

ORIGINAL ARTICLE

Views and practice of abortion among Queensland midwives and sexual health nurses

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Background: A significant barrier to the access of safe abortion is the lack of trained abortion providers. Recent studies show that with appropriate education, nurses and midwives can provide abortions as safely as medical practitioners.

Aims: To examine the attitudes and practices of registered midwives (RMs) and sexual health nurses (SHNs) in Queensland toward abortion.

Materials and Methods: A cross-sectional mixed-methods questionnaire was distributed to RMs and SHNs from the Queensland Nursing and Midwifery Union. Data were described and analysed both quantitatively and qualitatively.

Results: There was a 20% response rate ($n = 624$) to the survey from the overall study population. There were 53.5% who reported they would support the provision of abortion in any situation at all; 7.4% held views based on religion or conscience that would make them completely opposed to abortion. There were 92.9% who felt that education surrounding abortion should be part of the core curriculum for midwifery and/or nursing students in Australia. The qualitative responses demonstrated a variety of views and suggestions regarding the practice of abortion.

Conclusions: There was a wide variation in views toward induced abortion from RMs and SHNs in Queensland. While a proportion of respondents opposed abortion in most circumstances, a significant group was in support of abortion in any situation and felt involvement in initiating and/or performing abortion would be within the scope of RMs and SHNs.

KEYWORDS

abortion, Australia, midwifery, nursing

INTRODUCTION

Around 56 million women worldwide seek abortions each year; many are in low- and middle-income countries (LMIC) in situations where abortion remains illegal and unsafe.^{1–3} A significant barrier to access is the lack of appropriately trained abortion providers, even in high-income countries (HIC)⁴ such as Australia

where abortion is legal. This shortage is more pronounced in rural areas and among certain ethnic groups.^{5–11} Task-shifting from physician to non-physician providers has been a promising, cost-effective approach in some LMICs and HICs, increasing the pool of competent abortion providers.^{12–15} Recent studies show that appropriately trained nurses and midwives can provide abortions as safely as medical practitioners.¹⁶ As new models of abortion

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care emerge, it is important that the views and current practice of abortion care among these practitioners are understood, and that education is appropriately designed to incorporate contemporary knowledge around abortion care.

A recent study involving the International Confederation of Midwives (ICM), representing 132 midwife associations in 113 countries, recommends referral for abortion and post-abortion care be designated as essential knowledge or skills for all midwives and trainees.¹⁷ The ICM also supports direct provision of early medical abortion (EMA), using mifepristone and misoprostol, to ten weeks gestation and of manual vacuum aspiration by midwives wishing to do so, and the education of midwives in the techniques. A joint Consensus Statement between the International Council of Nurses (ICN), the ICM and the International Federation of Gynaecology and Obstetrics demonstrates a commitment to the provision of voluntary post-abortion care being the standard of practice across these professional bodies.¹⁸

The state of Queensland has an area of 1.8 million km²; the population of 5.1 million is concentrated in the southeast corner but a substantial number of people live in rural and remote areas. Telemedicine is now widely practised and has become more available during the COVID-19 pandemic.^{19,20} Abortion was decriminalised by the Queensland parliament in October 2018; prior to this date abortion was openly and safely provided in some settings but the restrictive archaic law meant for many Queensland women access remained difficult and abortion practice stigmatised. Since decriminalisation, abortion has become more widely available including in the public sector.²¹

It is known that, to some extent, registered midwives (RMs) and sexual health nurses (SHNs) are already involved in the provision of abortion care in Queensland, as in other states, as part of women's reproductive health care. However, there has been no study to date surveying the opinions and practice experience of abortion among this professional group in Australia. For the purposes of this paper, SHNs were defined as nurses who self-identified as primarily working in sexual health facilities or primary healthcare centres with a focus on reproductive health. We undertook a study to examine the attitudes and practices of RMs and SHNs in Queensland toward induced abortion.

MATERIALS AND METHODS

This is an observational cross-sectional study of reports that includes both exploratory data analysis and qualitative thematic analysis. We have utilised a questionnaire adapted from two previous studies examining the views and practices of Fellows and specialist trainees of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) toward induced abortion.^{22,23} The survey included both open- and closed-ended questions. Participants were able to conclude the survey at any time for any reason. RMs and SHNs, who were identified as such via the Queensland Nursing and Midwifery Union member

portal, and had a valid email address were emailed with information about the study and an invitation to respond to the questionnaire via a Survey Monkey link. A follow-up reminder email was sent out four weeks later to the same group.

Relationships between quantitative variables were assessed with two-tailed Pearson's product-moment correlation analysis. Significant correlations were subject to χ^2 analyses; simple logistic and linear regression were used to characterise relationships maintaining statistical significance. NVIVO was used to assign free text comments into themes, generating data to inform a thematic analysis and quotes to support the quantitative data – a method derived by Braun and Clarke.²⁴

Ethics approval for this study was obtained from the James Cook University Human Research Ethics Committee (reference H8060).

RESULTS

Both invitation emails were received by >99.9% of Union members identified as part of the study population ($n = 3109$ first email, 3090 second email); 624 responses were received (20%). This was consistent with the proportion of responses received from Australian RANZCOG specialists and trainees in the 2020 study. One person exited at question 1, leaving a total of 623 participants; some participants did not answer all questions.

Quantitative data

Demographics and current practices

Demographic details of participants are representative of the Union member base. Most participants were female ($n = 607$, 97.4%) and almost half were within the 41–60 years age range ($n = 278$, 44.6%). The majority were practising clinically in urban areas ($n = 446$, 71.6%) and most commonly were full-time midwives in the public sector ($n = 440$, 70.6%). SHNs comprised only a small proportion of the overall cohort ($n = 78$, 12.5%). RMs in the first ten years post-qualification comprised 48.7% of respondents ($n = 289$) (Table 1). These characteristics were closely aligned with those in the overall study group, making this a demographically representative sample (personal communication, Dr Belinda Maier, 30/4/21).

Many RMs and SHNs who were involved in abortion as part of their routine practice were involved in both early abortion, which was defined as abortion of pregnancies less than 13 weeks gestation, and late abortion ($n = 206$, 33.1%). There were 46% of participants who stated they were not involved in abortion practice at all ($n = 291$). Very few were involved with surgical abortion alone ($n = 7$, 1.1%); however, 23.6% were involved in medical abortion ($n = 147$) and 22.6% were involved in both medical and surgical methods ($n = 141$). Recency of qualification was associated with provision of abortion care ($\chi^2 = 17.92$, 4 df, $P = 0.001$). Logistic regression analysis demonstrated an inverse relationship

TABLE 1 Participant demographics and current practices

Demographic characteristics and current practices	<i>n</i> (%)
Age	
<30	149 (23.9)
31–40	146 (23.4)
41–60	278 (44.6)
>60	50 (8)
Gender	
Male	12 (1.9)
Female	607 (97.4)
Other	1 (0.2)
Prefer not to answer	3 (0.5)
Year of qualification	
1971–1980	31 (5)
1981–1990	89 (14.3)
1991–2000	72 (11.6)
2001–2010	111 (17.8)
2011–2020	289 (46.4)
Current practice location	
Urban only	446 (71.6)
Rural/remote only	100 (16.1)
Both urban and rural/remote	60 (9.6)
Academic/administrative only	10 (1.6)
Current practice type	
Full-time midwifery – public sector	440 (70.6)
Full-time midwifery – private sector	55 (8.8)
Private practice midwifery with public endorsement	9 (1.4)
Attachment to general practice for midwifery/women's reproductive health	33 (5.8)
Full-time practice sexual health or women's reproductive health clinic	7 (1.1)
Part-time practice sexual health or women's reproductive health clinic	38 (6.1)
Administration in a midwifery/women's reproductive health area	12 (1.9)
Academic in a midwifery/women's reproductive health area	16 (2.6)
Current involvement in performance of abortion as part of usual practice	
Not at all	291 (46.7)
Early abortion only (<13 weeks)	45 (7.2)
Late abortion only (>13 weeks)	82 (13.2)
Both early and late abortion	206 (33.1)
Medical abortion only	147 (23.6)
Surgical abortion only	7 (1.1)
Both medical and surgical abortion	141 (22.6)
Public patients only	194 (31.1)
Private patients only	21 (3.4)
Both public and private patients	75 (12)

(Continues)

TABLE 1 (Continued)

Demographic characteristics and current practices	<i>n</i> (%)
Do you counsel women regarding options for unplanned pregnancy but refer them elsewhere if choosing abortion?	
Yes	164 (26.3)
Yes, but only for late abortion	24 (3.9)
No	416 (66.8)
Has the availability of mifepristone nationally altered your practice of induced abortion?	
Yes	76 (12.2)
No	493 (79.1)

between the years since nursing and/or midwifery qualification and the likelihood of providing abortion care in routine practice ($\beta = -0.026$, $P < 0.001$), with the odds of being involved in pregnancy terminations declining with each postgraduate year (odds ratio (OR) = 0.974, 95% CI 0.961–0.987).

One-quarter of respondents ($n = 164$, 26.3%) indicated they would counsel women regarding options for unplanned pregnancy but refer them elsewhere if choosing abortion; a further 24 responded they would only refer women after counselling in the case of late terminations (3.9%). The role of RMs and SHNs in the termination of pregnancy varied according to practice location ($\chi^2 = 34.01$, 4 df, $P < 0.001$). RMs and SHNs working in rural and remote settings were three times more likely to counsel and refer women with unplanned pregnancies than their urban counterparts (OR = 3.148, 95% CI 1.972–5.025, $P < 0.001$); these findings were reflected in the dual urban/rural work cohort (OR = 3.038, 95% CI 1.712–5.391, $P < 0.001$); however, neither cohort demonstrated significance in women seeking late abortion.

Mifepristone availability does not appear to have had a significant impact on midwifery and nursing practices on induced abortion, with 79.1% of participants indicating that it did not ($n = 493$).

Views toward abortion practices

Over half of the participants ($n = 333$, 53.5%) reported they would support the provision of abortion in any situation at all; 7.4% held views based on religion or conscience that would make them completely opposed to the practice ($n = 46$). Other participants would support abortion only in early pregnancy ($n = 162$, 26%), in limited situations such as rape, incest or where the woman is a minor, ($n = 209$, 33.5%) or if fetal genetic disorders were diagnosed ($n = 225$, 36.1%) (Table 2). Logistic regression demonstrated a significant negative relationship between years since nursing and/or midwifery qualification and the likelihood of supporting abortion for any reason ($\beta = -0.018$, $P = 0.004$), with unconditional support of abortion declining as the number of years since qualification increased (OR = 0.982, 95% CI 0.970–0.994). Of the 43 participants totally opposed to abortion, 86% ($n = 37$) felt that SHNs

TABLE 2 Views of registered midwives and sexual health nurses toward elective abortion

Views toward abortion	
In which situations do you believe abortion care should be provided?	
No situation at all	46 (7.4)
Any situation at all	333 (53.5)
Limited situations such as rape, incest or where patient is a minor	209 (33.5)
Diagnosed fetal genetic disorders	225 (36.1)
Only in early pregnancy <13 weeks	162 (26)
Do you believe that induced abortion should be provided in the public sector, in accordance with the law, for all women requesting it?	
Yes	432 (69.3)
No	124 (20)
Unsure	53 (8.5)
Do you believe that provision of induced abortion should be part of general medical practice in Australia?	
Yes	394 (63.2)
No	138 (22.2)
Unsure	76 (12.2)
Should knowledge of the availability, practice and possible complications of abortion be part of the core curriculum for midwifery and/or nursing trainees in Australia?	
Yes	579 (92.9)
No	20 (3.2)
Unsure	12 (1.9)
Do you believe that it should be within the scope of practice of midwives/sexual health nurses to initiate medical abortion?	
Yes	221 (35.5)
No	257 (41.3)
Unsure	133 (21.3)
Has the decriminalisation of abortion in the Queensland law changed your perspectives on abortion	
Yes	51 (8.2)
No	557 (89.4)

and RMs should not be more involved in abortion care, whereas 85% ($n = 192$) of those supporting abortion in any situation at all felt they should ($P < 0.001$).

Four hundred and thirty-two (69.3%) participants believed that abortion should be provided publicly in accordance with the 2018 Queensland law for all women requesting it, whereas 20% ($n = 124$) did not. While nearly two-thirds believed that the provision of induced abortion should be a part of both specialist practice and general practice for doctors in Australia ($n = 394$, 62.3%), a smaller proportion believed that its initiation should also be within the scope of RMs or SHNs ($n = 221$, 35.5%).

Despite the smaller proportion supporting the initiation of abortion by RMs or SHNs, 579 (92.9%) respondents felt that knowledge of the availability, practice and possible complications of abortion should be part of the core curriculum for midwifery and/or nursing students in Australia. This percentage includes 71.1% ($n = 32$) of those totally opposing abortion and 98.2% ($n = 362$) of those supporting abortion in any situation at all ($P < 0.001$).

Qualitative data

Free text comments were provided by 31.6% of respondents ($n = 197$). Five themes emerged as a result of the qualitative analysis.

Pro-choice

Fifty-one participants provided responses indicating full support of the right for women to choose abortion as an option for unwanted pregnancy (see [Box 1](#)). Themes of autonomy were common and many expressed the view that abortion care is an essential part of women's healthcare services, and should be universally accessible.

The importance of unbiased health care for women choosing abortion was also a recurring idea.

Choices With Caveats

Twenty-seven participants described situations in which they felt abortion was acceptable (see [Box 1](#)). One common theme was support for early but not late abortions, and with some stipulations that late terminations should only be allowed in certain circumstances such as diagnosed medical conditions.

Pro-life

Thirteen comments came from participants who identified as totally opposing abortion in question 10 (see [Box 1](#)). Religious and conscientious objection were common themes, and many expressed a belief in the sanctity of life.

Others in this group believed informed consent and counselling should be more available for women undergoing abortion.

Alternatives and education for women

Eleven respondents expressed the need for alternative options outside of abortion to be explored (see [Box 1](#)). The most common comments surrounded adoption; however, others also discussed increased education about contraception, increased access to palliative care for babies and access to services allowing women to continue with the pregnancy.

Role of abortion in midwifery/ nursing practice

Twenty-six comments were made, either supportive of or against RMs or SHNs playing a role in elective abortion (see [Box 2](#)). There was a major focus on allowing these practitioners a choice about whether or not to be involved. Another theme was on the availability of appropriate education for staff providing abortion care,

Box 1. 'Pro-Choice', Pro-Life' and Alternatives for Women

General Pro-Choice Views

'I believe an elective termination is a fundamental health-care right for women and families in Australia and globally. It is a safe medical procedure and access to it will improve the health of Australians.'

Age group <31 years; public; rural, remote and urban.

'I have personal/religious views that believe that termination should not be given to any woman regardless of gestation. However, as a clinician, and over the early years of my career, I have seen women in many difficult circumstances that have chosen to go ahead with termination and it is always a difficult decision. As it is her body, it should also be her choice, regardless of my religious views.'

Age group <31 years; public; urban.

Choices With caveats

'I do believe in choice for women, but feel it should be limited to early abortion with only exceptional cases being considered for later term terminations.'

Age group 41-50 years; public; rural, remote and urban.

'[Abortion] should be available to all women who have been given appropriate and correct information and made an informed choice on the decision that is correct for them, with counselling.'

General Pro-Life Views

'For religious reasons I am definitely against abortion; however, I understand that for all sorts of reasons woman find themselves having them. The laws in my opinion are way too lax.'

Age group 41-50 years; private; urban.

'Midwives are available in the service of women to help promote and protect the mother baby bond...My instinct is not to take a life, but to protect it in any situation where natural death is not imminent.'

Age group 41-50 years; public; rural, remote and urban.

Alternatives and Education for Women

'I wish adoption would be a more available alternative for these women, and especially the later term social abortions I just don't agree with.'

Age group <31 years; public; rural/remote.

'There needs to be more access to palliative care for babies with terminal genetic diagnosis and improved access to

adoption services for women who find themselves pregnant in unwanted circumstances.'

Age group 31-40 years; public; urban.

'More effort and money should be spent on free contraception that is 'easy' for women such as the Mirena or copper IUD...As a midwife I would be more than happy to up-skill and become trained in inserting Mirenas. If we can rather prevent a pregnancy we can avoid the need to abort.'

Age group 31-40 years; public; urban.

as well as counselling and support services; 32 respondents commented on this.

Distress

Eight participants made comments about the emotional and psychological distress for staff members involved in abortion (see Box 2). In many instances, participants commented on the difficulty associated with the dichotomy of caring for women undergoing elective abortion while also attending to women who have had unexpected fetal or neonatal loss.

Models of care

Twenty-six participants expressed concerns about abortion care being conducted in mainstream public maternity units (see Box 2). Some suggested that the private sector would be better equipped to provide abortion care.

DISCUSSION

More than half of the survey participants support the provision of abortion care for Queensland women in any situation at all; a further 29% support abortion provision in certain circumstances. There was a significant correlation between likelihood of supporting abortion in any situation and recency of qualification, possibly indicating changing views toward abortion in the general Queensland population. While Queensland law does not distinguish between the reasons why women may seek abortion, the study results demonstrate the perspectives and comfort-levels of RMs and SHNs toward abortion may be influenced by these reasons. There is strong support for inclusion of education around abortion provision in the core curriculum for nursing and midwifery students. There is also considerable support for public provision of abortion services, in accordance with the law, and for abortion care to be an integral part of practice by both general practitioners and specialist doctors. A smaller proportion of respondents support midwife- or nurse-led initiation of EMA procedures.

It is also clear that a smaller but important group of RMs and SHNs hold views completely opposed to the practice of abortion; these numbers are similar to those responding to the two surveys conducted of Fellows and trainees of RANZCOG.^{22,23} The responses

Box 2. Role of Abortion in Midwifery and Nursing Practice and Models of Care

General views

'I believe that if abortion continues to become a common place practice in QLD maternity health care, that health-care professionals who believe this conflicts with their beliefs, should have the right to transfer primary care of that patient to another healthcare professional.'

Age group 41-50 years; public; urban.

'Although I believe ALL women have the right to safe abortion, in accordance with our current laws, no one appears to be asking, 'what about the midwives?' We are not well enough supported when an elective termination occurs at 22 weeks, the baby is born alive and the family do not wish to see it. It is heart breaking and hard. More support is required for staff working with these families.'

Age group 31-40 years; public; urban.

Distress

'Many midwives are very distressed by dealing with caring for women who have an elective abortion of a perfectly healthy baby. These women are on the ward and can be next door to another who is grieving over the loss of her baby. It's hard to reconcile these paradoxes.'

Age group 31-40 years; general practice; urban.

Models of Care

'A woman has a right to an abortion. However, the support for this service in the public sector does not belong in a birth suite. It should be a dedicated service that nurses and midwives choose to be a part of not encompassed into current midwifery practice. Midwives prepare women for birth not prepare them to terminate their babies.'

Age group 41-50 years; public; urban.

'In many organisations they are cared for on maternity wards where midwives also care for women and newborns and the workloads can be very high. It's for this reason, the public hospital system must only provide terminations for women with special circumstances and not for maternal choice without medical indication. This type of termination should be left to private organisations.'

Age group <31 years, public, urban.

of this group also elucidate their wish to be able to formally express conscientious objections in the workplace, and to exclude provision of abortion from their scope of practice. The right to conscientiously object and the corresponding responsibilities for

health professionals with these views are well covered in the 2018 Termination of Pregnancy Act of the Queensland Parliament.²⁵

A number of respondents, including those supporting the provision of abortion in any situation, expressed strong views that women undergoing abortion should not be cared for in the same facilities as women continuing a pregnancy and giving birth. There are sound arguments to support this contention—the emotional, psychological and physical needs of both women undergoing abortion, and those providing care, are very different from those arising in the care of women during pregnancy and birth; however, they are equally important. The process of EMA generally takes place in the woman's home with outpatient consultation; early surgical abortion is likely day surgery. Both procedures should be offered by any medium-sized or large institution in a setting separated from the maternity unit. Later medical abortion, usually for major fetal or maternal indications, must take place in a hospital. In this circumstance, it is desirable that women undergoing elective abortion are cared for separately from women delivering healthy infants or women experiencing stillbirth.

The large proportion of respondents supporting education regarding abortion in the core curriculum for nurses and midwives is in accordance with the ICM and ICN recommendations.^{17,18} The number of respondents supporting initiation of EMA by nurses and midwives would seem to suggest that this should become an option for such practitioners who wish to train in this procedure. There would also appear to be a role for increasing nurse and midwife-led involvement in the provision of pre- and post-abortion care for Queensland women. Recent Victorian-based research by de Moel-Mandel et al suggests that a lack of training, funding and support as well as associated stigma may be significant barriers to nurse-led initiation of EMA.²⁶ The findings of our study suggest there is likely to be support toward addressing such barriers.

As with other survey-based research, a limitation was self-selection bias as participation was voluntary. This is further compounded by the polarising nature of the research question. Thus, there is a possibility that data may be skewed toward extreme views on either end of the spectrum. Furthermore, due to the sensitive nature of the subject, participants were able to skip questions, leading to missing data. However, the participant sample is demographically similar to the entire union membership and therefore, we believe our findings provide a solid basis for future policy and planning of abortion services in Queensland.

In conclusion, our study demonstrates a wide variation in views toward induced abortion from RMs and SHNs in Queensland. While a sizeable portion of respondents opposed abortion in most circumstances, a significant group were in support of abortion in any situation and felt involvement would be within the scope of RMs and SHNs. Despite their views, almost all participants felt that education surrounding induced abortion should be included in the core curriculum of nursing and midwifery. Further issues raised during the survey included those relating to the right of conscientious objection, counselling for women regarding alternatives to abortion, the need to

separate abortion care from mainstream maternity care and the need for appropriate education and support services for clinicians working in the abortion sector.

This is the first study of its kind in Australia with a large sample size comparative to other similar international papers. It supports the possibility of introducing abortion care into the scope of practice of RMs and SHNs for those who would like to be involved, subsequently increasing the accessibility of these services to women across the country.

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