**Termination of pregnancy for fetal abnormality: a meta-ethnography of women’s experiences**

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**Abstract**. Due to technological advances in antenatal diagnosis of fetal abnormalities, more women face the prospect of terminating pregnancies on these grounds. Much existing research focuses on women’s psychological adaptation to this event. However, there is a lack of holistic understanding of women’s experiences. This article reports a systematic review of qualitative studies into women’s experiences of pregnancy termination for fetal abnormality. Eight databases were searched up to April 2014 for peer-reviewed studies, written in English, that reported primary or secondary data, used identifiable and interpretative qualitative methods, and offered a valuable contribution to the synthesis. Altogether, 4,281 records were screened; 14 met the inclusion criteria. The data were synthesised using meta-ethnography. Four themes were identified: a shattered world, losing and regaining control, the role of health professionals and the power of cultures. Pregnancy termination for fetal abnormality can be considered as a traumatic event that women experience as individuals, in their contact with the health professional community, and in the context of their politico-socio-legal environment. The range of emotions and experiences that pregnancy termination for fetal abnormality generates goes beyond the abortion paradigm and encompasses a bereavement model. Coordinated care pathways are needed that enable women to make their own decisions and receive supportive care. © 2014 Reproductive Health Matters

**Keywords:** abortion, fetal abnormality, meta-ethnography, lived experience, systematic review, bereavement, USA, UK, Brazil, Sweden, Finland, Israel, Viet Nam

In England and Wales in 2013, pregnancy termination for fetal abnormality represented 1% of all terminations. [1] As antenatal screening techniques develop and maternal age rises, thus increasing the risk of abnormalities, [2] more women are likely to be diagnosed with fetal abnormality and face the prospect of ending their pregnancy. Research indicates that terminating a pregnancy for fetal abnormality is a complex decision, [3] which can have long-term psychological consequences such as depression, post-traumatic stress and complicated grief for women and their partners. [4-9] Grief reactions following this event have been likened to those experienced in other types of perinatal loss such as stillbirth or neonatal death. [10-12]Nevertheless, termination for fetal abnormality is distinct in that parents choose to end the pregnancy. This element of choice places this phenomenon at the centre of ethical debates, which have implications for women’s experiences. The first debate relates to abortion rights and to whether abortion harms women’s mental health. However, the most comprehensive and recent reviews have concluded that abortion does not harm women’s well-being. [13-15] The second debate relates to the question of eugenics and is illustrated by deliberations about the timeframe and the medical conditions for which pregnancies can be terminated, which have occurred in the past decade. [16] The third debate focuses on health professionals’ attitudes about termination for fetal abnormality and their right to conscientious objection. [17]

Current research on women’s responses to pregnancy termination for fetal abnormality is limited by a focus on quantitative measurement of psychological outcomes. Two systematic reviews, [18, 19] published in 2011, provide useful insights but do not address women’s experiences holistically. These limitations warrant a review of qualitative studies about the experience of terminating a pregnancy for fetal abnormality. This article describes the first systematic review of qualitative studies about women’s experiences of pregnancy termination for fetal abnormality. The review aims to provide an evidence base for clinical practice and policy making in the hope that it will help professionals provide the best possible care. Although the rationale for this review was rooted in a political, cultural and clinical context specific to England and Wales, the review examines women’s experiences across seven different countries and, in doing so, broadens the relevance of its findings.

***Methods***

This systematic review is a meta-ethnography. The data were selected and analysed following the guidelines outlined by Noblit and Hare. [20] Eight electronic databases were searched up to April 2014) to identify qualitative studies of women’s experiences of pregnancy termination for fetal abnormality: Academic Search Elite, Cumulative Index to Nursing and Allied Health Literature, Embase, Maternity and Infant Care, MEDLINE, PubMed, PsychINFO and PsychARTICLES. A manual search was conducted on relevant authors and reference sections of key articles. Search terms included: pregnancy termination, induced abortion, therapeutic abortion, fetal abnormality, fetal anomaly, adaptation, adjustment, experiences, qualitative research, qualitative studies, and interview.

To be included, studies had to report findings from primary or secondary data about women’s experiences and be based on identifiable and interpretative qualitative methods of analysis (e.g. grounded theory). Purely descriptive qualitative studies were excluded. Studies also had to be peer-reviewed, be written in English to avoid translation bias, and offer a valuable contribution to the synthesis. The last criterion differed from others because it involved a subjective appraisal; however this is in line with meta-ethnographic guidelines. [20] Still, to enhance the review’s validity, study quality was assessed using the Critical Appraisal Skills Programme, [21] a framework successfully used in other meta-ethnographies. [22-24] Each study was evaluated on ten questions covering methodological and ethical considerations, clarity and transparency of the analysis, and its contribution to knowledge. Agreement about the articles to include in the review was high. Any divergence of opinion was resolved through discussion. Although the review’s focus was on women’s experiences, studies containing men’s or health professionals’ accounts were included provided that women formed a substantial part of the sample and that the analysis of women’s accounts was clearly identifiable.

Data were synthesised using meta-ethnography. [20] This approach centres on interpretation of qualitative findings rather than aggregation, and thus is comparable to the qualitative methods of the studies it synthesises.[25] It involves analysing studies (participants’ quotations and themes identified by the study’s authors) in relation to one another to determine whether the themes relate to or refute each other. The analysis then involves creating new themes, which are compared across studies, and from which an interpretative framework (line of argument) is generated. [20, 25, 26] The analysis was conducted by Author 1 and cross-validated by Author 2. Both authors were in agreement that the themes and interpretative framework were rooted in the data and provided a meaningful interpretation of women’s experiences.[[1]](#footnote-1)\*

***Findings***

Altogether 4,281 records were identified. Of those, 4,142 were excluded and 40 duplicates removed. Full texts of 99 articles were assessed; 85 were excluded because they did not fit the inclusion criteria, were mixed with cases of other perinatal losses or continuing pregnancy, mostly did not cover abortion for fetal abnormality, or the full text was unavailable. Fourteen studies, published between 1997 and 2013, were selected for review. Five were conducted in the USA, four in the UK, and one each in Brazil, Viet Nam, Israel, Sweden and Finland. They originated from the fields of anthropology, nursing, obstetrics, public health, social work and sociology.

The synthesis generated four themes: a shattered world, losing and regaining control, the role of health professionals, and the power of cultures. Throughout this paper, the terms ‘baby’ and ‘child’ have been used because they reflect the language used by participants and convey that, in most cases, the pregnancy was desired.

**A shattered world**

*Emotional earthquake*

For many women, pregnancy termination for fetal abnormality is akin to an emotional earthquake that shakes their core beliefs and requires reconstruction.utchoHutchison, 2001) Women describe intense physical and emotional pain, with some mentioning “*want[ing] to die*”.[30] The psychological pain is usually the most difficult to overcome, particularly when feticide (*in utero* injection causing fetal demise) is involved [27, 29] and women feel or witness their baby’s last movements on screen. [29, 34] They also find it challenging to labour/recover in wards with women who had positive pregnancy outcomes. [31] The brutal transition between the state of pregnancy and non-pregnancy contributes to feelings of devastation. [27, 33] For women giving birth to their baby after a medical termination, the transition between “*saying hello and goodbye*” [27] within the same encounter is inconceivable. Many women are stunned and unprepared for making decisions surrounding the baby’s birth, whether to see or hold the baby, what type of funeral to have, and whether to take the baby’s photo or hand/foot prints.[33] The magnitude of the discrepancy between pregnancy expectations and outcome only furthers women’s distress. [31]

Following the termination, women contemplate their loss, often yearning for their child long after the termination. [31] The mourning process is ongoing and women accept that this is a “*lifelong affair*” [28] with the pain subsiding but never disappearing entirely. Women lose the immediate future they had imagined, having often gone to great lengths to prepare for the baby’s arrival. [30, 31] A loss of reproductive self-esteem is also observed, with some women feeling that they have failed to bear a healthy child, and failed themselves and those around them. [31]

*Assault on the self*

Pregnancy termination for fetal abnormality also represents an “*assault*” on the self [34] and undermines women’s sense of security. [27, 30] Many women start their pregnancy with a (false) sense of security that “*their baby would be fine*,” [30] and the pregnancy normal. [30, 38] Learning of the abnormality represents a “*loss of innocence*”, which women long to recapture and generates a heightened sense of vulnerability. [28] Some struggle with their values and spiritual beliefs over the decision to terminate. [27, 29-31, 38] Terminating the pregnancy also has profound consequences for women’s self-identity as mothers, as it implies choosing between becoming the “*mother of a disabled child or a bereaved mother*”. [30] Some women blame themselves for the abnormality, while others question their moral courage for choosing not to have a child with impairment. [31]Childless women experience the additional difficulty of being denied the social status of motherhood. [30] Women also question their bodies which some hold responsible for creating an imperfect child [31] or healing too quickly compared to the mind. [27, 30] The return of menstruation signals the physiological readiness to be pregnant, often in contrast with how women feel emotionally. [27] Incongruence between body and mind is also experienced with lactation, which women find particularly difficult. [31]

*Ambivalence*

Ambivalence is manifest in the decision to terminate the pregnancy as it involves conflicting feelings. It is a subtle balancing act between the baby’s prospects and potential quality of life, and the woman’s, her partner’s and children’s needs. [27-29, 31, 38] It often carries high levels of uncertainty as many diagnoses are based on probabilities. [34] For many women, the decision to end the pregnancy is a decision they wish they never had to make as it goes against *“maternal instinct”*. [38] However, the distress at having to make the decision can co-exist with relief at being given the opportunity to make it, [27, 29, 31] sparing this child a life of suffering and sparing other children having to care for an impaired sibling. Ambivalence is also apparent in women’s emotional relationship to the baby, moving between the need to protect and distance themselves, and “*fighting love for their baby*”. [27] Some Vietnamese women consider the baby’s abnormality to be the result of family members’ immoral behaviour and welcome the opportunity to prevent the birth of an impaired child. Others feel guilty at robbing their child of a life and fear that the baby’s soul may return to haunt them, potentially hindering their reproductive future. [31] Women are also conflicted between their need for time to gather and process information and the difficult experience of continuing “*giving life while thinking about taking it*”. [34]

**Losing and regaining control**

*The paradox of choice*

Most women depict their decision-making as a choice between two “*alternatives, both of which are*

*unpleasant*” [30] and taking the decision to terminate because the situation was hopeless and *“there was nothing else to do”*. [36] They feel this is not a real choice, and that their agency is limited. [30, 36, 39] This is particularly true for women who had to obtain authorisation to terminate, as was the case in Brazil when the study was conducted. [29] This is also the case in Israel where state approval is required beyond 24 weeks’ gestation. [34] Yet most women feel that their decision is right. For many, it is the first (and only) parental decision they get to make for this baby, [27, 28, 31] and one of the only ways they can exert control. This may explain the sense of achievement reported in some studies. [29]

*Regaining control*

Many women feel, to various degrees, powerless, with a lack of control over emotions and grief. They are unprepared for the magnitude and duration of the pain [27-31, 36] and the “*rollercoaster*” [27, 38] of emotions experienced post-termination. Attempts to regain control over the situation include controlling their social environment by limiting contact with others [27, 40] and self-disclosure. [27, 28, 30, 37] These strategies are both for self-protection and attempts at controlling emotions. Others reclaim control through their decisions post-termination, e.g. organising the baby’s funeral. [33, 40] Women also mention keeping emotional control during subsequent pregnancy through the development of “*emotional armour*”. [28]

*Surviving the ordeal*

The aftermath of the termination is akin to “the day after” (the earthquake). Women are in shock, but feel very much alive. Some consider it an ultimate test of strength of character [29] and of the relationship with their partner. [28] They are acutely aware that the decision to terminate is theirs alone, even if in consultation with their partner. [29, 31] Casting themselves as survivors, women describe going through “*the hardest thing they ever did*” [27] with bravery and resilience. [28, 29] Some report growing stronger as a result of the termination [29, 40] and discovering new strengths. [39] Following the termination, women engage in the laborious task of rebuilding their internal world. Deriving meaning is important for some and positive growth is one way to impart meaning to their experience. [40] Putting the experience to good use (e.g. sponsoring charities), redefining life priorities and addressing unresolved issues all contribute to feelings of empowerment and growth. [40] Women also find solace in “*renewed empathy*” [27] towards others and the consolidation of family ties. [27, 29] Another pregnancy is generally soothing but can be bitter-sweet, another illustration of ambivalence. [40] Women consciously lower their expectations of a new pregnancy and seek information in an attempt to prepare themselves for potential setbacks. [28] A new pregnancy is seen as a leap of faith requiring courage and determination, but which is eventually rewarding: “*no guts, no glory*”. [28]

**The role of health professionals**

***Information as empowerment***

Women value timely, clear and unbiased information about the abnormality, the termination procedure and what to expect post-termination [35, 36] that they can understand. [31] Advice on how to disclose the end of the pregnancy to others, [37] and information about what to expect emotionally long-term are also important but these are seldom provided by health professionals. Some women report having to source information themselves, [38, 39] which some resent, [39] while others consider it an integral part of their coping process. [40]

Information provision can be seen as a way to empower women to make informed decisions. [33, 38] A lack of information not only generates distress, [31] but maintains women in a state of passivity and uncertainty, and leaves them feeling unprepared for the termination and its aftermath. [33] In comparison, women welcome information enabling them to make decisions that are right for them. Choice of termination method is a good example, [28, 35] in that women are able to reconcile the experience with their own values and beliefs. [35] Some women value the opportunity to give birth after a medical termination, create bonds and have their baby blessed, while others opt for surgical termination in a bid to distance or protect themselves as they fear “*never want[ing] to let [the baby] go*”. [35]

*Empathy and compassion*

Above all, women value empathic and compassionate care. They are grateful when health professionals acknowledge that their pregnancy is wanted, and care for them in a non-judgmental way. [35, 36] They derive comfort from health professionals’ acts of kindness, which at times can stretch beyond the usual doctor−patient boundaries. [40] Receiving respect and dignity for themselves and their baby is critical. [36, 40]

*The lack of aftercare*

Women repeatedly point to a lack of aftercare. They feel “*unsupported*”, almost abandoned, [36, 39, 40] which furthers their distress. To fill this vacuum, some women seek support from counselling services [40] but these come at a financial cost. [36] Others turn to support groups to share their story [36, 39, 40] and reciprocate support, which some find therapeutic. [40] Given the lack of aftercare, memories of encounters with caregivers during the termination can have a long-lasting influence on how women cope. [40] However, although the feeling of isolation women experience post-termination is partly due to a lack of aftercare, it also results from women’s inability to share their story due to the stigma surrounding pregnancy termination for fetal abnormality.

***The power of cultures***

***Stigma and secrecy***

The stigma attached to abortion generates an atmosphere of secrecy and shame, and many women report a fear of being judged. The Israeli study refers to termination for fetal abnormality as a “*taboo*” and describes women facing a “*wall of silence*”. [34] This leads women to censor themselves [27, 28, 30, 38], only sharing part of their story [34, 37, 39], labelling their experience a miscarriage or only disclosing the full story to a selected few. [37] Partial disclosure can be a double-edged sword, protecting women from potentially hurtful reactions, while hindering healing through the inability to access support. [37] By only sharing part of their story, women may be unable to fully process their loss, undermining their identity as a bereaved mother. Hence, some women choose full disclosure − they want people to know. [37] Generally women who have chosen full disclosure report positive experiences. [30, 37]

*Disenfranchised grief*

Whether women disclose their full story or not, women’s grief is disenfranchised as their loss is generally not sanctioned by society. Because theirs is a “*chosen loss*,” [31] and “*nobody knew the baby*” [33] women feel inadequate in expressing their grief. In Viet Nam, women are encouraged to forget about their baby and the location of the grave is often kept secret from them. [31] The language used to define termination for fetal abnormality also matters. Although women agree that the procedure is an abortion, they want their experience to be differentiated from abortions for non-medical reasons. [36] Some find the terms “*abortion*” and “*termination*” harsh [37] and would rather call it “*therapeutic premature delivery*” [29] or compare it to switching off a life support machine. [27] The inadequacy of language to describe their experience further alienates women as they are unable to effectively communicate their story. This inadequacy is also noticeable in the absence of terminology, e.g. in Israel, where there is no word for feticide. [34] Terminology to refer to the baby is another example; some women find terms such as “fetus” hurtful. [40] Others, however, would rather not “*think of it as a baby,*” [33] or feel they have “lost a pregnancy more than a baby”. [32]

*Cultural landscape*

Social context greatly impacts women’s experiences. Polarised debates on abortion result in women being stigmatised and feeling like social outcasts. [27, 28, 30] Abortion laws are also influential as they dictate the timing and medical conditions for which pregnancies can be terminated. [29, 34] In the USA, abortion is legal but operates differently across states. Women may have to travel to a different state to access screening or abortion services. [38] In Viet Nam, feticide is not performed prior to inducing labour, resulting in some babies being born alive. [31] Conversely, to some women, feticide is the most traumatic part of the termination. [29, 34] Whether the cost of the procedure is covered by public healthcare systems also influences the outcome, since it may lead to unequal access to services. In the USA, many women struggle to obtain financial cover from their insurance providers. [38] Yet, many women may feel pressurised to terminate their pregnancy because of society’s strong support for antenatal screening. [34] Furthermore, this covert pressure takes place within political and social environments generally advocating the inclusion of people with disabilities, which some women find confusing. [30]

The environment in which women are cared for and the doctor−patient relationship also influence women’s experience. In Viet Nam, women’s deference to clinicians prevents their asking questions and some women describe feeling ashamed of involving physicians in an “*unpleasant experience*”. [31] This implicit power imbalance influences the level of control women feel they exert. In contrast, in other medical cultures women are encouraged to ask questions and, where possible, participate in their care. [33, 35]

Finally, the legacy of the past also contributes in shaping women’s experiences. The Vietnamese policy “*of enhancing the quality of its population*” linked to a rise in birth defects from Agent Orange after the Viet Nam war, may be an attempt to obliterate the past. [31] Similarly, early 20th century eugenicist policies in Finland may still influence the way antenatal diagnosis is perceived, and the way women experience terminations for fetal abnormality and are cared for, as health professionals now emphasise parental autonomy. [39]

***Discussion***

This meta-ethnography indicates that pregnancy termination for fetal abnormality affects women as individuals, patients and social beings. Women’s experience can be understood within a multi-dimensional framework (micro, meso, macro); each dimension corresponding women’s interactions with themselves, the health community or their environment.

The micro dimension centres on women’s internal world. Women’s experience is, first and foremost, an intimate experience. Across very different countries, the experience of terminating a pregnancy for fetal abnormality is traumatic, a finding consistent with the quantitative literature. It is akin to an existential crisis, a metaphor utilised in the Vietnamese study [31] and the literature about decision-making following a diagnosis of fetal abnormality. [3] However, It is also an illustration of resilience and, for some, an opportunity for growth, a finding in line with some bereavement studies. [41]

The meso dimension focuses on women’s experience of care during and after pregnancy. Providing women with information enables them to make informed decisions and cope with the termination long-term. Information provision can also be empowering, enabling women to regain control over a situation many feel they have no control over. This review, however, suggests that although women generally receive information on the abnormality and, to a lesser extent, the procedure, they mostly feel unprepared for its emotional toll. Health professionals would need to find ways to support women post-termination and reassure them that their pain is part of a normal grief response. Finally, the structure and duration of care and the care pathway need attention, as many women find these lacking or fragmented. The lack of aftercare is particularly manifest in this review, a finding supporting existing research. [4, 42]

Finally, the macro dimension focuses on the laws, policies, and historical background, which determine but are also the result of societal attitudes towards pregnancy termination for fetal abnormality. Whether or not these terminations are permitted, the timing and medical conditions for which they are performed, the quality of clinical practice, the attitudes of caregivers, societal expectations of women as mothers, as well as attitudes towards abortion and disability, collectively form the landscape within which women experience pregnancy termination for fetal abnormality. As long as societies send conflicting messages to women, extolling the acceptance of disability while encouraging antenatal screening, many women may feel unable to share their story and thus feel isolated and stigmatised.

**Implications**

**Acknowledging the complexity of women’s experiences**

Pregnancy termination for fetal abnormality is both a type of abortion and a unique form of bereavement, which is inconsistent with the clinical and societal paradigm of abortion when pregnancy is unwanted. Pregnancy termination for fetal abnormality also differs from other perinatal losses which do not arise from a woman’s decision, and from other types of bereavement in that the loss is not usually socially sanctioned. As pregnancy termination for fetal abnormality is a relatively new phenomenon, women (and health professionals) are unable to draw on previous knowledge. Furthermore, technological developments in screening mean that women are constantly faced with new questions which have yet to receive normative responses. [43] Thus, it is essential that health professionals and policy makers conceptualise and acknowledge the complexity of this phenomenon and the range of emotions it generates.

**The need for structured, coordinated and woman-centred care pathways**

As many women in the studies reviewed found their care pathway fragmented and, at times, lacking, it is important that health professionals develop, manage and implement better structured and coordinated care pathways. Women need information about the termination itself, the decisions to be made before and after it, and the emotional fallout in the short- and longer-term. Women should be supported throughout the process, including post-termination if need be. Care also needs to address psychological issues that are particularly relevant to pregnancy termination for fetal abnormality, such as self-blame and guilt. [44] These care pathways need to be woman-centred and reflect women’s preferences in terms of their clinical care (e.g. termination method), how to deal with the baby post-termination and the terminology used to refer to their situation. As part of coordinated care pathways, health professionals should consider early referral to support groups, or other organisations that may fill some of the gaps in the care they provide, and/or to therapy services if it seems warranted.

**Law and policy issues**

The Brazilian study provides a clear reason to legalise termination in cases of lethal fetal abnormality, while the Israeli study illustrates the importance of removing obstacles to accessing a procedure most women already find difficult to contemplate. Finally, the polarisation of the debate surrounding pregnancy termination for fetal abnormality (and more generally abortion) in the countries where it is raging leads to stigmatisation and harms women. Although these observations are specific to the countries from which the reviewed studies originated, the implications are relevant globally.

**Limitations**

This review has several limitations. It covers only articles written in English, excluding potentially insightful research. The USA and UK were over-represented, women in the studies originating from high-income countries were predominantly white, middle-class, and well-educated. This bias has been observed in other studies. [4,8] Nevertheless in the USA, this profile may accurately reflect the population who undergo these terminations, given that by law, states are not required to cover “elective” abortion. This results in many women relying on private insurance providers to cover the cost of the termination. [45] Lastly, none of the studies was longitudinal, therefore it is not possible to ascertain how women fared over time.

***Conclusion***

This review brings together important insights into a topic that has been largely dominated by quantitative research. We hope that our recommendations will enable women’s voices to be better heard in an often politically-charged debate and result in their needs being addressed more appropriately. It is noteworthy that only a relatively small number of studies were identified as relevant to the topic and considered to be of sufficient quality to be included in the review. The review also indicates that there remains a dearth of research in some areas, for example, on women’s experience of care and whether the care they receive meets their needs. It would also be beneficial to examine health professionals’ understanding of women’s experiences as this would help to identify potential knowledge needs. Given the importance of the cultural context, future research should also examine to what extent, women feel pressurised to experience and express their grief in a way that matches society’s idea of motherhood. [43] Finally, owing to the paucity of evidence, research into interventions to support women during and post-termination is required.

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**Table 1. Study characteristics**

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| --- | --- | --- | --- | --- | --- |
| **Articles** | **Country** | **Participants** | **Data collection** | **Methodology** | **Explored** |
| Bryar 199727 | USA | 3 women | Interviews | Phenomenology | Decisions to end the pregnancy, adjustment to loss, meaning of loss |
| Rillstone 200128 | USA | 13 women, 9 men 2 health professionals 3 cases continued with pregnancy | Interviews | Grounded theory | Coping with a new pregnancy, experiences of terminated pregnancy and management of anguish in new pregnancy |
| Ferreira da Costa 200529 | Brazil | 10 women | Interviews | Thematic analysis | Experiences of TFA from diagnosis to termination through to planning subsequent pregnancy, legal aspect |
| McCoyd 200730 | USA | 30 women | Interviews | Grounded Theory and Framework analysis | Psychosocial responses, expectations and dilemmas. Social factors and consequences of the loss |
| Gammeltoft 200831 | Viet Nam | 17 women | Observations and interviews | Ethnography & Thematic analysis | Experiences of the procedure and aftermath |
| Graham 200932 | UK | 9 women, 3 men, 21 health professionals | Interviews | Thematic approach, descriptive & post-structuralist discursive analysis | Attitudes to/experience of feticide |
| Hunt 200933 | UK | 38 women, 10 men | Secondary analysis of interviews | Framework analysis | Experiences of decision making immediately after termination |
| Leichtentritt 201134 | Israel | 9 women | Interviews | Narrative analysis | Experiences of feticide |
| Kerns 201235 | USA | 21 women,  4 cases of pregnancy complications | Interviews | Grounded theory | Experiences of decision making regarding the method of termination |
| Asplin 201336 | Sweden | 11 women | Interviews | Qualitative content analysis | Experiences of the care provided |
| France 201337 b | UK | 28 women,  9 men | Secondary analysis of interviews | Framework analysis | Experiences of disclosing the end of the pregnancy to others (including children) |
| Gawron 201338a | USA | 30 women | Interviews & medical records | Latent & constant comparative analysis | Experiences of decision making and pregnancy termination services |
| Koponen 201339 | Finland | 8 women | Online narratives | Discourse analysis | The ways women construct, experience and impart meaning to the experience through the use of language |
| Lafarge 201340 | UK | 27 women | Online narratives | Interpretative Phenomenological Analysis | Experiences of coping with the procedure and afterwards |

a Sample comprised women presenting for termination because of fetal abnormality. All other studies are based on women who had undergone termination.

b Sub-sample of the Hunt study but analysed independently.

1. \*Further methodological details are available from the corresponding author. [↑](#footnote-ref-1)