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ORIGINAL RESEARCH: EMPIRICAL RESEARCH - QUALITATIVE

Nurse practitioners on 'the leading edge' of medication abortion care: A feminist qualitative approach

Andrea Carson[1] | Emma Stirling Cameron[2] | Martha Paynter[1] | Wendy V. Norman[3,4] | Sarah Munro[5] | Ruth Martin-Misener[1]

[1]School of Nursing, Dalhousie University, Halifax, Nova Scotia, Canada

[2]Faculty of Health, Dalhousie University, Halifax, Nova Scotia, Canada

[3]Department of Family Practice, University of British Columbia, Vancouver, British Columbia, Canada

[4]Faculty of Public Health & Policy, London School of Hygiene & Tropical Medicine, London, UK

[5]Department of Obstetrics & Gynaecology, University of British Columbia, Vancouver, British Columbia, Canada

Correspondence
Andrea Carson, Research, Innovation, and Discovery, Nova Scotia Health, 90 Lovett Lake Ct, Halifax, NS B3S 1B8., Canada.
Email: andrea.carson@nshealth.ca

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Abstract

Aims: To explore nurse practitioners' experiences of medication abortion implementation in Canada and to identify ways to further support the implementation of medication abortion by nurse practitioners in Canada.

Design: A qualitative approach informed by feminist theory and integrated knowledge translation.

Methods: Qualitative interviews with stakeholders and nurse practitioners between January 2020 and May 2021. Data were analysed using critical feminist theory.

Results: Participants included 20 stakeholders, 16 nurse practitioner abortion providers, and seven nurse practitioners who did not provide abortions. We found that nurse practitioners conduct educational, communication and networking activities in the implementation of medication abortion in their communities. Nurse practitioners navigated resistance to abortion care in the health system from employers, colleagues and funders. Participants valued making abortion care more accessible to their patients and indicated that normalizing medication abortion in primary care was important to them.

Conclusion: When trained in abortion care and supported by employers, nurse practitioners are leaders of abortion care in their communities and want to provide accessible, inclusive services to their patients. We recommend nursing curricula integrate abortion services in education, and that policymakers and health administrators partner with nurses, physicians, midwives, social workers and pharmacists, for comprehensive provincial/territorial sexual and reproductive health strategies for primary care.

Impact: The findings from this study may inform future policy, health administration and curriculum decisions related to reproductive health, and raise awareness about the crucial role of nurse practitioners in abortion care and contributions to reproductive health equity.

Patient or Public Contribution: This study focused on provider experiences. In-kind support was provided by Action Canada for Sexual Health & Rights, an organization that provides direct support and resources to the public and is committed to advocating on behalf of patients and the public seeking sexual and reproductive health services.

KEYWORDS
abortion, feminist theory, health services research, nurse practitioner, nursing, qualitative methods, reproductive health

1 | INTRODUCTION

More than 73 million abortions occur annually worldwide (Bearak et al., 2020). Access to safe and efficient abortion is a matter of gender and reproductive equity, ensuring an individual's ability to control one's life, enjoy sexuality and "participate fully in society" (Our Bodies Our Selves, 2022, p. n/a). Where available, medication abortion via the drug combination mifepristone (200 mg) and misoprostol (2 × 400 mcg) has expanded access to abortion. It is a safe and effective form of abortion (Aiken et al., 2022; Chen & Creinin, 2015; Schummers et al., 2022; Upadhyay et al., 2022) available in over 60 countries worldwide. Patient acceptability of medication abortion is high (Reynolds-Wright et al., 2021) and may provide pregnant people autonomy during their abortions as it can be taken at home (Erdman et al., 2018).

In Canada, medication abortion is authorized to be prescribed up to 63 days (9 weeks) gestation. Prior to mifepristone, only physicians were authorized to perform abortions in Canada. Due to the safety of medication abortion and ample international evidence of the competency and effectiveness of nurse-delivered abortion (Barnard et al., 2015; de Moel-Mandel et al., 2019; Mainey et al., 2020), nursing regulatory colleges across Canada began in 2017 to authorize nurse practitioners (NPs) to independently provide mifepristone medication abortion care. The decision was transformative; NPs became the first "non-physician" independent providers of abortion in the country. Nurses have played key roles in the provision of essential family planning services including sexual health education, contraceptive counselling, and abortion care. Nurse practitioners hold a Master of Nursing graduate degree, and their legal scope of practice includes assessment, diagnosis, prescription and treatment. In Canada, there are over 6600 NPs who work in a variety of settings, including primary care, community care, public health and long-term care (Canadian Institute for Health Information, 2021; Canadian Nurses Association, 2022). NPs provide a range of family planning services for communities and can increase the availability of medication abortion in rural and remote areas (Canadian Nurses Association, 2017; Norman et al., 2019). The optimization of the nursing role in abortion care has great potential for health equity and for meeting the needs of those facing significant structure and social barriers including Black, Indigenous and people of colour (BIPOC) and 2SLGBTQi + individuals (Carson et al., 2022; Lathrop, 2013) because of the settings in which they work, training and nursing ethos (McCaffrey & McConnell, 2015).

The experiences of NPs with the recent implementation of medication abortion and the impact on their practices and communities require further exploration. NP provision of medication abortion has the potential to further normalize abortion in primary care, and support health equity and patient autonomy (Carson et al., 2022). In what follows, we present qualitative findings from a study about NP implementation of medication abortion in Canada. We include perspectives from NPs who provide and do not provide medication for abortion and key stakeholders in government, health administration and advocacy. We take a critical feminist approach to understand: What roles have NPs played in the implementation of medication abortion in Canada? What value do NPs bring to abortion care and what are the ongoing challenges they face? We categorize our findings into three themes: (1) Facilitating implementation through informal education, mentorship and networking; (2) Navigating resistance to NP-provided medication abortion; (3) Promoting equity values and normalizing accessible medication abortion in primary care. We discuss the implications of these findings and provide recommendations for policy and organizational stakeholders and researchers to support the implementation of NP-provided medication abortion to improve reproductive health equity.

2 | BACKGROUND

The availability of medication abortion expands the options for those experiencing an unintended pregnancy and may mean more control for pregnant people over their abortions. In a review of qualitative literature about women/pregnant people's choice to terminate a pregnancy, Lie et al. (2008) found that for those who were concerned about negative judgements, social attitudes, and privacy about their abortions, medication abortion was appealing, albeit with some concerns about management and safety at home. Medication abortion may provide patients more autonomy and comfort during their abortions.

Like many health services, medication abortion access in Canada evolved during the COVID-19 pandemic, including improved availability of consultations and counselling through telemedicine and ordering prescriptions over the phone. Some propose taking abortions entirely out of the clinical realm. Prandini Assis and Larrea (2020) argue this is not a new practice and that women and pregnant people have used self-care methods to regulate fertility and prevent pregnancy for centuries. According to Joffe (2009), laws to regulate abortion were introduced in the nineteenth century and physicians were some of the loudest proponents of abortion regulation. This extended the medical purview to family planning from its prior location in intimate circles of care.

The integration of abortion into formal health care institutions and criminal law facilitated the development of a perspective that abortion outside formal clinical settings is less safe and a temporary measure until barriers and legal restrictions are removed and people can access formal facilities (Erdman et al., 2018). However, Erdman et al. (2018) argue that medication abortion outside formal facilities

is a form of harm reduction that allows people facing intersecting structural and social barriers to avoid surveillance and potential violence. In dozens of countries, feminist abortion hotlines exist where people and providers are joined together outside formal settings virtually or by phone. In countries with restrictions on pharmacies dispensing mifepristone/misoprostol, internet-based telemedicine services allow people to access information as well as medications via mail (Jelinska & Yanow, 2018).

There are scholars and health professionals who have advocated for autonomy in clinical decision-making and people having control over their health. Medicine has a long history of paternalism and violence, especially towards 'non-normative' bodies including women, people of colour, and people living with disabilities (Jewkes & Penn-Kekana, 2015; Page, 2020; Samra & Hankivsky, 2021). Altshuler et al. (2017) interviewed 21 women in the United States about their abortion experiences and found that their emotional needs during abortion care varied and that women valued being affirmed as 'moral decision makers' by their health providers.

Nurses are well-positioned to support pregnant people during their abortions. In the United States, a prospective observational study of over 9000 women about experiences with abortion care found that patients were very satisfied with abortion care from providers who were trained in abortion, including nurses (Taylor et al., 2013). In a scoping review of nurses' and midwives' roles in abortion care, Mainey et al. (2020) found nine studies identified that psychosocial aspects of care were important to nurses and midwives who provided abortions (e.g., non-judgmental counselling, interpersonal skills, developing therapeutic relationships, professional boundaries, awareness of patient comfort and emotional needs). Nurses who are trained in abortion care are well-suited to support harm reduction due to the identity and ethos of nurses which centres on engaging with patients from a compassionate perspective that considers the whole person and the needs of their families (McCaffrey & McConnell, 2015). Further, as primary care providers with a high presence in rural and remote communities in Canada (Martin-Misener et al., 2020), nurses and NPs may increase awareness of pregnancy termination options for people in the communities where they practice and facilitate informed decision-making (Mainey et al., 2020).

In this paper, we take a feminist qualitative approach to examine NP experiences of abortion provision. Lebold and MacDonnell (2020) call for the application of critical feminist lenses in nursing for a deeper reflection on the evolving practice of abortion in nursing care. A qualitative approach allows for in-depth and nuanced reflection on experiences and how broad policies and health systems structures affect the adoption of abortion into nursing practice. In this article, we describe the experiences of NPs with medication abortion implementation in Canada and explore how values, structures, and dynamics of power constrain and facilitate the implementation of mifepristone in NP practice. These findings contribute to advancing the international literature on nursing and abortion.

3 | THE STUDY

3.1 | Aim/s

This study had two overarching aims: (1) To describe the experiences of NPs with medication abortion implementation—including those not currently providing. (2) To identify how to further support the implementation of medication abortion amongst NPs in Canada.

3.2 | Design

In this article, we report on the qualitative findings of The CART NP Mifepristone Study, a nationally funded study about NP implementation of medication abortion in Canada. The study used a qualitative design and analysis informed by critical feminist theory. Critical approaches aim to investigate the meaning and taken-for-granted concepts and ideas that are shaped by our social structures, communication processes and language, which are ever-changing and historically situated (Campbell, & Bunting, 1991; Clarke & Braun, 2019). Broadly, feminist theories investigate topics or social issues in terms of their impacts and implications with respect to sex and gender. Feminist approaches engage with perspectives that elucidate power structures, often taking critical positions whilst pursuing social and political change (Grosz, 1990; Wigginton & LaFrance, 2019). Using a critical feminist approach (Campbell, & Bunting, 1991; Clarke & Braun, 2019), we explored NPs' experiences providing medication abortion care and how these experiences were shaped by sex and gendered dynamics of abortion and nursing, and social values and norms. This approach allowed us to unpack participants' experiences through a lens of health and social systems, policies and values.

3.3 | Sample/participants

The sample included licensed NPs in any Canadian province or territory who provided medication abortion and NPs who were not providing medication abortion, as well as stakeholders including decision makers in the health policy system and related to medication abortion. Participants were recruited through: (1) health professional organizations and societies; (2) snowball sampling; (3) The CART NP Mifepristone Survey (https://cart-grac.ubc.ca/np-mifepristone-study/). An email invitation to participate in a qualitative interview was sent to potential NP and stakeholder participants through health professional organizations, societies, and networks. Snowball sampling (Given, 2008) was done at the end of each interview, by asking participants to share information about our study with NPs or stakeholders who they thought might be interested in speaking with us. Lastly, participants were recruited from a sample of NPs who responded to our study's quantitative survey component, and who indicated they would be willing to be contacted about participating in a qualitative interview. The following nursing associations assisted with survey distribution: British

Columbia Nurse Practitioners Association; L'Association des infirmières praticiennes spécialisées du Québec (AIPSQ); Newfoundland and Labrador Nurse Practitioners Association; Nurse Practitioners Association of Alberta; Nurse Practitioners Association of Canada; Nurse Practitioners Association of Ontario; Nurse Practitioners Association of Manitoba; Nurses Association of New Brunswick; Nurse Practitioners Association of Nova Scotia; Prince Edward Island Nurse Practitioners Association; Saskatchewan Association of Nurse Practitioners. Additionally, the survey was distributed amongst members of the National Abortion Federation of Canada and the Canadian Abortion Providers Support (CAPS) Network. The sample of survey respondents was purposefully selected (Coyne, 1997; Patton, 1990) to allow for a deeper understanding of perspectives across different settings and communities. Participants were not remunerated for their involvement in the qualitative interviews.

3.4 | Data collection

All participants were offered participation in English or French. We designed the NP interview guide to elicit participants' experiences with medication abortion, including their perceptions of the implementation process broadly and in their own practices, the impact on their patients and communities, ongoing challenges, and the value of NP provision of abortion care. For NPs who were not currently providing medication abortion, we asked questions about their motivation to provide or not provide, their practice settings and population challenges to provision and the priority level for the provision of abortion care in their practices. We asked participants about their training to provide abortion, including mentorship. The stakeholder interview guide was designed to capture the legislative, regulatory, scope of practice and/or health administrative landscape of medication abortion in Canada and included questions about the introduction and evolution of mifepristone in Canada, key facilitators and/or champions and barriers. The interview guides were developed iteratively. Co-investigators, including clinical and methodological experts, met several times to review and revise questions as needed. Four researchers trained in qualitative research conducted the interviews (including co-authors AC, ESC, MP).

3.5 | Ethical considerations

Ethics approval for this study was obtained in 2019 from Nova Scotia Health (previously Nova Scotia Health Authority) and the University of British Columbia. Participants were given the choice to be interviewed in English or French and emailed an informed consent document to review and sign prior to participation.

3.6 | Data analysis

The focus of our analysis was on participants' perspectives of, and experiences with, medication abortion and contextualizing these stories within the socio-historical context in which they were told. This included the evolution of legislation and regulatory restrictions in each province/territory, health professional culture and norms and acceptance and/or stigma surrounding abortion care. We highlighted recurring ideas and concepts throughout and between interviews, including inconsistencies or contradictions. The analysis process was as follows: The interviewers wrote memos following each interview which included impressions and key takeaways from the conversation. Weekly meetings were held with members of the researcher team during the interview phase to debrief about the process and to make any adjustments to the questions or approach. Two researchers (AC, ESC) conducted multiple readings of each transcript. They then categorized the data into broad descriptive categories (e.g., descriptive of care process; motivation for providing abortion; collaboration with other health professionals) to understand the topics in the interviews. Following this descriptive categorization or coding, each researcher read through each transcript again whilst writing 'analytic memos' directly onto the transcripts using the footnotes and highlight features. These analytic memos were a way for the researchers to add their interpretive voice and reflections on what was going on in the text, in open-ended long-form. During analysis, regular weekly meetings were held with several members of the research team to discuss developing findings, raise questions and refine ideas.

3.7 | Credibility, dependability, transferability

We use the concepts of credibility, dependability and transferability to ensure the trustworthiness of findings. Credibility refers to the interpretation of experiences in a way that someone who shared that experience would recognize and relate (Lincoln & Guba, 1985). We ensured credibility through study design by co-developing the protocol with researchers, clinicians—including NPs—and stakeholders in government and advocacy. During analysis, we ensured credibility through reflexivity, peer examination and debriefing, and maintaining a closeness to participants' words during the presentation of findings. Reflexivity is a researcher's orientation toward any research endeavour in which they view themselves as an active and ongoing part of interpretation, one in which social location and assumptions should be continuously reflected on, including their role in shaping the production of knowledge (Kincheloe et al., 2017). As such, reflexivity is an active part of the research process. We held regular weekly meetings with team members (nurses, NPs, physicians, researchers), and quarterly meetings with the larger team, including knowledge users, to get feedback on data and the emergent categories and themes. This process involved questioning the findings and our interpretations such that the final themes would adequately reflect the data, the NP experience, and the context of medication abortion in Canada.

Dependability in qualitative research occurs when another researcher is able to follow the decision trail of the study including choice of participants, data collection, and recruitment, in a way that is logical and appropriate, and interpretation and analysis are

well-explained (Lincoln & Guba, 1985). We documented all decisions and any changes made to the original protocol were reviewed and approved by senior researchers on the team. Transferability refers to the degree to which findings or methods/theories from a qualitative study can be transferred to other contexts (Lincoln & Guba, 1985). As such, we thoroughly described and tracked our research approach (theory, methods, analysis) and participant demographics so as to be adapted by other researchers if desired.

4 | FINDINGS

Forty-three people participated in the qualitative study. Stakeholders ($n = 20$) worked in the following settings: health administration, government, advisory roles, regulation, nursing advocacy and reproductive/sexual health advocacy. Of the 23 NPs who participated, 16 provided medication abortion at the time of participation and seven did not provide medication abortion at the time of participation. The number of years in practice since becoming an NP ranged from less than 2 years to over 20. We have included additional demographics of NP participants in Table 1. Interviews ranged from 30 min to 1 h in length. Pseudonyms were used for all participants.

We organized the data into three main themes that capture the NP role in medication abortion in Canada since mifepristone's approval, their leadership, and ongoing challenges: (1) facilitating the implementation of medication abortion through informal education, mentorship, and networking; (2) navigating resistance to the implementation of medication abortion; (3) promoting equity values and normalizing accessible abortion in primary care.

4.1 | Facilitating implementation of mifepristone through mentorship and education

Provider NPs described ways they facilitated the implementation of medication abortion in their practices to make provision more efficient and to improve patient experiences. No participant reported having received abortion training as part of their initial NP education, outside of individually-sought practicums in reproductive and sexual healthcare. They came to abortion provision through independent pathways. They developed and tailored protocols for medication abortion; hired, supported and mentored colleagues to share the work of medication abortion provision; provided informal education to other health providers about Health Canada regulations and best practices; networked with lab technicians and allied clinics to expedite referrals and appointments for blood work or ultrasound dating. One NP, referred to as 'Chloe', describes her role in educating physician colleagues about mifepristone and becoming the 'spokesperson' for this care. This was common across interviews, where current NP providers were engaged in educating colleagues or health professionals in the community.

> There's a lack of [provider] knowledge [about medication abortion]. I did a number of information sessions,

TABLE 1 NP participant demographics

Category	Sub-category	Total
Province	Atlantic Canada (NB, NS, PEI, NL)	5
	British Columbia	3
	Northwest Territories, Nunavut, Yukon	1
	Ontario	8
	Prairies (AB, SK, MB)	5
	Quebec	1
	Total:	23
Gender[a]	Female	20
	Male	3
	Total:	23
Community setting	Remote	1
	Rural	6
	Urban	16
	Total:	23
Practice type	Primary care	14
	Sexual and reproductive health	4
	Women's health	5
	Total:	23

Abbreviations: AB, Alberta; MB, Manitoba; NB, New Brunswick; NL, Newfoundland & Labrador; NS, Nova Scotia; PEI, Prince Edward Island; SK, Saskatchewan.

[a]NP participants were asked the open-ended question, "what is your gender?" The binary categories represented here reflect participants' responses.

> I actually had a few physicians who came to the sessions, and I think that my role is just to try to teach them. I also did some one-on-one, answered some questions from a lot of doctors during medical meetings on the subject, so I remain the spokesperson and I really tried to take initiative in that sense. It's been a lot better since I've been able to inform them, getting my colleagues in line with that and orient them toward the best treatment for the patient. – Chloe, NP provider

Reflecting on their leadership and the informal education and mentorship in which they were engaged, participants discussed their impact on other health professionals. For example, Pamela, an NP abortion provider in an interprofessional practice in an urban setting, reflected on the eagerness of other providers to implement medication abortion in their practices after observing her role as a provider.

> I found that since I've started doing this that it's been a bit infectious in our clinic. The other providers have been excited, like 'why is she doing it and I don't get to'. [...] There's been a really good uptake in people that are interested and we have even more providers that don't normally do it are like 'yeah, I want to' or I've had physicians that normally don't do it but they are seeing a patient that wants it and they were like calling me and saying 'could I start doing it? Can you tell me about it because I want to learn?'. That's been kind of cool. It might just be good for people to know that you might seem like you're the only one in your practice that does it but once other people see that it's actually pretty straightforward and very doable and a really helpful service for your clients that you might see some momentum come from that and that other people also want to get on board and provide that service as well. – Pamela, NP provider

In the account above, Pamela suggests being a source of support and a visible provider has increased interest in providing amongst other health professionals in her community and helped them to feel less isolated when beginning to implement mifepristone in practice. Similarly, NP providers of mifepristone stated that mentorship from colleagues was a key reason they started providing abortion and for their success in implementing it into practice.

> [My colleague] made it really easy. I think if I didn't come into this clinic with her already having the trail blazed I may have found it overwhelming to put together the assessment and the education documents, but she very widely shared that and very graciously shares it with anyone that asks. At the presentation that we did last month, she shared everything. Take it, adapt it, do whatever you want. This is the education sheet. You can take off my logo and my name and put on yours. [...] If it weren't for that I would probably feel a little overwhelmed with how to keep all the moving parts straight, but she's made it so brainless. – Lori, NP provider

Several participants expressed that mentorship was important for their confidence and feeling supported as new providers. Those without access to a provider mentor or colleague(s) found implementation more isolating. Some felt less confident troubleshooting more complex patient scenarios when they did not have a more experienced provider to consult. For some non-providers, lack of mentorship was one of several reasons for not providing. Erica, a stakeholder and physician abortion provider, emphasized the value of mentorship:

> In terms of confidence and familiarity, I think having a mentor is so important. In my province, we're small enough that I don't mind being a mentor to anybody [...] What I'm finding now is that once people get experience, I don't hear from them. They're just off doing their thing and the medical abortion piece is just one small part of their general primary care practice whether they're an NP or family physician. – Erica, stakeholder

4.2 | Navigating resistance and lack of support for medication abortion provision

The stigma surrounding abortion continues to impact its integration and implementation in Canada's healthcare system. For the NPs in this study, the resistance and/or lack of support for abortion that most impacted their provision of care came from colleagues, employers and fellow health providers in their communities and workplaces.

> One of the nurses that works here said to me that my patients don't deserve access to social work because they're choosing not to have their babies. So there definitely is that underlying culture of, you know, we're the bad guys. It creates extra stress and it also bubbles over into other programs and people's willingness to work with you on other things as well. There's definitely some cultural stuff in the clinic that's just always been here and I'm not sure if it will ever be completely avoidable. – Kristen, NP provider

For provider NPs, they tried to navigate resistance or hesitation from others by educating them about professional responsibilities, or, failing that, they decided to work around those specific health professionals. Whilst NPs suggested this was not a major ongoing barrier, some stated there were pharmacies in their communities that refused to stock the medication. NPs knew which pharmacies were efficient and supportive of stocking mifepristone reliably, and which refused to stock it: NPs did not attempt to maintain a relationship with unsupportive pharmacies. In Amanda's story, she describes one incident of

this explicit refusal to stock/dispense the medication from a local pharmacist and how they navigated this situation:

> I did have partnership with some pharmacy. One of their part time pharmacists decided they were going to pull some moral bullshit with me and get on a high horse about you shouldn't be terminating pregnancies, this is not appropriate and as a healthcare provider I should not be doing it. I certainly let her know what I was thinking […] I won't subject my clients to this which is too bad because the pharmacy is across the street from the clinic. The manager told the part time pharmacist either you never do that again or you quit. There are no other options because this is a service we provide, and we provide it for the community and we stock it on our shelves. You don't get to make any judgment call on it. Since then I've had no complaints and no concerns so that's been good, but there are some pharmacies who have declined. – Amanda, NP provider

Whilst Amanda states that these instances are not especially common, this was frustrating and required them to navigate a professional space in which a fellow provider was unwilling to do what was in their professional duty. However, this example demonstrates how, despite pro-choice medical professionals' attempts at normalizing abortion care as 'just another health service', it is still bound up with gendered value judgements and expectations.

Several participants described hiring practices in their clinics/workplaces that attempt to avoid future conflict or refusal to support or provide medication abortion, in situations where that is part of the clinic's day-to-day available services. For example, Pamela describes how during the interview process at their interprofessional primary care clinic, potential hires are asked about their position on abortion care and whether they are pro-choice:

> Everyone now is super supportive and even our new locums, it's part of our interview process. We ask any new providers what their thoughts are on abortion, are they supportive of offering that option, would they consider providing medical abortion because we want to make sure we have the right people working that have similar views on pregnancy options and supporting youth. We actually have it as part of our interview process now to make sure that we have people with the right philosophy and stuff coming on board. – Pamela, NP provider

In the example above, hiring providers based on values (i.e., pro-choice) was intentional and not necessarily something that is needed for a range of other health services in health professional scopes of practice. For others, these hiring practices do little to address prevailing hierarchies in medicine which impact NP's abilities to provide efficient care for patients. For example, Ben is an NP not currently prescribing medication abortion, but who is heavily involved in the coordination of abortion care (e.g., counselling, referral to physician partner), who faces delays for services such as ultrasounds due to medical hierarchies which shape how lab technicians process their requests.

> My colleague and I have said 'should we do it, shouldn't we do it?' Really it comes down to a multifactorial reason. One is that, ideally you would have efficient access to ultrasound services and your population would be prioritized. I think your NP's would feel a lot more comfortable performing a medical abortion on a client who had a confirmed gestational age by an ultrasound which is recommended, but having that relationship with your Radiology Department where they're going to prioritize your patients in some reasonable fashion isn't necessarily there [for us]. There's different dynamics between a nurse practitioner calling and there's different dynamics between a physician calling asking for an ultrasound. We find we're not always prioritized well for access to dating ultrasounds in terms of needing it for a medical abortion whereas, if our physician calls it would be much more rapidly done so access to imaging. – Ben, NP, non-provider

Ultimately, such hierarchies and lack of acknowledgement of NPs' authority and expertise may jeopardize patient care and the efficiency at which they can provide abortions to patients. This is one factor as to why Ben does not prescribe medication abortion.

There were also stories from participants of less explicit examples of resistance from employers. For example, several NPs recounted that they did not advertise their provision of mifepristone or were careful about what they told funders so as not to compromise future financial support. For some NP providers, this was inconvenient but did not stop them from providing mifepristone. For other NPs, the potential to lose funding, in combination with a lack of employer support to implement medication abortion in their practices, and lack of mentorship or motivation to provide, impacted their decision not to provide mifepristone. Cindy, an NP providing medication abortion in a specialized clinic in an urban area, described the resistance she faced when it came to funding for a point-of-care ultrasound machine that would assist in their provision for abortions:

> When we apply for funding, it's often around anti-violence, sexual assault, and those kinds of topics. We wanted to get a point-of-care ultrasound, but we can't figure out how to couch that, because as soon as we say it's for termination of pregnancy there's no one that's going to fund that. Nobody wants to put their name on getting an ultrasound to, you know, 'kill babies'. That's the way they see it […] We're funded by [regional health authority] but sometimes we'll apply for grants for equipment like a point-of-care

> ultrasound or if we need a new exam table or something like that and then you have to justify why you need it and what population you're seeing and that's where our hands get tied. We'd love to have a point-of-care ultrasound but we don't do prenatal care here and so it become sort of like 'why are you needing this?' – Cindy, NP provider

The above example is indicative of the politics which continue to surround medication abortion, despite it being a safe, common and normal healthcare service. Whilst no legislative restrictions exist in Canada around mifepristone, values and attitudes and employer/system priorities and dynamics impact NPs' ability to provide abortion care efficiently (e.g., hesitation to fund equipment being used for abortions).

4.3 | Promoting equity values and normalizing accessible abortion in primary care

All participants acknowledged the value that NPs bring to abortion care. Stakeholders specifically discussed the roles that NPs play in communities and how they fill a crucial gap in primary care across the country, especially in rural and remote areas. NPs improve accessibility by increasing the number of abortion providers, as well as providing care closer to home for people.

> It's really hard to find a family doctor but nurse practitioners are increasingly involved in community health and they actually know their patients and people trust them and I think that when it comes to somebody seeking an abortion, including medical abortion, it's a huge difference to be able to speak to someone that you trust that you actually know from the community. It's kind of scary going to, potentially having to go a long way to go to a walk-in clinic, an ER room, talk to a stranger after investing a lot of money and time and effort into travelling. I think community health is really high-quality health and nurse practitioners seem to be on the leading edge of that. - Olivia, stakeholder

As Olivia describes, patient trust is particularly important when providing abortion care because it is a stigmatized service, there may be safety concerns for the patient, and time and efficiency are crucial to individuals who are pregnant and no longer want to be.

Participants discussed how, because they do not receive payment on a fee-for-service basis, NPs are able to spend more time with patients, providing information and answering questions. They described the trust that they had built with their patients and that there are many NPs working in primary care, which would allow them to see patients they already know them and with whom they had good relationships. Several participants also discussed the gendered component of the nursing profession and that, whilst there are certainly male abortion providers, pregnant patients may feel more comfortable with receiving abortion care from a woman provider. Zachary sums up the value of NPs well:

> As nurse practitioners, we fill a gap sometimes in the slightly more complicated areas. A fee-for-service, walk-in clinic is not going to do this because it takes a lot of work, but nurse practitioners often fill those gaps for more complicated types of things that require a bit more extended involvement. I think we want to be able to provide that comprehensive care wherever possible and not just refer out all the time and actually have really good conversations around what are the options and how do we approach each one. I think we have a bit of a different approach as well, partly, than medicine does sometimes and just accessibility, having more providers just makes it more accessible to people, especially in rural places, they don't really have other options. Nurse practitioners, nurses, it's a gendered profession as well, it's mostly women, so maybe it's having that large number of female providers might be useful as well rather than having the, I mean don't fit that obviously but just having that as a group that's predominantly female, maybe that would be useful as well. – Zachary, NP provider

Participants further described the value of NP provision of abortion in terms of patient emotional well-being. For example, time was not only discussed by participants in terms of longer appointments, but also in terms of the efficiency of the care process, which was a key factor in terms of mental health and compassionate care.

> There is a tendency among our patients who are looking to access medical termination that the sooner the better. Once they've made that choice they want it to be done and they want it to happen now so delays in accessing service can be very hard on them mental health wise, I think and it's causing them anxiety. I get the feeling that they feel almost worst about terminating a pregnancy that's eight weeks versus six and a half. They just want as quick of access as possible. Having that kind of relationship, like I said, with our physician [partner] where usually I can get someone an appointment within two days. It is quite beneficial to the patient. – Ben, NP non-provider

> Things change in a week very quickly. You weren't pregnant last week and now you're pregnant and now we're going in a completely different direction because you don't have alternatives and that's why abortion through pill, if it could possibly be feasible in the north, that would be really wonderful because I think that people do change their minds and if we have options available it can change people's lives dramatically. – Diana, NP non-provider

In both examples above, participants describe the need to have an efficient abortion care process, because being pregnant when you do not wish to be is hard on patients and can have mental health implications.

Further, Sophie, a clinic director, emphasizes the importance of including abortion [training] in primary care education from a health equity perspective, because the service potentially impacts at least half of NP patients—those capable of becoming pregnant.

> I know that it seems wrong to me that one in three Canadian people capable of becoming pregnant will have an abortion in their lifetime and that half of, at least half of the patient load that any nurse practitioner or physician will see in their, especially in family practice will be capable of becoming pregnant that abortion care isn't an absolutely routine part of the education of nurse practitioners and family docs but it doesn't seem to be. I'm not surprised because abortion has historically been a woman's issue and women's issues are historically not prioritized so I think when I talk about reproductive justice that's another component is moving the needle on what is covered in family medicine education. – Sophie, stakeholder

Importantly, Sophie draws attention to the historical (and present) context of abortion in Canada and broadly, in which sexual and reproductive health services that predominantly affect women and people with a uterus, are not prioritized in healthcare training.

5 | DISCUSSION

Our study identified three themes about how NPs experienced the implementation of medication abortion and/or how they understood their roles in relation to medication abortion: (1) educating, mentoring, and networking with other health providers in the community about medication abortion; (2) working around resistance from colleagues/employers/the public to medication abortion provision; (3) integrating health equity principles into abortion provision and advocating for abortions in primary care. For those who were providing, they were often mentors and leaders in their communities. When they were knowledgeable about medication abortion and had the infrastructure and support to incorporate this service in their practice, NPs in this study were at the forefront of normalizing abortion as primary care and expanding access in their communities (e.g., coordinating stock with local pharmacies, hiring pro-choice employees, creating accessible abortion information materials for patients, advocating for sex and gender equity). The perspective of NPs not offering abortions provided important context about gaps in health professional abortion education, health system hierarchies that subordinate the NP role despite their advanced scope of practice and skills, and social norms and values (e.g., moral judgements about abortion) that permeate clinical spaces through resistance to abortion care.

Our findings are consistent with previous literature which emphasizes the importance and potential impact of educational exposure to sexual and reproductive health training as a student or through an employer (McLemore & Levi, 2017). We found that when NPs possessed the knowledge and motivation to provide medication abortion (and the necessary resources required to provide the service), they were advocates and leaders of abortion provision in their communities. Feminist-informed approaches to medication abortion and patient care are timely and urgent to myth-bust around abortion in Canada, to make the case for abortion training in nursing and medicine pre-licensure education (Cappiello et al., 2017; McLemore & Levi, 2017; Paynter et al., 2019), and to justify the allocation of resources necessary to provide medication abortion in communities and clinics where gaps exist (e.g., timely ultrasound and emergency services closer to home). Programs that provide technical and emotional support to new providers are valuable for the implementation of medication abortion in communities (LaRoche et al., 2022). Such steps will further normalize mifepristone/misoprostol in primary care and destigmatize abortions, with the potential to reduce patient harm and make the process more comfortable—allowing individuals to end an unwanted pregnancy sooner, and with a provider they know and trust (Godfrey et al., 2010; World Health Organization, 2020; Yanow, 2013). Care that is closer to home and from a trusted provider is especially important for pregnant people who face intersecting oppressions and barriers to health system access (Baker et al., 2021).

This study explored the nurse practitioner's experience with medication abortion provision in Canada. We envision that further research will contribute to these findings by investigating patient experiences with abortion care provided by nurse practitioners and interprofessional care teams. We recommend that nursing educators integrate sexual and reproductive health, including abortion care, into curricula and in a way that is feminist and health equity-oriented to be inclusive of all genders, cognizant of intersecting oppressions, and prioritizes patient empowerment. Further, we recommend policymakers and health administrators partner with nurses, physicians, midwives, social workers and pharmacists, for comprehensive provincial/territorial sexual health strategies to reduce barriers for patients, improve care efficiencies, and increase public and provider knowledge of medication abortion.

5.1 | Limitations

This study focused on health providers. Future research about patient experiences with abortion, which are feminist-oriented, would enhance knowledge about this important service, including its potential impact on a diversity of patients and communities. Medication abortion via mifepristone/misoprostol is relatively new to Canada;

as the number of providers of medication abortions continues to increase, experiences with implementation and practice may evolve.

6 | CONCLUSION

In this study, we aimed to understand the recent implementation of medication abortion in NP practice and communities. Using a feminist framework, we found that NPs navigate social stigma, health system resistance to abortion and health professional hierarchies, to provide medication abortion. NPs are resilient leaders of abortion care in their communities and are trusted by patients to provide care that is inclusive and cognizant of their needs, they continue to confront socio-cultural barriers and power structures which prevent interested NPs from providing this service. NP provision of medication abortion can be supported at multiple levels including nursing education and policy to facilitate interprofessional collaboration and to meet community needs.

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CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

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DATA AVAILABILITY STATEMENT

The data that support the findings are described in detail within the manuscript. The data are not publicly available due to privacy or ethical restrictions.

ORCID

Andrea Carson https://orcid.org/0000-0003-4223-9418
Emma Stirling Cameron https://orcid.org/0000-0001-9388-2556
Martha Paynter https://orcid.org/0000-0002-4194-8776
Wendy V. Norman https://orcid.org/0000-0003-4340-7882
Sarah Munro https://orcid.org/0000-0002-3884-6592
Ruth Martin-Misener https://orcid.org/0000-0003-4554-7635

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