal's requirements. For general guidance on the publication process at Taylor & Francis please visit our Author Services website.

This journal uses Editorial Manager to peer review manuscript submissions. Please read the guide for Editorial Manager authors before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

This journal utilises format-free submission. Authors may submit their paper in any scholarly format or layout. References can be in any style or format, so long as a consistent scholarly citation format is applied. For more detail see the format-free submission section below.

New title: Citing articles in this journal

The change of name for the journal to '*Sexual and Reproductive Health Matters*' took effect from 2019. To reference journal articles, cite the journal name that was used at the time of publication:

- Articles published in 2018 and before should be cited as '*Reproductive Health Matters*', or '*Reprod Health Matters*' (standard journal abbreviated title)
- Articles published in 2019 onwards should be cited as '*Sexual and Reproductive Health Matters*', or '*Sex Reprod Health Matters*' (standard journal abbreviated title)

Editorial policy

Sexual and Reproductive Health Matters welcomes contributions by authors from all parts of the world. Our overall mission is to enhance, share and use knowledge and evidence for the advancement of sexual and reproductive health and rights. The journal proactively seeks articles from multiple disciplines, on current and emerging issues globally, and which explore neglected and marginalised issues across the breadth of sexual and reproductive health and rights. We aim to ensure that rigorous evidence and rights based analysis is used to inform advocacy, policy and practice, and that articles bring together the diversity of voices and perspectives from around the world, with emphasis on those working at grassroots level and in resource-limited environments.

Article publishing charges and waivers policy

The journal will not make Article Publishing Charges (APCs) for submissions to the themed issues in 2019. Please see the current Call for Papers for the upcoming themed issue.

When submitting to the current call for papers on Universal Health Coverage: Sexual and Reproductive Rights in Focus, please quote waiver code ZRHM-2019-UHC.

An APC of €1700/\$1921/£1479 is charged for all other articles exceeding three typeset pages in length, irrespective of submission type, including articles for the annual Open Issue. Depending on your location, these charges may be subject to local taxes. Waivers apply in some circumstances, including for authors in countries classified by the World Bank as low income (100% discount) and lower-middle income (50% discount) (see ‘discounts and waivers for researchers in developing countries’ <https://authorservices.taylorandfrancis.com/publishing-open-access/#funding>). **Authors will need to make an application for waivers at first submission. If you have any questions, please contact apc@tandf.co.uk**

Articles of three typeset pages or less will be published free of charge. One typeset page is often approximately 650-700 words, although this may vary considerably.

The total costs will be charged to the corresponding authors upon acceptance of the manuscript (and after final files are typeset), unless they indicate otherwise (e.g. that the invoice be sent to an institution or funder).

To find a complete country listing for fee waiver eligibility visit [here](#).

Please note that a discretionary fee waiver may be granted for authors of significant papers from any country who are without institutional backing and would otherwise be unable to publish. All accepted non-theme papers are subject to the APC unless a fee waiver is agreed.

You will be able to request your waiver when you make your submission in the journal’s Editorial Manager site.

Editors and reviewers have no access to author payment information. Waiver status will not influence editorial decision.

NB: Authors resident in any of the countries of the European Union must add UK Value-Added Tax (VAT, currently 20%). Institutions outside the UK paying the fee on behalf of the author and who provide their VAT registration number will not be charged UK VAT. If the place of supply of your services is outside the EU you should not charge UK VAT but, as you may need to account for the local tax, you’ll need to consider the tax rules of the country into which you are making your supply.

Withdrawal of manuscript

We assume that submission of a paper to the journal implies the intention to take that paper to publication, if accepted. If you withdraw your paper after acceptance, the APC will not be reimbursed.

Ethical considerations

Ethical approval

Authors are responsible for attaining ethical clearance from their own institutions and other relevant bodies in the context of their own research.

The journal follows the Uniform Requirements for Manuscripts Submitted to Biomedical Journals (International Committee of Medical Journal Editors, updated December 2016: <http://www.icmje.org/icmje-recommendations.pdf>). Taylor & Francis is also a member of the Committee on Publication Ethics. For more information, the Taylor & Francis ethics in publishing guidelines can be found at: <http://authorservices.taylorandfrancis.com/ethics-for-authors/>

Authorship

An author is defined as an individual who has participated sufficiently in the work to take public responsibility for the content. Authorship credit should be based only on substantial contributions to: a) conception and design, or analysis and interpretation of data; b) drafting the article or revising it critically for important intellectual content; and c) final approval of the version to be published. Anyone who does not meet all three of these criteria (e.g. someone who participated in data collection or analysis only) should be credited for their contribution in the acknowledgements.

All persons designated as authors should qualify for authorship. The order of authorship should be a joint decision of the co-authors, and the authors' contributions should be explained at the end of each manuscript.

We strongly encourage principal authors to explore the engagement and inclusion of colleagues or partners in study settings as potential co-authors, where possible and relevant.

One author must be appointed by the authors as corresponding author; she/he will be responsible for communicating with the editor and co-authors about revisions at all stages of editing and final approval of the text, proofreading, and completing the Author Publishing Agreement. In general, the corresponding author should be available to take charge of revisions, copyediting and proofreading in the months following receipt of peer-reviews and acceptance of the manuscript, up to publication.

Funding details

If applicable, please supply all details required by your funding and grant-awarding bodies as follows:

For single agency grants: This work was supported by the [Funding Agency] under Grant [number xxxx].

For multiple agency grants: This work was supported by the [funding Agency 1]; under Grant [number xxxx]; [Funding Agency 2] under Grant [number xxxx]; and [Funding Agency 3] under Grant [number xxxx].

Conflict of interest

Please ensure you have included a disclosure statement in your submission. This is to acknowledge any financial and non-financial interest or benefit that has arisen from the direct applications of your research. For further guidance on what is a conflict of interest and how to disclose it, please visit author services.

Preparing your paper

In general, research articles should include an abstract, an introduction, methods, results, a discussion and a conclusion. In line with our Editorial policy authors should consider the policy and practice implications of their article carefully and provide 2-3 clearly articulated statements in the abstract and conclusion on how the evidence presented in their paper can be used to inform future action, advocacy, or research.

Some resources for prospective authors are listed below which are useful in preparing papers before submission. To assist and encourage new and less experienced authors, Sexual and Reproductive Health Matters is committed, to the extent that capacity is available, to provide mentoring, provided the study and findings sufficiently merit publication.

The following resources may be helpful in preparing your paper:

- Taylor and Francis ‘Author Services’ <https://authorservices.taylorandfrancis.com/how-taylor-francis-editing-services-can-help-you-improve-your-manuscript/>
- Health[e]Foundation’s Scientific Writing Module for assistance and guidance in the formulation and organisation of papers.
- Authoraid <https://www.authoraid.info/en/> providing resources and guidelines for researchers and authors in low and middle income countries.
- Ensuring the quality and transparency of health research (Equator Network) <https://www.equator-network.org/> with reporting guidelines for various study types.
- Sex and Gender Equity in Research (SAGER) guidelines which encourage systematic reporting of sex and gender in research.

Submission categories

We accept submissions across a range of categories. While we will consider articles and submissions that surpass the maximum length if justified by the content, we request that authors please adhere to the following guidelines. The word limits exclude references, figures, abstract and tables.

We also invite video submissions. Please see the video submission guidelines for further details <https://authorservices.taylorandfrancis.com/video-abstracts/>

Research Article

- A full report of data from an original research study
- Word count: 3000-8000 words; References: 50 maximum; No. of figures and tables: 6; Additional files: yes

Review Article

- A comprehensive, authoritative description and summary of a specific subject area
- Word count: 3000-8000 words; References: 100 maximum; No. of figures and tables: 6; Additional files: yes

Roundtable

- An article highlighting multiple perspectives from different authors on a specific theme or topic
- Word count: 3000-5000 words; References: 50 maximum; No. of figures and tables: 4; Additional files: no

Commentary

- A short analytical article drawing attention to and expanding upon a topical subject, highlighting an emerging or contemporary issue, or critically engaging an article or topic under consideration in the journal
- Word count: 1500-2500 words; References: 8 maximum; No. of figures and tables: none; Additional files: no

Perspective

- A short article presenting the author's own viewpoint on an issue, concept or problem in the field, or a topical personal reflection or story
- Word count: 1500-2500 words; References: 5 maximum; No. of figures and tables: none; Additional files: no

Bookshelf

- An informed review of a recently published book in the field
- Word count: 1000 words; References: 5 maximum; No. of figures and tables: none; Additional files: no

Cover letter

Please include a cover letter that states that the manuscript has been read and approved by all authors. This letter should name the corresponding author. It should include assurance that the findings of the study have not already been published, and that the manuscript has not already been submitted elsewhere, and is not otherwise under consideration elsewhere. It is strongly encouraged that authors highlight the novel contribution the article is making to the field. Authors are responsible for obtaining permission to reproduce any copy-righted material in their papers. A copy of any permission must accompany the submission and can be included in your cover letter, or uploaded separately under 'other.'

Title page

On your title page, please include all authors' full names, position, institution or affiliation, city and country. Clearly identify the corresponding author. Authors' affiliations are the affiliations where the research was conducted.

Abstract and key words

Please prepare an abstract for your submissions, with a maximum of 250 words. Abstracts are required for research articles, review articles and roundtables.

When submitting, authors will also need to select five to ten specific keywords, to increase the visibility of your research in article searches.

Footnotes

Footnotes are comments or additional information on the text, should be used sparingly and be brief. If they include a reference, this should be numbered in or at the end of the footnote and appear in the reference list. Any footnotes to the text should be superscripted in the text and appear at the bottom of the page where they are noted, using the Word footnote function. Choose the following sequence: *, †, **, ‡.

Personal communications should be cited in the text as follows: name, position, personal communication, date. They should not be treated as footnotes or references.

- **Data availability statement.** If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found. Where applicable, this should include the hyperlink, DOI or other persistent identifier associated with the data set(s). Templates are also available to support authors.
- **Data deposition.** If you choose to share or make the data underlying the study open, please deposit your data in a recognized data repository prior to or at the time of submission. You will be asked to provide the DOI, pre-reserved DOI, or other persistent identifier for the data set.

Photos, figures and tables

Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be saved as TIFF, PostScript or EPS files. More information on how to prepare artwork.

Format-Free Submission

Authors may submit their paper in any scholarly format or layout. Manuscripts may be supplied as single or multiple files. These can be Word, rich text format (rtf), open document format (odt), or PDF files. Figures and tables can be placed within the text or submitted as separate documents. Figures should be of sufficient resolution to enable refereeing.

- There are no strict formatting requirements, but all manuscripts must contain the essential elements needed to evaluate a manuscript: abstract, author affiliation, figures, tables, funder information, references. Further details may be requested upon acceptance.
- References can be in any style or format, so long as a consistent scholarly citation format is applied. Author name(s), journal or book title, article or chapter title, year of publication, volume and issue (where appropriate) and page numbers are essential. All bibliographic entries must contain a corresponding in-text citation. The addition of DOI (Digital Object Identifier) numbers is recommended but not essential.
- The journal reference style will be applied to the paper post-acceptance by Taylor & Francis.
- Spelling can be US or UK English so long as usage is consistent.

Note that, regardless of the file format of the original submission, an editable version of the article must be supplied at the revision stage.

Submitting your paper

Submission of an article to the journal implies that:

- this work has not previously been published (except in the form of an abstract, or as part of a published lecture or academic thesis);
- this work is not under consideration for publication elsewhere;
- the publication of this work is approved by all authors;
- the study has been tacitly or explicitly approved by the responsible ethical authorities where it was carried out;
- the authors intend to go forward with publishing, and commit to investing further time and energy into bringing their work to publication standard.

Please note that *Sexual and Reproductive Health Matters* uses iThenticate to screen papers for unoriginal material. By submitting your paper to the journal you are agreeing to originality checks during the peer-review and production processes.

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style and language, with the approval of the text by the authors. Some cuts may be necessary closer to publication, due to length, repetition of points made in other papers, or type-setting requirements.

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All co-authors must check, correct and approve the final version, and this must be arranged by the corresponding author. The corresponding author will receive a PDF copy of the typeset text for correction; ideally, all co-authors should also be able to suggest and approve any corrections via the corresponding author. Prior to printing, the editors will also proofread and reserve the right to make changes.

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Authors are further encouraged to cite any data sets referenced in the article and provide a Data Availability Statement.

At the point of submission, you will be asked if there is a data set associated with the paper. If you reply yes, you will be asked to provide the DOI, pre-registered DOI, hyperlink, or other persistent identifier associated with the data set(s). If you have selected to provide a pre-registered DOI, please be prepared to share the reviewer URL associated with your data deposit, upon request by reviewers.

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Appendix B: Worked example of article selection

Study	Location	Date	Participants	Qual / Quant	Legal ³	Rationale	Research Question
7 Attitudes & intentions of future H/C providers towards AB providers	USA	2004	1st & 2nd year students in health science programmes	Survey Quant	✓ USA	little know about future H/c providers	Students' intentions to incorp. AB in practice willingness to see AB training.
8 Attitudes & intentions AB provision amongst med students in S.A	South Africa	2012	med students	Survey Quant.	✓ S.A.	Barriers service provision lack of trained & willing providers	Attitudes & beliefs of AB amongst student
9 Attitudes of med students to induced AB	South Africa rural	2002	med students	Questionnaire Quant	✓ S.A.	willingness of future providers affecting access	Assess attitudes of med students to induced AB factors affecting attitudes
10 Attitudes of med students of Mostar according to induced AB	Uot Mostar Bosnia & Herzegovina	2017	medical students	Quant	X	?	Attitudes & connections w/ religion, sex
11 Attitudes on AB among group of Sri Lankan Med students	Sri Lanka	2010	med students		X	Research letter. fetal anomalies	
2 Attitudes toward AB in Thailand - survey of senior med students	Thailand	1977	med students	Quant Questionnaire	X	Could a mail survey on genuine maternal be successful	

Appendix C: Data extraction form

Extraction form	
Title	
Researchers	
Date	
Country	
Legality of terminations	
Rationale	
Research questions	
Participant characteristics	
Age	
Sample size	
Methodology and results	
Design	
Key findings	

Appendix D: NICE quality assessment checklist

Study identification: Include full citation details		
Study design: <ul style="list-style-type: none"> Refer to the glossary of study designs (appendix D) and the algorithm for classifying experimental and observational study designs (appendix E) to best describe the paper's underpinning study design 		
Guidance topic:		
Assessed by:		
Section 1: Population		
1.1 Is the source population or source area well described? <ul style="list-style-type: none"> Was the country (e.g. developed or non-developed, type of health care system), setting (primary schools, community centres etc), location (urban, rural), population demographics etc adequately described? 	++ + - NR NA	Comments:
1.2 Is the eligible population or area representative of the source population or area? <ul style="list-style-type: none"> Was the recruitment of individuals, clusters or areas well defined (e.g. advertisement, birth register)? Was the eligible population representative of the source? Were important groups underrepresented? 	++ + - NR NA	Comments:
1.3 Do the selected participants or areas represent the eligible population or area? <ul style="list-style-type: none"> Was the method of selection of participants from the eligible population well described? 	++ + -	Comments:

<ul style="list-style-type: none"> What % of selected individuals or clusters agreed to participate? Were there any sources of bias? Were the inclusion or exclusion criteria explicit and appropriate? 	NR NA	
Section 2: Method of selection of exposure (or comparison) group		
2.1 Selection of exposure (and comparison) group. How was selection bias minimised? <ul style="list-style-type: none"> How was selection bias minimised? 	++ + – NR NA	Comments:
2.2 Was the selection of explanatory variables based on a sound theoretical basis? <ul style="list-style-type: none"> How sound was the theoretical basis for selecting the explanatory variables? 	++ + – NR NA	Comments:
2.3 Was the contamination acceptably low? <ul style="list-style-type: none"> Did any in the comparison group receive the exposure? If so, was it sufficient to cause important bias? 	++ + – NR NA	Comments:
2.4 How well were likely confounding factors identified and controlled? <ul style="list-style-type: none"> Were there likely to be other confounding factors not considered or appropriately adjusted for? 	++ + –	Comments:

<ul style="list-style-type: none"> Was this sufficient to cause important bias? 	NR NA	
2.5 Is the setting applicable to the UK? <ul style="list-style-type: none"> Did the setting differ significantly from the UK? 	++ + – NR NA	Comments:
Section 3: Outcomes		
3.1 Were the outcome measures and procedures reliable? <ul style="list-style-type: none"> Were outcome measures subjective or objective (e.g. biochemically validated nicotine levels ++ vs self-reported smoking –)? How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)? Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)? 	++ + – NR NA	Comments:
3.2 Were the outcome measurements complete? <ul style="list-style-type: none"> Were all or most of the study participants who met the defined study outcome definitions likely to have been identified? 	++ + – NR NA	Comments:
3.3 Were all the important outcomes assessed? <ul style="list-style-type: none"> Were all the important benefits and harms assessed? 	++ + –	Comments:

<ul style="list-style-type: none"> Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison? 	NR NA	
3.4 Was there a similar follow-up time in exposure and comparison groups? <ul style="list-style-type: none"> If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison. Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years). 	++ + – NR NA	Comments:
3.5 Was follow-up time meaningful? <ul style="list-style-type: none"> Was follow-up long enough to assess long-term benefits and harms? Was it too long, e.g. participants lost to follow-up? 	++ + – NR NA	Comments:
Section 4: Analyses		
4.1 Was the study sufficiently powered to detect an intervention effect (if one exists)? <ul style="list-style-type: none"> A power of 0.8 (i.e. it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard. Is a power calculation presented? If not, what is the expected effect size? Is the sample size adequate? 	++ + – NR NA	Comments:
4.2 Were multiple explanatory variables considered in the analyses? <ul style="list-style-type: none"> Were there sufficient explanatory variables considered in the analysis? 	++ + – NR	Comments:

	NA	
4.3 Were the analytical methods appropriate? <ul style="list-style-type: none"> Were important differences in follow-up time and likely confounders adjusted for? 	++ + – NR NA	Comments:
4.6 Was the precision of association given or calculable? Is association meaningful? <ul style="list-style-type: none"> Were confidence intervals or p values for effect estimates given or possible to calculate? Were CIs wide or were they sufficiently precise to aid decision making? If precision is lacking, is this because the study is under-powered? 	++ + – NR NA	Comments:
Section 5: Summary		
5.1 Are the study results internally valid (i.e. unbiased)? <ul style="list-style-type: none"> How well did the study minimise sources of bias (i.e. adjusting for potential confounders)? Were there significant flaws in the study design? 	++ + –	Comments:
5.2 Are the findings generalisable to the source population (i.e. externally valid)? <ul style="list-style-type: none"> Are there sufficient details given about the study to determine if the findings are generalisable to the source population? Consider: participants, interventions and comparisons, outcomes, resource and policy implications. 	++ + –	Comments:

Appendix E- Checklist ratings for the included studies

Table 1: Breakdown of quality checklist ratings

Study	1.1	1.2	1.3	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	3.5	4.1	4.2	4.3	4.4	5.1	5.2
Agostino et al (1991)	+	++	+	NA	-	NA	-	++	+	++	-	NA	NA	NA	+	++	+	+	++
Begun et al (2016)	++	+	++	NA	++	NA	-	+	+	+	++	NA	NA	NA	++	++	++	+	+
Begun et al (2017)	++	++	++	NA	++	NA	-	+	+	++	++	NA	NA	NA	++	++	++	+	+
Bennett et al (2018)	++	++	++	NA	+	NA	-	++	-	+	++	NA	NA	NA	++	+	++	+	+
Buga (2002)	+	+	++	NA	+	NA	-	+	-	+	+	NA	NA	NA	++	++	++	+	+
Dans (1992)	++	++	++	NA	+	NA	+	++	-	+	-	NA	NA	NA	+	+	-	-	+
Ely et al (2012)	++	++	++	NA	++	NA	-	+	++	-	+	NA	NA	NA	+	++	-	+	+
Espey et al (2004)	++	++	+	NA	+	NA	+	++	-	++	+	NA	NA	NA	+	++	+	+	+
Gleeson et al (2008)	++	++	++	NA	++	NA	+	++	+	+	++	NA	NA	NA	+	++	++	+	++
Rosenblatt et al (1999)	++	++	++	NA	+	NA	+	++	+	++	+	NA	NA	NA	+	++	++	+	++
Rodríguez-Calvo et al (2012)	++	++	++	NA	++	NA	++	+	+	++	++	NA	NA	NA	++	++	++	++	+
Shotorbani et al (2004)	++	++	+	NA	++	NA	+	++	+	+	++	NA	NA	NA	+	++	-	++	++
Sjöström et al (2014)	++	+	++	NA	++	NA	-	+	+	++	++	NA	NA	NA	++	++	-	+	+
Wheeler et al (2012)	++	++	++	NA	++	NA	++	++	++	++	++	NA	NA	NA	++	++	++	++	+
Yanikkerem et al (2018)	+	+	+	NA	++	NA	+	++	+	++	+	NA	NA	NA	++	++	++	+	+

Appendix F: Confirmation of ethical approval

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Appendix G: Recruitment poster



Are you a woman aged between 18-25 years and a student?

Have you ever ended a pregnancy?

Do you have a story and want to tell it?

I am really interested in hearing your story about ending a pregnancy and how you you came to your decision

If these questions apply to you then may be interested in taking part in some research

For more information about the research you scan the code below or contact Alicja

If you do not want to take part in the study but want some support, scan the code for contact details



Telephone: [REDACTED]
Email: A.Bellamy@2016.hull.ac.uk

Appendix H: Email invitation to students

Hello!

I'm a trainee clinical psychology at the University of Hull and for my research I am interested in hearing the stories of young women between 18-25 years who have ended a pregnancy and how they came to this decision. It can sometimes be helpful to share stories with others and is hoped that the stories will contribute to understanding women's decision making when ending a pregnancy.

Taking part in the study would involve an interview either face to face or via Skype.

I have attached some helpful information about the study that you are welcome to share. This includes the poster, information sheet for any participants that are interested and the link to the website which contains some more information about the research (inclusion/exclusion criteria).

<https://abellamy41.wixsite.com/storiesonabortion>

If you have any questions you can also email or contact me on the number below

Best wishes,

Alicja

Trainee Clinical Psychologist, Tel: [removed for hard binding]

Appendix I:

Dear Email invitation to lecturers

I'm a trainee clinical psychologist at the University of Hull and for my thesis I am interested in hearing the stories of young women between 18-25 years who have ended a pregnancy and how they came to this decision. My supervisors are Dr Annette Schlosser and Dr Lesley Glover (Faculty of Health Sciences) and I have University ethics for the study- see attached.

I wonder whether it would be possible to spend a few minutes either at the beginning or end of a lecture to share my research with the students in your lectures. I am contacting lecturers across the university so that as many people as possible have the same opportunity to share their story. Additionally, it may be beneficial for prospective participants to see the researcher and know who they will be talking to.

I understand that this may be a sensitive topic for some and therefore, would like to give you the opportunity to discuss this with your cohort first. If you do agree, then you can decide whether you would like me to speak at the beginning or end of the lecture.

I have also attached the poster and information sheet for the study alternatively you can view my website: <https://abellamy41.wixsite.com/storiesonabortion> this also contains the details of where further support can be found.

Please let me know if you have any queries or want to discuss any aspect of the research with me. Looking forward to your reply.

Best wishes,

Alicja

Trainee Clinical Psychologist, Tel: [removed for hard binding]

Appendix J: Email invitation to university societies

Dear XX,

I am contacting you as chair to the X Society. I am a Trainee Clinical Psychologist at the University and would like to share a research opportunity with you.

As part of the research for my doctorate, I'm interested in hearing the stories of young women, between the ages 18-25, who have ended a pregnancy. It can sometimes be helpful to share stories with others and is hoped that the stories will contribute to understanding women's decision making when ending a pregnancy.

Taking part in the study would involve an interview either face to face or via Skype.

I would be grateful if I could attend one of your meetings to discuss this with other members. I understand that this may be a sensitive topic for some and therefore, would like to give you the opportunity to discuss this with other members first.

I have also attached the poster and information sheet for the study alternatively you can view my website: <https://abellamy41.wixsite.com/storiesonabortion> this also contains the details of where further support can be found.

If you would like any more information feel welcome to contact me via phone or email.

Looking forward to your reply

Best wishes,

Alicja

Trainee Clinical Psychologist, Tel: [removed for hard binding]

Appendix K: Study website


[Home](#) [Current Research](#) [Taking Part](#) [Support](#) [Contact](#)

[Home](#) [Current Research](#) [Taking Part](#) [Support](#) [Contact](#)

Taking Part

Taking part in the study will involve being interviewed about your story, the interview will last between 60-90 minutes, this can either be face-to-face or over Skype

Follow the link to access more information about taking part in the study.



Before you are able to take part in the study, there are some important inclusion and exclusion criteria you may need to consider:


Inclusion criteria:

- If you are currently aged between 18-25 years
- If you have had either a medical or surgical termination between ages 18-25 years
- There is no minimum or maximum time since having a termination just as long as you were between the ages of 18-25 and are still within this age range

Exclusion criteria

- Women who have had a forced termination
- Women who have had terminations that take place after 24 weeks
- Women who do not speak English
- Women who have had an illegal termination

The findings of the study will be available on this website in summer of 2019



[Home](#) [Current Research](#) [Taking Part](#) [Support](#) [Contact](#)

Support

If you feel like you would benefit from some support, this can be found from the following sources:

Mind (Monday-Friday, 9am-6pm)
<https://www.mind.org.uk/>
Telephone: 0300 123 3393


Samaritans (24hrs)
<https://www.samaritans.org/>
Telephone: 116 123

Refuge (Monday-Friday, 9am-5:30pm)
<https://www.refuge.org.uk/>
Telephone: 0808 2000 247

University of Hull, student support for Hull students only (8.45am to 5.30pm)
<https://www.hull.ac.uk/choose-hull/student-life/student-support/>
Telephone: 01482 462222

British Pregnancy Advisory Service (24hrs)
<https://www.bpas.org/>
Telephone: 03457 30 40 30

Marie Stopes (24hrs)
<https://www.mariestopes.org.uk/>
Telephone: 0345 300 8090



Contact Information

Thank you for taking the time to read about our research

If you are interested in taking part in the study or would like more information please contact myself or my supervisors for further questions

Primary Researcher

A.Bellamy@2016.hull.ac.uk

Mobile:

Supervisors

A.Schlusser@hull.ac.uk

L.F.Glover@hull.ac.uk



This study has received ethical approval from the University of Hull Ethics Committee REF FHS91





Research Study Information Sheet

Exploring young women's stories in their decision to end a pregnancy

We would like to invite you to take part in a research study which is looking at the personal stories of young women making a decision to end their pregnancy. Before you decide if you want to participate we would like you to understand why this research is being done. We would also like you to understand what it will involve for you if you decide to participate. You can talk to others if you would like before you decide if you want to take part. The primary researcher will answer any questions you may have.

What is the study about?

This study aims to explore the personal stories of young women making a decision to end their pregnancy, considering contextual factors.

Why have I been invited?

We are asking women from the University of Hull between the ages of 18-25 years, and who have ended a pregnancy within this period, to share their story about their decision.

What will I have to do?

If you are interested in sharing your personal story about ending a pregnancy, you will be invited to participate in a one-to-one interview with the primary researcher. This interview would be arranged at a time that is convenient to you between 9-5pm at the University of Hull and will take place privately to ensure full confidentiality. The interview will be audio recorded.

What will happen to the recording?

The audio recording will be securely stored electronically. Only the primary researcher will have access to it. They will listen to the recording of the interview and transcribe it. This transcript will be anonymous (people will not be able to identify you from it) and securely stored. The primary researcher will then read through the transcript of the interview in order to better understand your personal story. The audio recording will be destroyed following transcription.

Will other people know what I have said?

During the interview, you may talk about things which you do not want others to know about. Everything you speak about in the interview will remain anonymous and confidential. The audio recording will only be listened to by the primary researcher and supervisors. Direct quotations may be used in the research however; they will be anonymised and given a pseudonym so others will not know what you have said, none of your personal details or any identifiable information will be included.

Non-anonymised information (e.g. signed consent forms and your personal information) will only be accessible to the primary researcher and will be securely stored at the University and kept separate to the recordings and transcriptions.

Confidentiality may have to be broken if you tell the primary researcher something which gives them concern for your own or someone else's safety. In these cases we would discuss this with you before any action was taken but in some cases the primary researcher may need to tell someone about these concerns without asking you first.

Do I have to take part and what if I change my mind?

You are under no obligation to participate in this study. Participation is completely voluntary. If you decide to take part you will be asked to sign a consent form to indicate that you agree to take part. Even if you give consent to participate, you can still ask to withdraw at any time up to the point when the results are analysed without giving a reason for doing so.

What will happen to the results of the study?

After the study is completed the results will be written-up as part of the primary researcher's thesis and may be submitted for publication in an academic journal or presented at conferences. Some direct quotes from your interview may be used in the write-up but none of your personal details or any identifiable data will be included.

Who is organising and funding the study?

The primary researcher is a doctoral student in Clinical Psychology at the University who is also employed by the Humber NHS Foundation Trust. This study is part of her doctoral research project. Research expenses are being provided by the University of Hull.

Who has reviewed the study?

Independent Research Ethics Committees protect the interests of people who participate in research. This study has been reviewed and approved by the Faculty of Health Sciences Ethics Committee at the University of Hull.

What if there is a problem?

If you have any concerns about the study, it might be helpful to discuss these with the primary researcher, who will do their best to answer your questions. You may also contact either of the primary researcher's supervisors at the University of Hull or alternately contact Professor Mark Hayter Associate Dean for research to take complaints to.

Expenses and Payments

Your participation in this study is voluntary; therefore there will be no payment for taking part.

What are the possible disadvantages and risks of taking part?

The study will require you to give up 60-90 minutes of your time. Some people may, at times, find it upsetting talking about their experiences because it may bring to mind some difficult issues. However, if this happens to you, the primary researcher will offer support and will help you to gain access to further support from your GP, if needed.

What are the possible benefits of taking part?

Although there will be no direct benefit or payment as a result of your involvement in this study, some people find it useful to talk about their experiences. It is hoped that the information you give us will contribute to understanding women's decision making when ending a pregnancy.

I am interested in participating and would like further information

If you are interested in participating you can contact the primary researcher via the details on the bottom of this page.

Contact Details

Primary Researcher: **Alicja Kowalski Bellamy**
Clinical Psychology Programme
Aire Building
University of Hull
Cottingham Road
Hull
HU6 7RX

Email: A.Bellamy@2016.hull.ac.uk

Research supervisors

Dr Annette Schlösser	Dr Lesley Glover
Email: A.Schlösser@hull.ac.uk	Email: L.F.Glover@hull.ac.uk

Clinical Psychology Programme
Aire Building
University of Hull
Cottingham Road
Hull
HU6 7RX

Thank you for taking the time to read this information leaflet



If feel you need further support, then below is a list that might help.

If you have any specific problems or questions that taking part in the research has raised, you can contact the research team:

Alicja Kowalski Bellamy *[removed for hard binding]*

If you are worried about your own health or well-being: You could speak to a family member, friend or your doctor.

Online support and general information available:

Samaritans

Website: <https://www.samaritans.org/>

Telephone: 116 123 (available 24/7)

Mind

Website: <https://www.mind.org.uk/>

British Pregnancy Advisory Service

Website: <https://www.bpas.org/>

Marie Stopes

Website: <https://www.mariestopes.org.uk/>

Rape Crisis

Website: <https://rapecrisis.org.uk/>

Telephone: 0808 802 9999

Refuge

Website: <https://www.refuge.org.uk/>

Telephone: 0808 2000 247

University Student Support

You can also contact your local University support service through your University website

University of Hull, Student Support (for Hull students only)

Website: <https://www.hull.ac.uk/choose-hull/student-life/student-support/student-support.aspx>

Appendix N: Participant consent form



CONSENT FORM

Title of Project: Exploring young women's stories in their decision to end a pregnancy, an ecological perspective

Name of Primary Researcher: Alicja Kowalski Bellamy

Please initial boxes

1. I confirm that I have read and understand the information sheet dated (insert date) for the above study. I have had the opportunity to consider the information. If I had any questions, they have been answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to leave the study at any time without giving any reason up to the point of data analysis and transcription. If needed, a date which will be made specific at the time of interview.

☐

3. I confirm that direct quotes from the interview may be used in future publications or conference presentations and understand that they will be anonymised. Any quotes that risk breaching confidentiality will not be used in publications.

☐

4. I agree to take part in the interview of the study and understand that my interview will be audio recorded.

☐

5. I understand that personal data will be held securely and destroyed 6 months after collection

☐

Name of participant

Date

Signature

When completed: 1 for participant; 1 for researcher site file; Version 1.1, Date 1st July 2018

Appendix O: Breakdown of phases for ‘*Letting go and moving on*’

Table 2: Breakdown of phases for ‘*Letting go and moving on*’

Phase	Theme
1	The relationship
2	Knowing
3	Telling
4	The decision
5	The clinic
6	Letting go and moving on

Appendix P: Breakdown of phases for '*Making meaning of the fantasy*'

Table 3: Breakdown of phases for '*Making meaning of the fantasy*'

Phase	Theme
1	The relationship
2	Knowing
3	Telling
4	The decision
5	The clinic
6	Making meaning of the fantasy

Appendix Q: Example of worked phases of holistic form

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Appendix R: Example of worked categorical content

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Appendix S: Epistemological statement

Ontology refers to the study of the nature of reality and truth (Willig, 2013) whereas; epistemology seeks to answer how we come to know what we know (Feast & Melles, 2013). A study's methodology is the process in which knowledge is acquired, using specific techniques to answer the research question (Feast & Melles, 2013). This epistemological statement will attempt to demonstrate the epistemology positions that have contributed to the development of the research. The aim of the empirical research was to understand the narratives that young women construct in their decision to end a pregnancy as well as the contextual factors that influence the decision making narrative.

There are various epistemological stances that one can approach research with (Girod-Seville & Perret, 2001). A positivist and realist position suggests that there is a single truth or reality that we can discover and therefore measure (Yilmaz, 2013). In order to go about measuring reality, experimental methodologies and quantitative approaches are more likely to be used (Feast & Melles, 2013). This epistemological stance did not fit with the current research as the research questions were more focused on hearing women's stories in which there was no variable present to be objectively measured.

An alternative epistemological position is constructivist (relativist). This view suggests that there is no single truth or reality and is more concerned with use of language in the construction of reality in relation to the context and environment of the individual (Willig, 2013). This position suggests that reality cannot be objectively measured but, instead interpreted (Feast & Melles, 2013). Though the current research was focused around the

way in which narratives were told as well as their content, there was an assumption that was present that when the women told their story, the narratives represented their experience. Furthermore, it has been argued that a constructivist position suggests that there is an inherent level of power within a social group which aids promotion of what constitutes as their reality or truth (Allen-Collinson, 2011). However, this has been criticised by the feminist approach as gender-centric as women are a marginalised social group and therefore have less power (Allen-Collinson, 2011). Therefore, it was considered that a pure constructivist position does not fit with the current research.

A phenomenological position attends to the lived experiences of individuals, understanding knowledge from subjective experiences rather than seeking a truth (Willig, 2013).

Furthermore, a phenomenological position also appreciates how thoughts and feelings influence experience (Hofer & Bendixen, 2012). This epistemological position fits more with the current research in understanding the women's narratives as representative of their experience. As the current research was to investigate terminations as a unique experience that only women can have, a feminist position was most appropriate. Specifically, a phenomenological feminist position, as importance was placed on gender and the unique biological and social experiences that women have as a group in comparison to men (Allen-Collinson, 2011). Phenomenological feminism considers the women's voice in relation to feminist theory and the meaning of their experience (Fisher, 2010). Therefore, this position was able to acknowledge the how narratives are rooted in experience and provide a certain level of empowerment in promoting women's narratives (Allen-Collinson, 2011).

As discussed, a quantitative approach is more in line with positivist epistemologies and

objective measurement and was therefore considered not appropriate for the current study. As a qualitative approach appreciates the events and experiences of an individual (Yilmaz, 2013), this appeared to fit with the research questions and phenomenological feminist epistemological position.

Initially, the primary researcher considered using an Interpretative Phenomenological Analysis (IPA) to answer the research question. This fits with a phenomenological position but was however, more focused on exploring lived experience rather than narratives which was not in line with the aims of the research (Smith, Flowers & Larkin, 2009). Thematic analysis was also considered, similar to IPA, it is consistent with a phenomenological stance and individuals' experiences are considered to be their reality (Braun & Clarke, 2006). Nevertheless, it was once again felt that this analysis would not answer the research questions, as part of the research aim was to understand how stories are constructed in their entirety.

A narrative approach was subsequently selected as the most appropriate form of analysis due to not being aligned with a specific epistemological position and ability to answer research questions (Willig, 2013). Narrative analysis takes the view that individuals understand their lives and experiences in the form of a story in which there are certain events (Sarbin, 1986). Individuals construct their own reality in order to understand events which are not necessarily factually correct but constructed for a specific event or audience (Mishler, 2004). Similarly, Gergen and Gergen (1988) posited that narratives are reflective of an individual's internal world, hence why they may differ from actual events. As such, narratives could be created through the perspective of the narrator rather than from a fixed

truth (Polkinghorne, 1995; Josselson, 2011). This complimented the feminist epistemology position well in highlighting the women's unique and personal stories. Narrative research additionally acknowledges that stories cannot be viewed in the absence of cultural context but ingrained within society and are continuously developed (Bruner, 1991).

Another important reason for selecting narrative analysis was the use of non-directive interviews. This enabled the participants the freedom to share what they felt comfortable to especially in telling such personal and potentially emotive stories. As there was no formally proposed way in which narrative research is conducted, this allowed the use of multiple methods of analysis that the approaches offers to analyse the telling of the stories and factors involved in decision making which were integral to answer the research questions.

The aim of the systematic literature review was to integrate and summarise findings of future health care professionals' attitudes towards terminations. The studies in the review were all quantitative with attitudes being objectively measured, producing a quantitative value. Therefore, the epistemological position falls more in line with a positivist stance, however, the results may still be considered within their cultural context.

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Appendix T: Reflective statement

To say this research journey has been a roller coaster ride is an understatement! Reflecting on the past three years seems like a marathon task, with so much changing and ultimately, so much being learnt. Finally writing my reflective statement, I realise that my research journey begins way before training so, just as I have asked my participants to share their stories I thought it would be appropriate to share mine.

Empirical paper

Choosing a topic

I believe my story starts way back in primary school when my female friends and I were confused why our school's football team would only let boys play. Ultimately, we were informed that this was the way that things were and football was a 'boy's game'. Yet, my 10 year old self just could not understand why our school had to separate boys and girls in a children's sports team. So, my friends and I tried out for the team in anyway, we wanted our voices and actions to be heard to show that our gender does not determine our sporting ability. However, our efforts were unsuccessful, to a 10 year old girl there was a sense of injustice but it made me wonder, what are the bigger issues in society affecting women's rights?

From then on I became captivated by the works of some of the most influential feminist writers. For example, Virginia Woofe's stream of consciousness and narrative perspectives, Margaret Atwood's dystopian novel *The Handmaid's Tale*, the timeless works

of Jane Austen, poet and civil rights activist Maya Angelou and of course Caitlin Moran's book *How to Be a Woman*. What resonated with me from these inspiring women and their books was the power in sharing stories of injustice and topics labelled as socially challenging. This served as a foundation in me developing values around gender equality and reproductive rights.

During my undergraduate degree, I began hearing the stories and experiences of my friends who had accessed sexual health services. There was power in hearing someone else's story, from the way in which it was told as well as the emotion behind it. This is something which I also came to learn once I started my clinical placements on the doctorate.

Throughout my research journey, things were changing in society and in the media. Trump's America was coming into the spotlight, with his misogynistic and reductionist views around reproductive rights sparking interest in the UK. Discussions were emerging around whether our 50 year old Abortion Act was still appropriate or out dated. With questions being raised why women from Northern Ireland were having to travel to England just to access services, risking prosecution. Within all the political clashes and statistics blasted across the media, women's stories and experiences were sparse. When discussing research topics with my supervisors, I wanted to investigate an area that I would be fully invested in throughout the three years of the course. From discussions with Lesley and Annette, my passion for working with marginalised groups and women's health emerged.

Designing the study

Designing this research project came with such enthusiasm which I felt was reciprocated by my supervisors. In our initial meetings, much of what we discussed was around feasibility especially, considering the potentially emotive nature of the topic. I was encouraged to dip my toe in the research pool to see where any potential gaps were. It was interesting to see geographically where research was coming from, which was predominately the USA and African countries, with a notable absence of literature from the UK.

From early on I decided on a qualitative approach. I considered whether to explore women's experiences through Interpretative Phenomenological Analysis. However, this didn't feel right as I thought that it would not be able to capture the true essence of the stories as well as there being an abundance of research in this area. Why women end a pregnancy was a common theme in the research but using stories to investigate decision making however, were far and in between.

Throughout my clinical training, I have regularly used a systemic approach to think about an individual and their context. Having a framework to guide the research such as ecological one provided scope to consider contextual factors involved in decision making from different elements of an individual's system.

Ethical approval

One of the first challenges that I encountered on this journey was obtaining ethical approval. I had long discussions with my supervisors about ensuring the safety of the participants which for example, led to the University's student wellbeing service offering

sessions for any participant that required support. The outcome of the ethics committee included suggestions such as providing more support systems and safeguards in place for the participants. Though completely understandable and valid, I couldn't help but feel that there were some assumptions of immediate distress made for women who had ended a pregnancy. After processing these thoughts and conflicting feelings, I felt that the committee raised some very important points. This led me to provide a clearer rationale for decisions made throughout the research as well as being aware of how my own beliefs and assumptions can influence the research. In hindsight, I think I underestimated how long ethical approval can take and would subsequently be aware of this if I conducted future research.

Recruitment and data collection

One of the most significant challenges that I came across was recruitment. This was something that I had anticipated to be a challenge but in hindsight, I don't think I fully understood the extent of this. In total, I must have contacted over three thousand people through emailing student mailing lists and student societies, canvassing the university with posters, using social media and contacting lecturers to speak in their lectures. Interestingly, the most resistance that I found in recruitment came from the University itself. I was initially disheartened when I received little responses to emails from students, societies and lecturers. I received defensive emails around why I was conducting and contacting people about the research. Recruitment proved to be a long process; I began to think if I would have enough participants and whether I needed a contingency plan. This left me feeling like I had potentially been a little over ambitious with my research topic. Nevertheless,

both Lesley and Annette reassured me that people would participate and to be patient.

Thank goodness I took their advice as a week later I had my first two participants!

Throughout the recruitment processes policy was being challenged and under threat in Northern Ireland and Alabama respectively. In response, many celebrities started to share their stories of ending a pregnancy, the abundance of disclosure and encouragement to share stories aided the recruitment process. Some of the participants said that the current global conversations had encouraged them to participate in the research.

The barriers that I encountered throughout the recruitment process to me were intriguing. I wondered how reflective this was of the women who access reproductive health services and the challenges that they face. From a societal perspective, I wondered about the impact of having a conservative government on altruism and willingness to help others in their pursuit of their goal or research. Overall, there was pressure to complete this work to standard that does justice to the women who have told their stories as well as the people around me who were excited to see the findings of the research. Despite such challenges, there were memorable moments during the recruitment stage. A particular highlight being the presenters of BBC Radio 4 Woman's Hour, Dame Jenni Murray and Jane Garvey Retweeting my research! Furthermore, I found that more personal approaches such as speaking in lectures were extremely helpful in recruiting participants as well as engaging in conversation on social media. This is definitely something that I would consider using for future research.

It was not until my first research interview that it proved to be a true turning point. Hearing the stories of the women was unbelievably powerful, not just the content of their stories but the realisation that my research was happening. I found it fascinating that many of the participants had shared experiences and phrases in relation to their experience. Through the data collection process, I was able to reflect on my own perceptions around sharing emotive stories and that for some participants this was a cathartic experience and for others challenging. I enjoyed how narrative research allows the participant the freedom to tell their story without interruption but also the flexibility to clarify and follow up on certain points of the narrative. I was taken aback by the participants' reflections on the research, on how they were grateful for the opportunity to share their story and that someone was researching this area. Listening to the stories and meeting the participants in this study gave me the motivation and momentum to finish the research.

If I was to conduct research in the future, I would explore all recruitment processes before going through ethics. I think this would have made my time management more effective in completing other parts of the thesis.

Analysis and writing up

The analysis stage for my empirical paper came more organically than I was originally expecting. One the best pieces of advice I received from my supervisors was to approach the recordings as if they were pieces of music. To someone with a musical background, this advice proved to be invaluable. Using this approach, I was able to analyse the events and emotion from the stories that meant so much to the participants, it also made the task of transcribing a lot easier! Analysing the holistic form of the stories was one of the most

thought provoking elements of the analysis stage. I found the works of Frye (1957) so interesting in thinking about the way in which stories are told; falling into certain categories. When applying this to my research, I was surprised that all of the participants told their story in such a similar and linear way. Despite my interviews being relatively short, there was an abundance of data. I covered whiteboards and flip chart paper with notes and started to grow attached to some of the quotes. I eventually came to use what I now know to be a common phrase when completing research, 'when is a theme a theme?' Saying the categories out loud with fellow trainees and at one point my cat is exactly what I needed to do to consolidate the results and major categories. From then on, it became an enjoyable experience in which I had fun creating the results section.

Juggling writing up my research alongside my final clinical placement was especially challenging. There were points when I wondered whether I would ever complete the research and be fully present whilst on placement. I sometimes felt like I had been split in half, one side in a library and the other on an inpatient unit! Finishing the research on time was something I knew to be unrealistic and deep down something that I found difficult to accept. It didn't really help when I was constantly seeing pictures of fellow trainees handing in their research! However, I began to see the extension as an opportunity to complete this research to a standard that I feel it deserves.

The whole process

Reflecting upon this research journey, I feel I have been left with a sense of what it takes to conduct research especially in the face of such significant challenges. Though I think for now, I need to catch my breath before considering undertaking another research project! I

have learned so much about my approach to research as well as developing qualitative research skills. I think that my longstanding passion in reproductive and women's health served as just an important motivation to complete the research. Though, there were times when I felt I needed to take a step back. I went through some incredibly trying stages but I didn't ever want to give up because I knew the importance of the research and the trust that the participants had placed in me in telling their story. In writing this statement and formatting my research into one document, I feel the reality of this journey coming to an end. So, thinking back to the beginning, over fifteen years ago when I stood up for a cause that I believed in. Now at 25 years old I hope I can say that I have done the same again but this time just a little bit differently!

Systematic Literature Review

Choosing a topic for my literature review was a challenge. There were so many different avenues in reproductive and sexual health that I could take, it felt overwhelming. I went to my research supervision meetings claiming that despite searching on the data bases for hours on end I had done no work. To which my supervisors responded with what I was doing was in fact work. Upon reflection, I feel as if I had become so engrossed with the minutia I needed to gain some perspective.

Gaining perspective is easier said than done however, it led to me finalising a topic and search terms which I felt complemented my empirical paper well. The research terms however, generated so much data, I remember manually going through over 2000 searches about three times to ensure all relevant papers had been identified thinking to myself 'what have I done?'. Yet, this comprehensive approach did pay off in producing a good number

of relevant papers and subsequent findings. In hindsight, I feel that I underestimated the amount of time that data extraction takes and would definitely consider this for future research.

Despite my somewhat challenging relationship with my literature review, it ultimately highlighted so many interesting findings thus, increasing the value that I place on such research approaches. Additionally, I was able to develop skills through completing a literature review which most definitely are applicable to clinical practice.

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