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Who do Australian women seek social support from during the reproductive decision-making process?

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Abstract

Limited evidence exists about women's experiences of social support for reproductive decision-making, particularly who women seek social support from during decision-making. Using a concurrent mixed methods approach, this research explored who women aged 25–35 years living in Victoria, Australia, seek social support from during reproductive decision-making. Women seek social support for reproductive decision-making from multiple sources. However, through exploring women's support seeking for reproductive decision-making, rather than once a reproductive decision had been made, the study highlights the nuanced and contextual nature of support seeking for reproductive decision-making demonstrating support seeking is influenced by: type of reproductive decision; women's relationships with members of their social network; previous experiences of support seeking for reproductive decisions; expectations of the support they would receive; homophily; and temporality. This research provides important insight into who women seek support from for reproductive decision-making. Understanding this will help inform future social and public health interventions.

KEYWORDS
abortion, contraception, decision-making, mixed methods, reproduction, reproductive autonomy, social support

1 | INTRODUCTION

Implicit in the right to health is the right to reproductive health including the freedom to decide the number, spacing, and timing of any children; access to safe, affordable, and effective contraception and termination of pregnancy; and autonomy and privacy in the decision-making (United Nations, 2014; United Nations Human Rights Office of the High Commissioner, 1979). Reproductive decision-making is a process; it occurs over time and is influenced by intersections of multiple historical and contemporary factors at the individual, community, and macro-societal levels (Graham et al., 2016). Autonomy and privacy in decision-making are critical to the empowerment of women to decide if and from whom to seek social support for reproductive decision-making. Reproductive decision-making involves all aspects of a woman's fertility: whether or not to have children, and the timing, spacing, and number; and mechanisms for regulating fertility including sexual activity, contraception, termination, and assisted reproduction (Redshaw & Martin, 2011). As such, reproductive decision-making is not static nor focused on one type of decision; it is a dynamic and iterative process in which multiple reproductive decisions are constantly

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negotiated by women simultaneously throughout their reproductive years. The term reproductive decision-making is used throughout to capture both factors and processes that shape and influence women's decision-making. Despite this, very little is known or understood about women's reproductive autonomy in relation to who women seek social support from for reproductive decision-making. The aim of this study was to explore who women seek social support from during reproductive decision-making.

Social support plays an important role in health and wellbeing, including reproductive health (Bernardi, 2003; Heaney & Israel, 2008). There are many definitions of social support; however, the central idea in all definitions is the provision of assistance through interpersonal relationships (Heaney & Israel, 2008; Song et al., 2011), and the perception that one belongs to social networks where reciprocal regard, obligations, and assistance function (Taylor, 2012). Social support functions through various types of social connections, social networks, and relationships, including partners, family, friends, colleagues, and acquaintances (Leahy Warren, 2005). Social networks, a key functional aspect of social support, can impact on health either positively or negatively, as can the lack of social networks, and have a role in establishing and perpetuating social norms and expectations, and thus influence health behaviour and decisions, including reproductive decisions (Lam & Dickerson, 2013).

Social support and social networks are important to women's reproductive decision-making (Baheiraei et al., 2012; Price & Hawkins, 2007) by enabling or hindering access to information, resources, tangible assistance, and autonomy. The influences of social support are driven not only by the tangible experience or use of support resources, but also by beliefs and perceptions about the availability of, and access to, support (Taylor, 2012). Previous research demonstrates the influence of social networks on reproductive decision-making (Baheiraei et al., 2012; Bernardi, 2003; Markham et al., 2010; Price & Hawkins, 2007), with emphasis on understanding socially constructed gender roles in reproduction and reproductive decision-making (Fennell, 2011; Slauson-Blevins & Johnson, 2016; Throsby & Gill, 2004).

While it has been established that women do not generally make reproductive decisions in isolation (Lowe & Moore, 2014), nuanced understanding of how women come to make their reproductive decisions and who they seek social support from within their social networks is limited. Previous research has primarily focused on the impact of social support on the confidence of first-time mothers (see for example Leahy Warren, 2005), or has examined reproductive decision-making in non-Western cultures (see for example Samandari et al., 2010) which while important may not be transferable to Western societies. Reproductive decision-making within couples can be shared (Alvarez, 2018; Riggs & Bartholomaeus, 2016), yet despite men's role in reproduction and reproductive decision-making, women often assume the dominant role and can regulate their fertility without negotiation with their sexual partners (Fennell, 2011), thereby constructing agency and autonomy over their reproduction. This reproductive agency and autonomy is underpinned by a woman's right to control her body and fertility (Redshaw & Martin, 2011; Wigginton et al., 2015), yet is constrained by mechanisms of reproductive governance including policy, legislation, economic regulations, service availability, and socio-cultural norms (Graham et al., 2016; Morgan & Roberts, 2012).

There is currently limited evidence about women's experiences of social support for reproductive decision-making, particularly who women seek social support from during decision-making. Greater understanding about the role of social support in women's reproductive decision-making, including knowledge of the sources of social support and recognising the social support needs of diverse women, will assist with advocating for future social and public health interventions. This research explored who women aged 25–35 years seek social support from during reproductive decision-making.

What is known about this topic?

- Reproductive decision-making is continuously negotiated by women during their reproductive years.
- Social support and a woman's social networks can both enable and hinder women's reproductive decision-making.

What this paper adds?

- Who and how many people women seek social support from for reproductive decision-making varies by the type of reproductive decision.
- Women's social support seeking for reproductive decision-making is informed by their past experiences.
- Women's reproductive autonomy is generally high, although varies by demographic characteristics.

2 | MATERIALS AND METHODS

A concurrent mixed methods study was undertaken to describe who women aged 25–35 years living in Victoria, Australia, seek social support from during reproductive decision-making. The quantitative component describes who women seek social support from while the qualitative component explores in greater depth the reasons why women draw on these people for social support in their reproductive decision-making. Ethics approval for this study was granted by Deakin University and La Trobe University Human Research Ethics Committees (2017-104).

2.1 | Sample, sampling, and recruitment

Congruent with a concurrent mixed methods design (Onwuegbuzie & Collins, 2007), non-probability purposive and snowballing sampling methods were used, as proportionality of the target sample to the population was not the main concern of the research (Valerio

et al., 2016). Sample size was determined using the framework for mixed methods research proposed by Onwuegbuzie and Collins (2007). Women living in Victoria, Australia aged between 25 and 35 years of age were eligible to participate in this study. This age range was selected as it is considered peak reproductive age (Australian Institute of Health & Welfare, 2021). While there were no specific exclusion criteria, the questionnaire was only produced in English, potentially creating selection bias as it excluded women who could not read English (Neuman, 2011), and required access to the internet. Recruitment involved promoting the study via a dedicated Facebook page and through health and community-based organisations of relevance to women in the target population. The use of social media in non-probability samples has been shown to increase sample size and representativeness (Baltar & Brunet, 2012) due to the wider geographical reach and accessibility of social media channels.

2.2 | Data collection

An anonymous online questionnaire was developed and administered via Qualtrics. As no single instrument describes social support in relation to reproductive decision-making, a questionnaire was constructed based on existing validated instruments and a review of literature. The questionnaire included three domains: demographic characteristics; reproductive decision-making autonomy; and who women seek social support from for reproductive decision-making.

Items to measure demographic characteristics (age, relationship status, sexual orientation, highest level of education, employment status, total weekly income, geographic location of residence, country of birth, language spoken at home, Aboriginal and Torres Strait Islander status, and religiosity) were based on items from the Australian census (Australian Bureau of Statistics, 2016b) and aimed to describe the sample and determine whether experiences varied across different demographic characteristics (Kearney & White, 2016).

To assess participants' control over their reproductive decisions and their ability to achieve their reproductive intentions, the Reproductive Autonomy Decision-Making Scale was used (Upadhyay et al., 2014). Factor analysis suggest the scale has high overall reliability (Alpha = 0.78; Upadhyay et al., 2014). The scale assesses a woman's power to control matters regarding contraceptive use, pregnancy, and childbearing by measuring decision-making power through a set of questions regarding who has the final say in different reproductive situations. The original scale allowed participants to choose from three response choices: my partner (or someone else), me and my partner (or someone else) equally, or me. For this research, response choices were extended to me, my sexual partner, both me and my partner equally, my parent/s, my parent/s in-law, and other, to capture the broader diversity of who women may seek support from in the Australian context. With regards to who women seek social support from before making reproductive decisions, items were developed based on the existing literature for varying types of reproductive decisions.

The questionnaire captured qualitative information regarding positive and negative experiences relating to seeking social support for reproductive decision-making using the critical incident technique. This technique ascertains the significance participants attach to real-life experiences, yielding rich, contextualised data that provides valuable *"insight into how and why people engage in the activity"* (Hughes et al., 2007, p. 49). These questions allowed researchers to develop an understanding of the simple, numerical data ascertained through the preceding sections (FitzGerald et al., 2008).

2.3 | Data management and analysis

A total of 382 women completed the questionnaire. The data were cleaned to check for eligibility, resulting in 46 participants being excluded for not meeting the age criteria and / or residing outside of Victoria. Participants were excluded if they did not click submit at the end of the questionnaire (n = 102) as per the Plain Language Statement which indicated that participants could withdraw up until they clicked submit. Therefore, it was assumed that even if the questionnaire had been completed, those who did not click submit had decided to withdraw their consent and as such their data were excluded from analysis. The final sample size consisted of 234 women.

Postcode of residence were re-coded into major cities, inner regional, outer regional, remote, and very remote based on the Accessibility and Remoteness Index of Australia (ARIA+) (Australian Bureau of Statistics, 2016a). The Reductive Autonomy Decision-Making Scale was re-coded so that the response option "me" was given the highest score (3) followed by me and my partner (or someone else) equally (2), or my partner (or someone else; 1). A summary score was created (range 4 to 12) with a higher score indicating greater reproductive autonomy (Upadhyay et al., 2014).

Descriptive statistics were used to describe the demographic characteristics of the women. In order to determine how similar the sample was to all Victorian women aged 25 to 35 years, the sample demographic characteristics were compared to available population data. The difference in proportion and p-value are reported. Reproductive autonomy decision-making is reported using the mean and standard deviation. The Mann–Whitney U Test and the Kruskal–Wallis H Test describes differences in reproductive autonomy decision-making and demographic characteristics. Frequencies and percent describe who women sought support from and how many people they sought support from before making reproductive decisions.

The quantitative and qualitative data collection and analysis was connected, enabling exploration of the statistical results through analysis of qualitative comments (Creswell & Creswell, 2009). As such, the qualitative data generated from the open-ended critical incident technique were analysed to interpret and expand on the three key areas derived from the quantitative data; namely reproductive autonomy, who the women sought support from, and the number of supports sought. Deductive analysis, driven by these three areas, was used with the qualitative data

enabling greater detail and discussion of the statistical findings (Braun & Clarke, 2006). Data from the open-ended questions are presented as participant quotes and attributed using identification number and age.

3 | RESULTS

Table 1 describes the demographic characteristics of the women and how the sample compares to women aged 25 to 35 years in Victoria. The women in the sample were less likely to be in a relationship, and more likely to be married compared to Victorian women aged 25 to 34 years. The sample had a higher proportion of women who identified as non-heterosexual compared with Australian women aged 18 years or more. More women in the sample held a bachelor and / or postgraduate degree and less women held only year 12 or below as their highest educational qualification compared to Victorian women aged 24 to 34 years. The women in the sample were less likely to have a negative income or no income, or an income of \$1–\$299 or \$400–\$799 per week, and more likely to have an income of \$1250–\$1999 per week compared to Victorian women aged 25 to 34 years. The sample had a higher proportion of women who were born in Australia compared to Australian women aged 24 to 44 years, and more women in the sample spoke English at home compared to the Australian population of all women. The proportion of women in the sample who reported having no religion was higher than all Australian women.

3.1 | Reproductive autonomy

The mean reproductive autonomy decision-making score was 9.3 (*SD* 1.6). There was a statistically significant difference between relationship status (Kruskal-Wallis H = 15.6; *df* = 3; *p* = 0.001) and reproductive autonomy decision-making with women who were married and living with their spouse reporting lower reproductive autonomy decision-making (mean rank = 107.8) than women who were not legally married but living together (mean rank = 112.7), women who were in a relationship but not living together (mean rank = 135.1), and women who were not in a relationship (mean rank 157.3). There was a statistically significant difference between employment status (Kruskal–Wallis H = 12.5; *df* = 3; *p* = 0.006) and reproductive autonomy decision-making with employed women (full-time mean rank = 129; part-time mean rank = 107.4; employed but away from work mean rank = 133.4) reporting higher levels of reproductive autonomy decision-making than unemployed women (mean rank = 83.8; Table 2).

3.2 | Who women sought social support from

The women were asked who they first sought support from before making a reproductive decision. As shown in Table 3, who the women sought support from varied by type of reproductive decision.

The qualitative data revealed a diversity of contextual experiences in relation to who the women sought support from. Who women sought support from varied according to the context or circumstances of support seeking and was influenced by a range of factors including the type of decision support was being sought for, the timing of support seeking, women's relationship with social networks and past experiences of support seeking, and contextual intersections of these factors.

A commonly reported experience among the women with regards to who they sought support from was seeking support from sources to attain reproductive autonomy. Women sought support, particularly from partners, in circumstances where they felt the support would be positive and contribute to exercising their reproductive autonomy; that is, when the women felt they had control over their reproductive decisions, even in shared decision-making situations, experienced the support as empowering, or affirmational when they received confirmation for their decisions. For example, their sense of control and reproductive autonomy was embedded within supportive relationships, particularly with their partners and family:

> Having a very open and well supported family environment, I've always had the support and ability to seek assistance and direction. My husband has also had a similar upbringing, which enables us to have open discussion and equal parts in decision-making. I have always felt in control of my reproductive decision-making (181; Age 32).

As the quote demonstrates, while this participant felt she had control over her reproductive decision-making, it was still within the context of her partner having an equal say in reproductive decisions which ultimately shifts reproductive autonomy from the participant to shared decision-making with her partner.

Women's support seeking from partners to achieve autonomy in reproductive decision-making was further highlighted by examples in which women made a decision and then negotiated that decision with their partner. For example, one woman commented that her partner *"was very receptive to my concerns"* (285; Age 28) when discussing her concerns about no longer wanting to take the oral contraceptive pill and instead negotiated with her partner to use condoms. Another discussed her experience as, *"Always empowered by my partner and had my decisions fully supported"* (275; Age 32). Similarly, another woman (277; Age 32) explained how her body "*needed a break from synthetic hormones…After discussing this with my partner and also my best friend, my partner and I decided to use male condoms as contraception"*. This decision-making resulted in the woman feeling "*very supported*" and demonstrates how women take control of their reproductive decision-making by first making a decision individually, discussing it with their family or friends, and then negotiating it with their partner, ultimately empowering women and increasing their autonomy.

TABLE 1 Demographic characteristics of the women (n = 234)

Demographic characteristics	Sample *N*	Sample %	Victoria *n*	Victoria %	% Difference (*p*-value)
Age					
25–29	101	43.2	223,709	45.2	−0.02 (0.54)
30–35	133	56.8	271,692	54.8	0.02 (0.54)
Relationship status[a]					
Not in a relationship	31	13.2	156,443	34.6	−0.18 (<0.001)
In a relationship, not living together	17	7.3			
Not legally married but living together	55	23.5	77,128	17.1	0.05 (0.07)
Married and living with spouse	131	56.0	175,356	38.8	0.13 (<0.001)
Sexual orientation[b]					
Heterosexual	212	90.6	2,310,099	96.6	−0.06 (<0.001)
Lesbian	2	0.9	80,790	3.4	0.06 (<0.001)
Bisexual	17	7.3			
Other	3	1.3			
Highest level of education[c]					
Year 12 or below	16	6.8	420,399	17.6	−0.51 (<0.001)
Certificate or diploma	48	20.5	107,225	23.7	0.06 (0.011)
Bachelor degree	92	39.3	140,680	31.1	0.2 (<0.001)
Postgraduate degree	78	33.3	63,574	14.1	0.25 (<0.001)
Employment status[d]					
Full-time	120	51.3	178,852	39.6	−0.04 (0.213)
Part-time	77	32.9	105,572	23.4	0.003 (0.936)
Employed, away from work	13	5.6	18,377	4.1	−0.001 (0.9315)
Unemployed	24	10.2	20,446	4.5	0.04 (0.014)
Total weekly income[e]					
Negative/Nil income	9	3.8	47,176	11.3	−0.07 (<0.001)
$1–$299	14	6.0	42,840	10.3	−0.04 (0.03)
$300–$399	8	3.4	24,559	5.9	−0.02 (0.11)
$400–$799	47	20.1	107,274	25.7	−0.06 (0.05)
$800–$1,249	65	27.8	104,065	24.9	0.03 (0.31)
$1,250–$1,999	83	35.5	75,367	18.0	0.17 (<0.001)
$2,000 or more	8	3.4	16,584	4.0	−0.006 (0.67)
Geographic location of residence[f]					
Major cities	102	43.6	–	–	–
Inner regional	122	52.1	–	–	–
Outer regional	10	4.3	–	–	–
Country of birth[g]					
Australia	223	95.3	487,290	61.7	0.35 (<0.001)
Other	11	4.7	308,255	38.3	−0.33 (<0.001)
Language spoken at home[h]					
English	228	97.4	2,045,460	72.2	0.25 (<0.001)
Other	6	2.6	785,881	27.8	−0.25 (<0.001)
Aboriginal and Torres Strait Islander[i]					
No	231	98.7	421,283	99.22	−0.005 (0.38)
Yes	3	1.3	3,319	0.78	0.05 (0.38)

TABLE 1 (Continued)

Demographic characteristics	Sample N	Sample %	Victoria n	Victoria %	% Difference (p–value)
Religiosity[j]					
No Religion	147	62.8	914,656	33.3	0.29 (<0.001)
Religious	87	37.2	1,831,242	66.7	−0.3 (<0.001)

[a]Relationship status data for Victoria is based on social marital status for aged 25 to 34 years (Australian Bureau of Statistics, 2017). The data provided for not in a relationship / in a relationship, not living together have been compared to social marital status for women in Victoria who are not married.

[b]Victorian data not available as the Census did not collect this information in 2016 (Australian Bureau of Statistics, 2016b). The 2016 Census measured relationships within each household to identify the number of same-sex couples; therefore, it is not a good indicator of sexual orientation. Estimates for Victoria are based on Wilson and Shalley (2018) for women aged 18 years or more. Denominator is total female population for Victoria in 2016 (Australian Bureau of Statistics, 2017).

[c]Highest level of education for Victoria is based on women aged 25 to 34 years. Postgraduate degree includes all degrees above bachelors level qualification (Australian Bureau of Statistics, 2017).

[d]Employment status is based on Victorian women aged 25 to 34 years (Australian Bureau of Statistics, 2017).

[e]Income is based on Australian women aged 25 to 34 years (Australian Bureau of Statistics, 2017).

[f]ARIA data by age, sex, and State not available.

[g]Country of birth based on Australian women aged 24 to 44 years and excludes country of birth not stated (Australian Bureau of Statistics, 2017).

[h]Language spoken at home is based on Australian population for all women and excludes language spoken not stated (Australian Bureau of Statistics, 2017).

[i]Aboriginal and Torres Strait Islander is based on women aged 25 to 34 years and excludes Aboriginal and Torres Strait Islander status not stated (Australian Bureau of Statistics, 2017).

[j]Religiosity is based on Australian population of all women and excludes religious affiliation not stated (Australian Bureau of Statistics, 2017).

In contrast, women also reported negative experiences of support from partners in which they did not feel empowered, or their reproductive autonomy was not enabled, potentially compromising their experience of reproductive autonomy.

> Being given an ultimatum to go on the pill by a partner then being forced to have an abortion alone when that same partner refused to support me through an unplanned pregnancy (20; Age 30).

Who women sought support from, and their reasons for seeking support from particular people, varied according to the type of reproductive decision. This also intersected with the nature of their relationship with that person, the women's previous experiences of support seeking, and the expectation of the kind of support they would receive form that person. In particular, the notion of homophily influenced who the women sought support from. That is, the women sought support from those in their social networks, particularly friends, who had previous and/or similar experiences. This was particularly the case in relation to contraceptive methods, as demonstrated in the quotes below:

> Friends are a good social support as we are open about contraception methods and what has worked and what hasn't (340; Age 28).

> Getting information and feedback about family and friends experiences with the IUD encouraged me to choose this form of contraception after having my children, and it has been extremely effective (84; Age 31).

The women also indicated that who they sought support from changed depending on their reproductive circumstances and the context of their support networks, and importantly, how they sometimes refrained from seeking support from social networks due to a lack of homophily. This was particularly the case for reproductive decisions related to family planning and having children, whereby those experiencing fertility issues and/or miscarriages found it difficult to seek support from those who had not experienced these.

> I found it was difficult to speak to many social supports as we were having infertility issues. Most of our friends had children. They were supportive but from my end I was jealous of them and didn't want to spend as much time with them as previously we had. Also felt like some friends didn't appreciate the impact it had on us saying things, things like - good things come to those who wait (247; Age 30).

> I've gone on to have five miscarriages after my abortion, the lack of social support in relation to the grief that one feels when going through the loss of a baby is enormous. I've lost many close friendships with other women who were starting out their own journey's [sic] into motherhood. Even asking for support via psychological means, there are very few people who understand the journey or are prepared to support you on it when they have their own happiness - a family (212; Age 33).

TABLE 2 Reproductive autonomy by demographic characterises (n = 234)

Demographic characteristics	Number	Rank	Test statistic	*p*-value
Age[a]			6622.0	0.85
25–29	101	116.56		
30–35	133	118.21		
Relationship status			15.6	0.001
Not in a relationship	31	157.31		
In a relationship, not living together	17	135.06		
Not legally married but living together	55	112.72		
Married and living with spouse	131	107.81		
Sexual orientation			7.3	0.063
Heterosexual	212	117.25		
Lesbian	2	4.25		
Bisexual	17	127.21		
Other	3	156.00		
Highest level of education			1.7	0.629
Year 12 or below	16	102.88		
Certificate or Diploma	48	114.55		
Bachelor degree	92	115.93		
Postgraduate degree	78	124.17		
Employment status			12.51	0.006
Full-time	120	129.00		
Part-time	77	107.42		
Employed, away from work	13	133.42		
Unemployed	24	83.75		
Total weekly income			11.0	0.089
Negative/Nil income	9	58.2		
$1–$299	14	95.3		
$300–$399	8	101.9		
$400–$799	47	127.0		
$800–$1,249	65	122.3		
$1,250–$1,999	83	120.8		
$2,000 or more	8	109.8		
Geographic location of residence			4.1	0.130
Major Cities	102	125.1		
Inner Regional	122	113.8		
Outer Regional	10	85.6		
Country of birth			1037.5	0.376
Australia	223	116.7		
Other	11	134.7		
Language spoken at home			660.0	0.880
English	228	117.6		
Other	6	113.5		
Aboriginal and Torres Strait Islander			306.0	0.721
No	231	117.7		
Yes	3	104.0		
Religiosity			5842.0	0.257
No Religion	147	121.3		
Religious	87	111.2		

TABLE 3 Who the women sought support from before making a decision (n = 234)[a,b]

	Partner		Parent		Parent in-law		Siblings		Friends		Work Colleagues	
	n	%	*N*	%	*n*	%	*n*	%	*n*	%	*n*	%
Contraceptive pill	80	34.2	76	32.5	1	0.4	22	9.4	72	30.8	5	2.1
Implants or injections	22	9.4	15	6.4	1	0.4	12	5.1	46	19.7	–	–
Vaginal ring (e.g. Nuvaring)	4	1.7	1	0.4	–	–	1	0.4	7	3	–	–
IUD	30	8.5	9	3.8	–	–	8	3.4	23	9.8	3	1.3
Barrier methods	128	54.7	5	2.1	1	0.4	7	3.0	32	13.7	1	0.4
Natural methods	56	23.9	4	1.7	1	0.4	2	0.9	13	5.6	2	0.9
Emergency contraception	39	16.7	2	0.9	–	–	4	1.7	28	12.0	1	0.4
Termination of pregnancy	20	8.5	13	5.6	1	0.4	3	1.3	12	5.1	1	0.4
Commencing a family or spacing of children	112	47.9	19	8.1	4	1.7	10	4.3	29	12.4	10	4.3
Assisted reproduction	16	6.8	8	3.4	3	1.3	6	2.6	13	5.6	6	2.6
Surrogacy or adoption	12	5.1	7	3.0	2	0.9	6	2.6	8	3.4	5	2.1
Not having children	41	17.5	14	6.0	1	0.9	9	3.8	19	8.1	4	1.7
Abstinence	24	10.3	5	2.1	–	–	2	0.9	1	0.4	–	–
Permanent methods of sterilisation	4	1.7	1	0.4	–	–	–	–	1	0.4	–	–

[a]Percentages do not add up to 100 as more than one response could be provided.

[b]The data show the women who responded "yes" to each type of person they sought support for each reproductive decision as a percentage of all women (n = 234).

Who women sought support from also had a temporal element; support seeking was influenced by the life stage of the woman when seeking support and the type of decision support was being sought for at that stage. Furthermore, the timing and experience of support (positive or negative) from key sources could have long-term impacts on women's reproductive decision-making and reproductive autonomy. For example, the women's mothers were often identified as an initial source of support, particularly about initiating the oral contraceptive pill as young people or in first sexual relationships. The women explained that their mothers were a source of support in two main ways: the first being their receptiveness and openness to reproductive decision-making needs, for example:

> My mother has always had a [sic] open door policy regarding sexual health and this has led me to feel supported and confident in my reproductive decision-making (324; Age 28).

> My mother played a very key role, and her encouragement of me to look after my reproductive health from a younger age has meant I've never had a pregnancy 'scare' (100; Aged 29).

As indicated in the quotes above, the initial support the women received from their mothers when they were younger often led to positive experiences with reproductive decisions in later years.

Second, the women sought support from their mothers due to their mother's knowledge and information they had accumulated through life experiences:

> When I started to go out with my first bf [boyfriend] (who is still my current partner), my Mum was very supportive in me going onto the contraceptive pill. She also spoke to me about the other benefits such as reducing acne, knowing when I would get my period and able to skip it. Mum discussed me going to the doctor and speaking to them about it further (1; Age 26).

> When I was younger and becoming sexually active, I spoke to my mum about going on the pill and not only was she supportive and took me to the Dr. She was very informative and helped me to make the right decision for me (19; Age 29).

However, not all women had a positive experience in seeking early support from their mother, and this had longer-term impacts for the women:

> My mother refusing to allow or discuss anything to do with reproductive decisions, other than abstinence. The greatest damage ever done to being informed about choices and how to be safe was

> through the narrow mindedness of my mother. Her opinion did not match her choices made in her own life and that inflicted my life. Further, her own negative reaction to the pill made it not an option for me and made me quite fearful until I was in my mid-20s (332; Age 28).

Given that parents, and particularly mothers, can often be the gatekeeper in early years regarding reproductive decisions, the lack of support received could have lasting impacts on future decision-making as well as influence who women seek support from in the future to meet their expectations of support. This was also the case with other negative experiences of reproductive decision-making support, whereby these experiences of a lack of support could lead to lasting detrimental impacts for women.

> I had a missed miscarriage and felt that the support I received from all people around me at the time was poor. The medical staff were 'practical' rather than understanding and my partner and family were sympathetic but in a disconnected way, not understanding how it felt or caring enough to support me adequately through it. I had medical and then surgical abortion methods to clear the remains and no real support throughout… I did not have close friends at the time. This experience changed me and my life completely (68; Age 31).

3.3 | The number of supports sought

Of the women that sought support, the number of people from whom the women sought support from prior to making a reproductive decision ranged from one to six and varied by the reproductive decision, with most women only seeking support from one person (Table 4).

The number and source of support was influenced by how receptive the women thought that source would be specific to their reproductive decision. For example, as indicated in the quote below, this woman sought support from multiple sources, but tailored this in terms of what she felt comfortable speaking about and with whom based on how receptive they might be. While family and friends were identified as a source of support, using online methods also enabled support as it comes with *"greater freedom"*:

> I'm finding a lot of people are going to online groups (forums, Reddit, Facebook groups) for anecdotes about reproductive choices. I think this gives us greater freedom to be able to discuss things that may be "unsavoury" or "taboo" in our real life social circles. So while with some friends and family I cannot bring up my miscarriage, with others I only talk about how I miscarried not that I chose to terminate the pregnancy, and with friends online I can be more open about why I chose to terminate rather than let nature take its course and what my experience was like so those going through similar things know some of the things they may have to expect (312; Age 26).

The women tailored the number of supports they sought based on factors such as age, partner status, and type of reproductive decision (i.e. contraceptive methods, family planning). Further, this number was impacted by homophily, representing family and friends past experiences which could impact their ability to provide support. For example, decisions about contraception were often initially supported by family members, with friends and partners being a more common source of support in later years. However, for those with previous positive experiences, family members may remain an important source of support for women over time.

> Deciding when to start trying to have children, a discussion completely up to my husband and I; however open for discussion with our friends and family - advice and first hand experience was offered by all of them (112; Age 29).

For partnered women, while the decision to have children was one that was predominantly made with partners, support and advice was still sought from others.

4 | DISCUSSION

The findings reveal that social support seeking for reproductive decision-making among Victorian women is nuanced and contextual. It is dependent upon several factors and circumstances including the type of decision that support is being sought for, temporal factors such as the life stage of the women when seeking support, women's past experiences of their social networks for support seeking, or similar decision-making situations. The key findings from this research are that women tend to draw on a small network of supports, usually only one person, and predominantly from their partner, friends, or mother. The women reported a generally high level of reproductive autonomy, but this varied by demographic characteristics including their relationship status and employment status.

The results highlight that who and how many people women sought support from for reproductive decision-making varied by the type of reproductive decision. For example, women making decisions about commencing a family or the spacing of children, assisted reproduction, surrogacy or adoption, or not having children sought support for their reproductive decision-making from six different groups within their social networks. It is possible that due to the complexity and sensitivity of these reproductive decisions, women were seeking a diverse range of supports to assist their decision-making. With regards to termination of pregnancy, women sought support from four people across their social networks. Possible reasons for this could be

TABLE 4 The number of people the women sought support from before making a decision[a]

	1		2		3		4		5		6	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
Contraceptive pill (*n* = 160)	89	55.6	51	31.9	16	10.0	3	1.9	1	0.6	–	–
Implants or injections (*n* = 62)	41	66.1	13	21.0	3	4.8	5	8.1	–	–	–	–
Vaginal ring (e.g. Nuvaring) (*n* = 10)	8	80.0	1	10.0	1	10.0	–	–	–	–	–	–
IUD (*n* = 38)	22	57.9	10	26.3	3	7.9	3	7.9	–	–	–	–
Barrier methods (*n* = 140)	114	81.4	19	13.6	6	4.3	1	0.7	–	–	–	–
Natural methods (*n* = 68)	60	88.2	7	10.3	1	1.5	–	–	–	–	–	–
Emergency contraception (*n* = 62)	50	80.6	12	19.4	–	–	–	–	–	–	–	–
Termination of pregnancy (*n* = 28)	12	42.9	12	42.9	2	7.1	2	7.1	–	–	–	–
Commencing a family or spacing of children (*n* = 118)	84	71.2	17	14.4	9	7.6	3	2.5	3	2.5	2	1.7
Assisted reproduction (*n* = 23)	11	47.8	4	17.4	3	13.0	2	8.7	2	8.7	1	4.3
Surrogacy or adoption (*n* = 17)	8	47.1	1	11.8	3	17.6	2	11.8	1	5.9	1	5.9
Not having children (*n* = 48)	29	60.4	7	14.6	6	12.5	3	6.3	2	4.2	1	2.1
Abstinence (*n* = 27)	22	81.5	5	18.5	–	–	–	–	–	–	–	–
Permanent methods of sterilisation (*n* = 5)	4	80.0	1	20.0	–	–	–	–	–	–	–	–

[a]The sample size changes for each type of reproductive decisions as it excludes women who did not seek support for the type of reproductive decision.

due to prevailing social attitudes, and perceptions among the women themselves, of stigma attached to termination. Further, women also tailor the number of people they seek support from, and who those people are, based on previous experiences, whereby those they anticipate being more receptive may be sought out.

Women can face inequality in reproductive decision-making based on their demographic characteristics (Hall et al., 2012). These inequalities can relate, but are not limited, to knowledge (level of education), access to services (geographic location, socioeconomic status, ethnicity, and religiosity), and affordability/access to resources (socioeconomic status). Overall, the women tended to reveal a generally high level of reproductive autonomy, but this varied by demographic characteristics including their relationship status and employment status. For instance, women who were married and living with their spouse reported lower autonomy in reproductive decision-making than women who were not legally married but living together, women who were in a relationship but not living together, and women who were not in a relationship. It is possible this reflects greater shared reproductive decision-making among married couples. Previous research suggests heterosexual couples tend to make shared decisions regarding when to have children (Alvarez, 2018), and this is likely to influence other reproductive decisions including contraception use.

Differences in employment status and reproductive autonomy decision-making may reflect the role of economic status and security in reproductive decision-making. Previous research suggests financial status and security influence reproductive decision-making, including financial goals, educational and career aspirations and progression, and perceptions about the financial impacts of reproductive decisions such as whether to have children or not (Biggs et al., 2013; Blackstone & Stewart, 2016; Brunner Huber & Ersek, 2009; Cooke et al., 2010; Deshpande et al., 2015; Jean et al., 2016; Kirkman et al., 2009, 2010; Mazerolle et al., 2015; Metcalfe et al., 2014; Mortensen et al., 2012; Myers, 2017; Settle & Brumley, 2014).

This research has several strengths and limitations. The large sample, a strength of this study, is broadly representative of women aged 25 to 35 years living in Victoria with some exceptions which are likely the result of population data for Victoria women aged 25 to 35 years not being available. While non-probability sampling methods are appropriate for mixed methods research (Onwuegbuzie & Collins, 2007), such approaches limit the representativeness and generalisability of the study findings. However, it has been suggested that social media as a recruitment tool can increase sample representativeness (Baltar & Brunet, 2012). The current study was only conducted in English and as such may not reflect the experience of non-English speaking women aged 25 to 35 years living in

Victoria. The mixed methods approach allowed greater insight into who and the reasons why women sought out social support from different people and for different types of reproductive decisions. By including a range of types of reproductive decisions, rather than a focus on a single type, such as contraception, this study was able to demonstrate that who and how many people women seek support from during reproductive decision-making varies by type of reproductive decision. Finally, the use of an anonymous online questionnaire was a strength of this study as it enabled ease of access to the intended audience, who are high users of social media and the internet, provided anonymity and convenience for respondents, increasing the response rate in a relatively short timeframe.

5 | CONCLUSIONS

This research provides important insight into who women seek support from for reproductive decision-making. Reproductive decisions such as contraceptive use, and if, and when, to have children, are important decisions for all women, and as such, adequate support is an essential component to ensuring women's health needs are met. Further investigation into women's support needs regarding reproductive decision-making is required, including expanding the sample of women to capture different ages and demographic characteristics. For example, a more culturally and ethnically diverse sample, including Australian Aboriginal and Torres Strait Islander women, would help to develop a better understanding of support seeking among kinship groups and social networks, and factors intersecting with and influencing who women seek support from in culturally contextual situations. Longitudinal research is needed to better understand the intersections of social networks, supports, and temporality on women's reproductive decision-making and how these change over time.

Reproductive decision-making is contextual, nuanced, and complex, and as such, the establishment and maintenance of appropriate support mechanisms is crucial to promote autonomy and equity in reproductive decision-making among diverse groups of women, and for the range of reproductive decisions. Understanding and recognising the support needs of diverse women will assist with advocating for future social and public health practice and interventions to support women in their reproductive decision-making. Examples could include service providers' practices which seek to consider and incorporate social networks in models of caregiving and engagement; or which seek to provide greater information to support networks to increase their understanding of their role and impacts in women's reproductive decision-making, to enhance the quality of support for women.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

AUTHORS CONTRIBUTION

All authors contributed to the study design. CD undertook recruitment and data collection. All authors contributed to the analysis of the results and to the writing of the manuscript.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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