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Review Article

Experiences of midwives and nurses when implementing abortion policies: A systematic integrative review

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ABSTRACT

Introduction: Policy implementation can be affected by what individuals believe to be right and wrong. When implementing abortion policies, providers' moral beliefs can be relevant in the success of the implementation process. Considering that midwives and nurses are direct providers of abortion care, exploring their experiences related to abortion policy implementation could provide helpful information to prevent policy failure.

Methods: Systematic integrative review. The studies were identified through an electronic search strategy and the screening of the reference lists of all selected articles. Studies were retrieved from eight medical and social sciences databases. Thirty-one studies focused on midwives' and nurses' experiences of implementing abortion policies, irrespective of setting or age of study were included in this review. Studies included used qualitative, quantitative and mixed methods. Study quality was appraised using the Mixed Method Appraisal Tool version 2018. No study was excluded from this review based on its quality appraisal.

Results: In terms of their quality, most studies included in this review were conducted appropriately. Three superordinate themes represent the main elements that challenge midwives and nurses when providing abortion care. The first superordinate theme identified that many midwives and nurses believed fetuses are sentient beings, making them worthy of compassionate treatment. The next superordinate theme was focused on preferences and expectations about abortion care. Finally, the third superordinate theme illustrates midwives' and nurses' experiences with other team members, highlights their creativity when challenged with insufficient resources and provides a glimpse of the numerous techniques used for coping with work-related stress.

Conclusion: Midwives and nurses worldwide face multiple challenges when providing abortion care. Guidelines aiming to support policy implementation should consider how abortion affects healthcare providers and suggest appropriate measures to reduce these and other barriers. Midwives and nurses technical and ethical competencies for abortion provision should be strengthened.

Introduction

Policy implementation can be affected by what individuals believe to be right and wrong, which in the case of abortion is often grounded in people's beliefs about human life and women's rights (Berer, 2017). Healthcare providers are considered *de facto* policymakers because their actions and attitudes shape policies (Akosa and Asare, 2017). For example, healthcare professionals could decide not to comply with clinical guidelines if they perceive them as a threat to their autonomy (Spyridonidis and Calnan, 2011), to their client's interest (Mercier et al., 2015), or to be too complicated (Checkland, 2004). This autonomy or discretion can also be used against procedures or regulations that providers consider immoral or burdensome, thus affecting the availability of certain services. Therefore, healthcare professionals can strengthen or undermine the policy implementation processes (Akosa and Asare, 2017; Berer, 2017; Campbell et al., 2006; Checkland, 2004; Keogh et al., 2019; Kim, 2020; Shelton et al., 1992; Sieverding et al.,

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2018; Solo and Festin, 2019; Sonfield, 2005; Spyridonidis and Calnan, 2011).

According to the World Health Organisation (WHO), midwives and nurses represent almost half of the total healthcare force worldwide and are indispensable to universal health coverage (World Health Organization, 2017). Depending on each country's legislation, midwives and nurses could be directly involved in providing abortion care. Considering the global importance of midwives and nurses in the healthcare system (World Health Organization, 2017), exploring midwives' and nurses' experiences related to abortion policy implementation could provide helpful information to prevent policy failure.

Considering that implementation of healthcare policies can be a complex issue, it could be best studied using a broad range of research data. The growing volume of evidence in all subjects reinforces the necessity of conducting reviews which allow synthesis of evidence to make recommendations or provide an overview of the studied topic. An integrative review was deemed beneficial for this task as it includes findings from quantitative, qualitative, mixed methods and unpublished literature to provide an insight into the studied topic (Cronin and George, 2020; Russell, 2005; Whittemore and Knafl, 2005). However, accomplishing the integration of different evidence types is not exempt from challenges, especially when trying to ensure rigor in the process (Hopia et al., 2016; Whittemore and Knafl, 2005). Thus, Whittemore and Knafl (2005) defined five stages which this integrative review has followed to ensure that it is robust.

Protocol registration

This systematic integrative review protocol was registered in the International Prospective Register of Systematic Reviews (PROSPERO), register identification: CRD42021230685.

Methods

Eligibility criteria

This review included all qualitative, quantitative, and mixed methods studies focused on midwives' and nurses' experiences of implementing abortion policies, irrespective of setting or age of study. The studies selected had to include midwives or nurses as research participants to be eligible. Additionally, these professionals had to be directly involved in the prescription or provision of emergency contraception, performing abortions or providing care before, during or after this procedure. Although the primary focus of this review was abortion policy implementation, it was expanded to include emergency contraception as some providers recognise this form of contraception as an action against human life.

Studies that did not include midwives and nurses among participants were excluded. Documents were also excluded if their focus was not on midwives' or nurses' experiences or addressed spontaneous abortion. Theoretical articles and personal opinions were also excluded, as well as those papers that were unavailable in full after exhausting all attempts to obtain them.

Identification of studies

The identification of literature was conducted in two steps. The first step included an electronic search using PICO (Population, Intervention, Comparator, Outcome) (Richardson et al., 1995) and SPIDER (Sample, Phenomenon of Interest, Design, Evaluation and Research type) (Cooke et al., 2012) strategies in eight databases of medical and social sciences. The databases used were: The Cumulative Index of Nursing and Allied Health Literature (CINAHL) Plus, the British Nursing Index (BNI), Medical Literature Analysis and Retrieval System Online (Medline), the Psychological Information Database (PsycINFO), the Applied Social Sciences Index Abstracts (ASSIA), and the Social Science database. To ensure that literature related to healthcare from Spanish speaking and Latin American countries, the search was also conducted in the Scientific Electronic Library Online (SciELO), and the Latin American and Caribbean Health Sciences Literature (LILACS). The electronic search (Table 1) was conducted using article abstracts and titles. To reduce the chances of missing relevant articles due to poorly written abstracts, literature related to the topic irrespective of who was providing care was identified during the first phase of the search, thus all healthcare practitioners were included. Once all relevant literature was identified, only those considering midwives or nurses as participants were finally included in the review. The second search strategy identified additional documents by screening the reference lists of all selected articles from phase 1. The result of the search strategy can be seen in detail in the PRISMA diagram (Page et al., 2021) (Fig. 1).

Selection of studies

All articles retrieved by the electronic search were uploaded to Zotero, where duplicates were removed automatically ($n = 5519$). The remaining documents were exported to an Excel spreadsheet where another 77 duplicates were removed by hand (Fig. 1). Abstracts were screened using an eligibility tool (see supplementary material) which excluded 9282 documents. Of the remaining, 40 full-text articles could not be found, which resulted in assessing 903 articles for eligibility (Fig. 1). The full-text assessment led to the exclusion of 873 reports. Thirty-two articles focusing on midwives' and nurses' experiences were deemed eligible for this review. Despite the intention to include them, two congress abstracts did not provide sufficient information for extraction (Armour et al., 2018; Bishop, 2005). Neither of them provided further contact details, making it impossible to contact the corresponding authors for more information. Consequently, both were excluded from the review.

After screening the reference lists of all selected articles, 43 additional references were identified. These were uploaded to Zotero, where 41 documents were removed for being duplicated within the main electronic search. The remaining two papers were assessed for eligibility using the eligibility tool. One of them was excluded because it was unclear if the nurses prescribed emergency contraception (Fallon, 2003). In summary, this review is based on the findings of thirty-one documents (Table 2).

Quality assessment

The quality assessment of the thirty-one articles included in this review was conducted using the Mixed Method Appraisal Tool (MMAT) version 2018 (Hong et al., 2019). This tool allows appraisal of qualitative, quantitative and mixed methods studies. Considering a growing number of researchers have started to discourage calculating overall quality scores for appraised articles (Colle et al., 2002; Crowe and Sheppard, 2011; Herbison et al., 2006; Stone et al., 2019), and following MMAT suggestions (Hong et al., 2019), no selected article was scored nor excluded for this synthesis.

Results

Overview of the studies

This review included thirty-one articles published between 2000 and 2020 from the five continents. The countries where the studies of this review were conducted were Australia ($n = 1$),

Table 1
Search strategies used for the electronic searches.

PICO Search		SPIDER Search	
Population	midwi* OR nurs* OR (general ADJ practi*) OR physici* OR medic* OR (medical ADJ practitio*) OR doctor* OR gynaecolo* OR gynecolo* OR obstetric* OR pharmac* OR provider* OR (healthcare ADJ staff*) OR (medical ADJ staff*) OR (healthcare ADJ personnel*)	**S**ample	midwi* OR nurs* OR (general ADJ practi*) OR physici* OR medic* OR (medical ADJ practitio*) OR doctor* OR gynaecolo* OR gynecolo* OR obstetric* OR pharmac* OR provider* OR (healthcare ADJ staff*) OR (medical ADJ staff*) OR (healthcare ADJ personnel*)
Intervention	(emergency ADJ contracepti*) OR (pregnancy ADJ terminatio*) OR (pregnancy ADJ interrupt*) OR abort*	**P**henomenon of **I**nterest	(emergency ADJ contracepti*) OR (pregnancy ADJ terminatio*) OR (pregnancy ADJ interrupt*) OR abort*
Comparison	(n/a)	**D**esign	interview* OR survey* OR (focus ADJ group*) OR questionnaire* OR (case ADJ stud*) OR observ*
Outcome	attitude* OR perception* OR perceive* OR opinion* OR feel* OR know* OR understand* OR view* OR experienc* OR belie* OR practic* OR behavio* OR conduct* OR polic* OR law OR legislat* OR proced* OR interventi* OR implement*	**E**valuation	attitude* OR perception* OR perceive* OR opinion* OR feel* OR know* OR understand* OR view* OR experienc* OR belie* OR practic* OR behavio* OR conduct* OR polic* OR law OR legislat* OR proced* OR interventi* OR implement*
		Research type	qualitative OR (mixed ADJ method)
This search strategy was conducted using the combination: ('P' AND 'I' AND 'C' AND 'O')		This search strategy was conducted as it follows: (('S' AND 'P of I') AND ('D' OR 'E' OR 'R'))	

Brazil ($n = 1$), Canada ($n = 2$), Denmark ($n = 1$), France ($n = 1$), Ghana ($n = 1$), Iran ($n = 1$), Italy ($n = 2$), Japan ($n = 1$), Poland ($n = 1$), South Africa ($n = 5$), Sweden ($n = 4$), Switzerland ($n = 1$), Taiwan ($n = 1$), Uganda ($n = 1$), United Kingdom (UK) ($n = 5$), and the United States of America (USA) ($n = 2$). According to the World Bank classification, the majority of the countries addressed in this review are upper-middle or high-income countries, except for Uganda (low income) and Ghana (lower-middle income), both located in the African continent (The World Bank, 2021).

Twenty-four of the studies were qualitative, five were quantitative, and two used mixed methods. Of the mixed-method studies, the quantitative component of the research conducted by Teffo and Rispel (2017) was not considered for this review as it was focused on determining the proportion of facilities that provided abortion in Gauteng and North West provinces. A general qualitative approach, grounded theory, and phenomenology were the preferred methodologies to address the research questions among the qualitative studies. All quantitative studies were descriptive

Table 2
List of Selected Articles.

	Authors	Year	Title	Country	DOI/URL
1	Andersson, IM; Gemzell-Danielsson, K; Christensson, K	2014	Caring for women undergoing second-trimester medical termination of pregnancy	Sweden	10.1016/j.contraception.2014.01.012
2	Aniteye, P; Mayhew, SH	2013	Shaping legal abortion provision in Ghana: using policy theory to understand provider-related obstacles to policy implementation	Ghana	10.1186/1478–4505–11–23
3	Chiappetta-Swanson, C	2005	Dignity and DirtyWork: Nurses' Experiences in Managing Genetic Termination for Fetal Anomaly	Canada	10.1007/s11133–005–2632–0
4	Christensen, AV; Christiansen, AH; Petersson, B	2013	Faced with a dilemma: Danish midwives' experiences with and attitudes towards late termination of pregnancy	Denmark	10.1111/scs.12004
5	Cignacco, E	2002	Between professional duty and ethical confusion: midwives and selective termination of pregnancy	Switzerland	10.1191/0969733002ne496oa
6	Cleeve, A; Nalwadda, G; Zadik, T; Sterner, K; Klingberg-Allvin, M	2019	Morality versus duty – A qualitative study exploring midwives' perspectives on post-abortion care in Uganda	Uganda	10.1016/j.midw.2019.06.004
7	Gallagher, K; Porock, D; Edgley, A	2009	The concept of 'nursing' in the abortion services	UK	10.1111/j.1365–2648.2009.05213.x
8	Garel, M; Etienne, E; Blondel, B; Dommergues, M	2007	French midwives' practice of termination of pregnancy for fetal abnormality. At what psychological and ethical cost?	France	10.1002/pd.1755
9	Gmeiner, AC; Van Wyk, S; Poggenpoel, M; Myburgh, CPH	2000	Support for nurses directly involved with women who chose to terminate a pregnancy	South Africa	10.4102/curationis.v23i1.611
10	Hallden, BM; Lundgren, I; Christensson, K	2011	Ten Swedish Midwives' Lived Experiences of the Care of Teenagers' Early Induced Abortions	Sweden	10.1080/07,399,332.2010.535937

(*continued on next page*)

Table 2 (*continued*)

	Authors	Year	Title	Country	DOI/URL
11	Hanna, DR.	2005	The lived experience of moral distress: nurses who assisted with elective abortions	USA	10.1891/rtnp.19.1.95.66335
12	Lindström, M; Jacobsson, L; Wulff, M; Lalos, A	2007	Midwives' experiences of encountering women seeking an abortion	Sweden	10.1080/01,674,820,701,343,505
13	Lindström, Me; Wulff, M; Dahlgren, L; Lalos, A	2010	Experiences of working with induced abortion: focus group discussions with gynaecologists and midwives/nurses	Sweden	10.1111/j.1471–6712.2010.00862.x
14	Lipp, A	2008	A woman centered service in termination of pregnancy: a grounded theory study	UK	10.5172/conu.673.31.1.9
15	Lipp, A	2011	Self-preservation in abortion care: a grounded theory study	UK	10.1111/j.1365–2702.2010.03462.x.
16	Mamabolo, LRC; Tjallinks, JE	2010	Experiences of registered nurses at one community health center near Pretoria providing termination of pregnancy services	South Africa	https://journals.co.za/doi/abs/10.10520/EJC19338
17	Mauri PA; Ceriotti, E; Soldi, M; Guerrini-Contini, NN	2015	Italian midwives' experiences of late termination of pregnancy. A phenomenological-hermeneutic study	Italy	10.1111/nhs.12180
18	Mauri, PA; Squillace, F	2017	The experience of Italian nurses and midwives in the termination of pregnancy: a qualitative study	Italy	10.1080/13,625,187.2017.1318846
19	Mayers PM; Parkes B; Green B; Turner J	2008	Experiences of registered midwives assisting with termination of pregnancies at a tertiary level hospital	South Africa	10.4102/hsag.v10i1.185
20	Mizuno, M; Kinefuchi, E; Kimura, R; Tsuda, A	2013	Professional quality of life of Japanese nurses/midwives providing abortion/childbirth care	Japan	10.1177/0,969,733,012,463,723
21	Moel-Mandel, C; Graham, M; Taket, A	2019	Snapshot of medication abortion provision in the primary health care setting of regional and rural Victoria	Australia	10.1111/ajr.12510

(*continued on next page*)

Table 2 (*continued*)

	Authors	Year	Title	Country	DOI/URL
22	Nicholson, J; Slade, P; Fletcher, J	2010	Termination of pregnancy services: experiences of gynecological nurses	UK	10.1111/j.1365–2648.2010.05363.x
23	Parker, A; Swanson, H; Frunchak, V	2014	Needs of Labor and Delivery Nurses Caring for Women Undergoing Pregnancy Termination	Canada	10.1111/1552–6909.12475
24	Santiago-Strefling, IS; Lunardi-Filho, WD; da Costa-Kerber, NP; Correa-Soares, M; Portella-Ribeiro, J	2015	Nursing perceptions about abortion management and care: a qualitative study	Brazil	10.1590/0104–07,072,015,000,940,014
25	Simmonds, KE	2018	Nurse Practitioners' and Certified Nurse Midwives' Experiences Providing Comprehensive Early Abortion Care in New England	USA	https://digitalcommons.uri.edu/oa_diss/699/
26	Susila, C	2012	A qualitative assessment on issues among nurses directly involved with women who choose to terminate their pregnancy	Iran	https://ajner.com/AbstractView.aspx?PID=2012–2–3–4
27	Teffo, M.; Rispel, L	2017	'I am all alone': factors influencing the provision of termination of pregnancy services in two South African provinces	South Africa	10.1080/16,549,716.2017.1347369
28	Teffo, M; Rispel, L	2020	Resilience or detachment? Coping strategies among termination of pregnancy health care providers in two South African provinces	South Africa	10.1080/13,691,058.2019.1600720
29	Yang, CF; Che, HL; Hsieh, HW; Wu, SM	2016	Concealing emotions: nurses' experiences with induced abortion care	Taiwan	10.1111/jocn.13157
30	Young, N; Bennett, R	2002	Visiting women after a termination	UK	10.12968/bjom.2002.10.1.10048
31	Zaręba, K; Banasiewicz, J; Rozenek, H; Ciebiera, M; Jakiel, G	2020	Emotional Complications in Midwives Participating in Pregnancy Termination Procedures-Polish Experience	Poland	0.3390/ijerph17082776

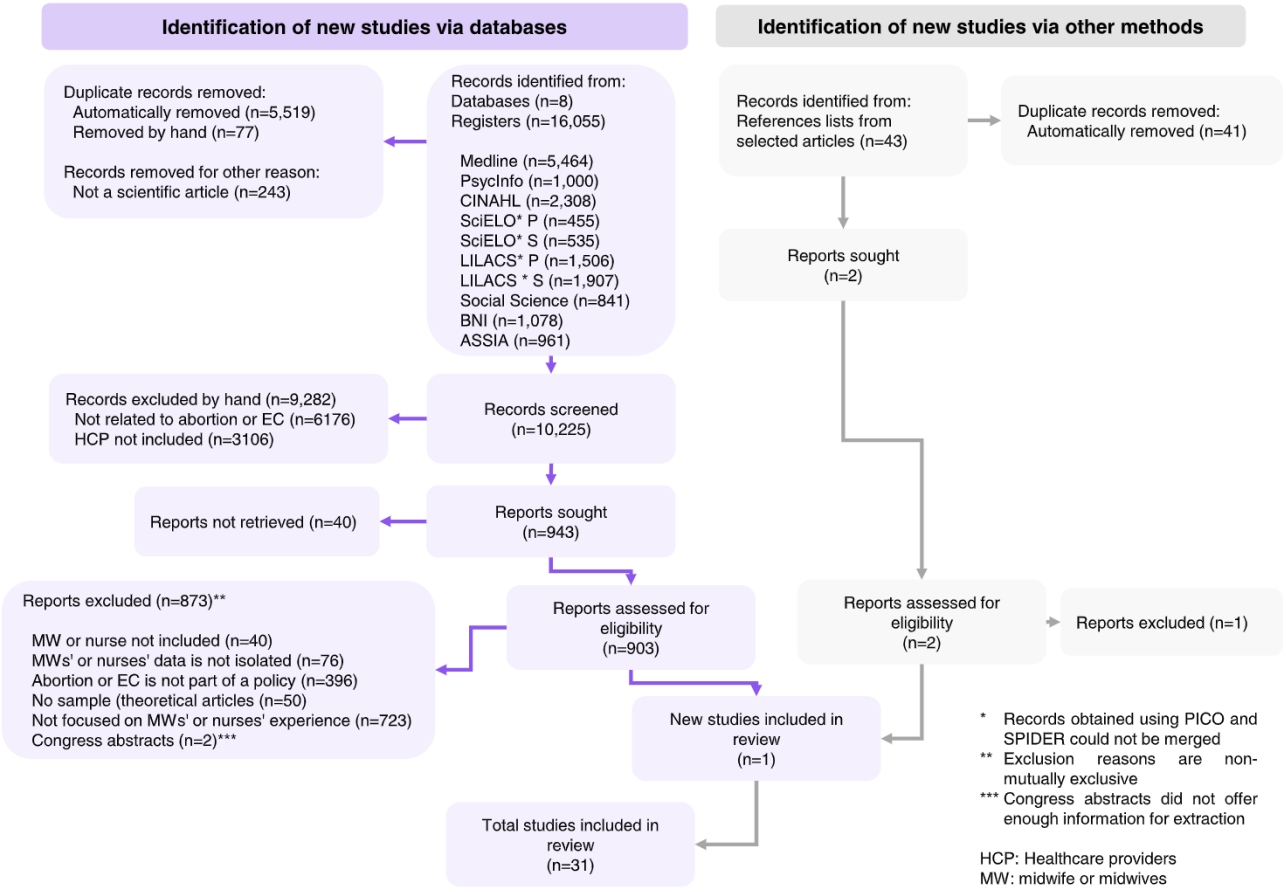

Fig. 1. PRISMA flow diagram.

and used cross-sectional surveys for data collection. All studies but one (Garel et al., 2007) confirmed that they had been examined by an Ethics Committee or had included written or verbal consent before data collection. Garel et al. (2007) retrieved information using a questionnaire; therefore, returning the survey could have been considered consenting to participate in the study. Most of the studies collected information from female midwives/nurses. Nevertheless, 13 of studies did not mention participant gender. Most studies ($n = 28$) did not provide explicit information about participant ethnicity. Similarly, only six studies gave some information on participant religious beliefs. The quality assessment demonstrates that most articles were conducted appropriately (see supplementary material). However, two quantitative descriptive studies (Mizuno et al., 2013; Moel-Mandel et al., 2019) used non-probabilistic sampling. In some qualitative studies, midwives/nurses were interviewed during their work breaks (Chiappetta-Swanson, 2005; Lindström et al., 2011; Mauri et al., 2015; Mauri and Squillace, 2017). One of the two mixed-method studies did not integrate quantitative and qualitative findings (Nicholson et al., 2010).

No articles about the experiences of midwives and nurses providing/prescribing emergency contraception were found. All thirty-one articles included in this review were focused on abortion provision. However, there were substantial differences across countries regarding the extent to which abortion is allowed (Table 3). Additionally, two articles were focused on abortion provision due to fetal anomaly (Chiappetta-Swanson, 2005; Cignacco, 2002), one on abortion at home (Lindström et al., 2011), one on late abortion (abortion after the 12th week of pregnancy) (Christensen et al., 2013) and two referred to post-abortion care exclusively (Cleeve et al., 2019; Young and Bennett, 2002). The quality appraisal for each study is available in supplementary material.

Synthesis of literature

Midwives' and nurses' experiences collected in this review show that despite belonging to different professions, they share similar experiences. Therefore, when describing the findings of this review, the two professions are sometimes addressed as a sole entity.

Data were synthesised in this integrative review following a convergent integrated process considering the recommendations suggested by Whittemore and Knafl (2005) and the Joanna Briggs Institute (Lizarondo et al., 2020). For this, the extracted data were reduced and 'qualitatised' by converting the data to words (when possible) to make the dataset manageable. Then, findings were constantly compared and grouped according to similarity (Table 4). Finally, these groups were divided into three superordinate themes where challenges and facilitators in each of them can be found (Table 5).

Categories in this review were grouped into three superordinate themes that represent the main elements that for midwives/nurses are a source of concern when providing abortion care (Table 5).

Personhood and the fetus

A dying fetus

Participant midwives in Garel et al. (2007) reported that feticide was helpful for the midwife (88%), the woman (80%), and

Table 3
Reasons to allow abortion and gestational limits within the countries/states included in the review.

Countries Included in the review	Abortion at the woman's request	GL	Economic or social reason	GL	Fetal impairment	GL	Rape	GL	Incest	GL	Intellectual or cognitive disability of the woman	GL	Mental health	GL	Physical health	GL	Health	GL
Australia	VJ		VJ		VJ		VJ		VJ		VJ		VJ		VJ		VJ	
Victoria	Yes	24	NS		NS		NS		NS		NS		NS		NS		NS	
Brazil	No		No		No		Yes	22	No		No		No		No		No	
Canada	Yes		n/a		n/a		n/a		n/a		n/a		n/a		n/a		n/a	
China***	Yes		NS		Yes		NS		NS		NS		NS		Yes		Yes	
Denmark	Yes	12	Yes	NS	Yes	NS	Yes	NS	Yes	NS	Yes	NS	Yes	NS	Yes	NS	NS	
France	Yes	12	NS		Yes	NS	NS		NS		NS		NS		NS		NS	
Ghana	No		No		Yes	28	Yes	28	Yes	28	No		Yes	28	Yes	28	No	
Iran	No		No		Yes	16	No		No		No		No		No		No	
Italy	No		Yes	90*	Yes	90*	No		No		No		Yes	Vi	Yes	Vi	No	
Japan	No		Yes	22	No		Yes	22	No		No		No		Yes	22	Yes	22
Poland**	No		No		No		Yes	13	Yes	13	No		No		No		Yes	NS
South Africa	Yes		Yes	22	Yes	NS	Yes	22	Yes	20	Yes	20	Yes	20	Yes	20	No	
Sweden	Yes	18	No		No		No		No		No		No		No		Yes	NS
Switzerland****	No		No		No		No		No		No		No		No		No	
Uganda	NS		NS		NS		NS		NS		NS		NS		NS		NS	
UK	NS		NS		Yes	NS	NS		NS		NS		Yes	NS	Yes	NS	NS	
USA	Yes		VJ		VJ		VJ		VJ		VJ		VJ		VJ n		Yes	NS

GL: gestational limit (in weeks) VJ: varies by jurisdiction NS: not specified Vi: Viability.
* First 90 days.
** Since 2021, abortions on the ground of several and irreversible fetal defects is forbidden (Committee of Ministers, 2021).
*** Taiwan data was not available.
**** Since 1937, abortion is exempted from penalties if necessary to prevent serious physical injury or psychological distress for women (Swiss Government, 1942; The Library of Congress, 2015).
Table data adapted from the Global Abortion Policies Database (Lavelanet et al., 2018).

Table 4
Example of meaning units, condensed meaning units, subordinate theme and superordinate theme.

Meaning unit	Condensed meaning unit	Subordinate theme	Superordinate theme
"It feels so much better when the parents want to see the baby to be able to present them a baby that looks like what new babies look like." (Andersson et al., 2014, p.482–483).	Keeping fetus' dignity after death	A dying fetus	Personhood and the fetus
"… the body [fetus] still felt warm and you had to go and put it in the fridge …" (Mayers et al., 2005, p. 22).	Dealing with an expected death		

the fetus (76%). Midwives in this study stated, "I am less anxious if the fetus is dead" (p.624). Likewise, they believe it was better for the parents to receive a dead 'child' than to hear them cry (Garel et al., 2007). According to Zareba et al. (2020), two critical contributors to burnout for Polish midwives were seeing the fetus (65%) and waiting for the fetus to die after birth (59%). Five studies in this review highlighted that midwives/nurses had concerns with late abortion, which usually refers to abortion after the 12th week of pregnancy (Gallagher et al., 2010; Lindstrom et al., 2007; Lindström et al., 2011; Nicholson et al., 2010; Yang et al., 2016). Seeing and handling the fetus is reported again in six other studies as distressing and disturbing for midwives/nurses (Andersson et al., 2014; Gallagher et al., 2010; Hanna, 2005; Mauri et al., 2015; Nicholson et al., 2010; Teffo and Rispel, 2017). Four other studies also highlighted that waiting for the fetus to die was distressing and provoked an ethical dilemma for midwives/nurses (Chiappetta-Swanson, 2005; Christensen et al., 2013; Mauri et al., 2015; Mayers et al., 2005). Four studies suggested that the moral dilemma when caring for the fetus was related to the fact that its death was expected (Chiappetta-Swanson, 2005; Mayers et al., 2005) and the feeling that the fetus deserved to live (Mauri et al., 2015; Mizuno et al., 2013). Regarding the former, in Christensen et al. (2013), Danish policies stated that if a living fetus is born after an abortion, it must be placed with its parents until death. However, midwives had to provide this care if the parents refused. This legal arrangement made midwives feel like having to be responsible for someone else's mistake when caring for the dying fetus (Christensen et al., 2013). Arguably this emotion has a global reach, with Japanese midwives stating that they believed "the aborted fetus deserved to live" (p.546), a response significantly associated with compassion fatigue ($f = 0.28$, $p < 0.001$) (Mizuno et al., 2013). In Hanna (2005), nurses believed that pre-

Table 5
Summary of findings.

Superordinate and subordinate themes	Summary	Number of studies contributing to each theme
(1) Personhood and the fetus	Some midwives/nurses attribute the fetus the category of person	17
1.1 A dying fetus	Beliefs that abortion involves a human death	17
1.2 Accepting women's grief	Acknowledgement of grief as an acceptable feeling related to abortion	6
(2) Midwives'/Nurses' preferences and expectations about abortion care	Preferences and expectations when providing abortion care	23
2.1 Abortion provokes an emotional response	Working in abortion care provokes mixed feelings	16
2.2 Expectations about women's behaviour	Women should prevent abortion and consider it as the last resource	10
2.3 Being part of the whole process	Expectations of being included in abortion counselling as well as providing abortion care	8
(3) External hostility and internal battles	Doing the best job they can while challenged by the environment	26
3.1 Team relationships can be challenging	Being an abortion provider carries stigma	16
3.2 Working with insufficient resources	Everyday challenges to provide abortion care when resources are lacking	17
3.3 Coping strategies	Strategies used to manage work stress	14

venting the fetus from feeling pain and receiving cruel treatment was essential to abortion care. Five other studies considered in this review suggested that embryonic tissue and fetus handling during abortion care should be respectful, though there was no specific injunction as to how this could be managed (Andersson et al., 2014; Chiappetta-Swanson, 2005; Christensen et al., 2013; Parker et al., 2014; Yang et al., 2016). Among midwives/nurses of this review, there appears to be a feeling that abortion involves a human death, and therefore some measures should be taken to ensure the dignity of this moment (Andersson et al., 2014; Aniteye and Mayhew, 2013; Chiappetta-Swanson, 2005; Christensen et al., 2013; Parker et al., 2014; Yang et al., 2016).

Accepting women's grief

Danish midwives reported that it was hard to distinguish between the grief provoked by a late abortion due to fetal anomaly and a stillbirth (spontaneous fetal death) (Christensen et al., 2013). This suggests that choosing an abortion under this scenario is somehow an inevitable choice. Likewise, two studies suggested that midwives/nurses saw abortion due to fetal anomaly as a preventative measure for the suffering of future child, the woman and her family (Garel et al., 2007; Yang et al., 2016). Acknowledging that some women experienced a loss when choosing an abortion, midwives in two studies believed it was positive for women's grief to see the fetus (Christensen et al., 2013; Garel et al., 2007). Midwives/nurses in Andersson et al. (2014) believed that saying goodbye to the fetus was important for women undergoing abortion due to fetal anomaly so they secured this chance for all of them. In all other cases, they believed the women undergoing abortion should request it, rather than it being mooted by the midwife/nurse as an option (Andersson et al., 2014). However, the authors provided no information about how women should make this request (Andersson et al., 2014). Danish midwives reported that when women experienced a sense of loss with their abortion, they managed the procedure as if it was a normal birth and treated the fetus as a 'child' out of consideration (Christensen et al., 2013). Other midwives/nurses described washing and dressing the fetus before presenting it to the woman/parents, taking a picture of the family and providing hand and footprints of the fetus to the woman/couple (Chiappetta-Swanson, 2005; Christensen et al., 2013; Parker et al., 2014). In Chiappetta-Swanson (2005), nurses put the fetus in a refrigerator to prevent tissue deterioration until they transferred the fetus for mandatory autopsy. Therefore, when a woman wanted to see her 'baby' one more time, nurses described they had to rewarm the fetus body by either re-washing it in warm water, wrapping it in a blanket or even cuddling it in their arms (Chiappetta-Swanson, 2005). These actions suggest empathy and subtle kindness often displayed by midwives/nurses when caring for women undergoing late abortion.

Midwives/Nurses' preferences and expectations about abortion care

Abortion provokes an emotional response

Midwives/Nurses display a broad range of emotions when providing abortion care. In two studies abortions after rape or an abusive relationship were considered 'necessary' (Mayers et al., 2005; Teffo and Rispel, 2020). According to Mayers et al. (2005), most South African midwives interviewed in their study displayed 'negative' feelings towards the procedure. Likewise, more than half (55%, $n = 47/86$) of French midwives reported feeling emotionally overwhelmed when providing abortion care (Garel et al., 2007). In other studies, midwives/nurses also reported feeling morally distressed (Hanna, 2005; Parker et al., 2014), emotionally burdened (Cignacco, 2002; Gmeiner et al., 2000), experiencing sleep deprivation due to traumatic experiences (Teffo and Rispel, 2017) and exhaustion (Susila, 2012). According to Teffo and Rispel (2017), vacuum aspirations disturbed South African nurses, mainly when fetal remains were observed during the procedure. Midwives/nurses of two studies included in this review reported that medical abortion was more emotionally challenging for them when compared with surgical abortion (Lipp, 2011, 2008). In this case, the challenge faced by midwives/nurses could be related to their active involvement with the woman until the complete expulsion of the embryo, compared to surgical abortion (Lipp, 2011). Conversely, 65% of surveyed Swedish midwives agreed their current experience in abortion had been positive (Lindstrom et al., 2007). Midwives/nurses from Canada, South Africa, Uganda and the USA highlighted that they got satisfaction and pride from providing appropriate care to women's needs (Chiappetta-Swanson, 2005; Cleeve et al., 2019; Simmonds, 2018; Teffo and Rispel, 2017). Two studies, one from Canada and another from Italy, described that midwives/nurses felt rewarded when thanked and showed gratitude by the woman under care (Mauri et al., 2015; Parker et al., 2014).

Expectations about women's behaviour

The least appreciated behaviour women display while undergoing abortion is described by six studies related to taking it 'lightly' or being unconcerned by it (Andersson et al.,

2014; Halldén et al., 2011; Hanna, 2005; Lipp, 2011; Mauri and Squillace, 2017; Mayers et al., 2005). In three studies, this attitude of being unconcerned was perceived by midwives/nurses when women underwent repeated abortion (Hanna, 2005; Lipp, 2011; Nicholson et al., 2010). Five studies also emphasised that midwives/nurses were adamant against repeated abortion (Halldén et al., 2011; Lipp, 2011; Mayers et al., 2005; Nicholson et al., 2010; Teffo and Rispel, 2020), especially despite being counselled about contraception (Halldén et al., 2011; Hanna, 2005; Mayers et al., 2005). A midwife in Halldén et al. (2011) study explained the mixed feelings that repeated abortion provoked her, "I'm really mad about this …I had a girl who has had her seventh abortion, and then you feel it in your heart, you know. … It's hard work, and you feel like a failure" (p.430). Cleeve et al. (2019) identified that not being able to provide contraceptive counselling to women after an abortion due to time constraints was a source of frustration for Ugandan midwives.

Swedish midwives/nurses reported it was also challenging for midwives to see how teenagers disregarded using contraception due to their potential effects on body appearance (Halldén et al., 2011). Far from Sweden, South African midwives stated feeling ambivalent when teenagers argued that they needed parental consent to use contraception after having had an abortion without their parent's permission, suggesting these concerns may be felt by midwives across the globe in developed and developing countries (Mayers et al., 2005). In both studies, midwives expected teenagers to be accompanied by their mothers or another adult during the abortion process (Halldén et al., 2011; Lindström et al., 2011). Swedish midwives believed that the relationships between the teenager and the surrounding adults were essential for preventing future abortions (Halldén et al., 2011). Midwives in this study judged absent parents as irresponsible, leading them to assume a mother-like role (Halldén et al., 2011). For these midwives, it was hard to accept that teenagers perceived abortion as their right and a more convenient option than using contraception (Halldén et al., 2011).

Being part of the whole process

Swiss midwives maintained that when providing abortion care, it was essential that midwives were included during abortion counselling and the decision-making process (Cignacco, 2002). For Cignacco (2002), not including midwives at this stage "…shakes the very foundations of the professional understanding by which midwives see themselves as an integral part of a procedure" (p.184). Three studies in this review highlighted that abortion counselling should always be non-coercive (Christensen et al., 2013; Lipp, 2008; Simmonds, 2018). Midwives/nurses in two studies explicitly referred to being concerned with how physicians provided abortion counselling, arguing that they did not take the necessary time to explain, and they were not neutral parties (Chiappetta-Swanson, 2005; Christensen et al., 2013). In the study conducted by Aniteye and Mayhew (2013) among South African midwives, only four out of fourteen midwives interviewed declared to counsel women seeking an abortion about all the options available. Three of the remaining midwives admitted not referring women seeking an abortion to abortion services (Aniteye and Mayhew, 2013). Aniteye and Mayhew explained midwives' behaviour as a coping mechanism allowing them to accommodate their professional duty to counsel with their beliefs. Aniteye's and Mayhew's study is the only one where midwives/nurses openly admitted to conducting coercive counselling. However, all midwives/nurses interviewed by Lipp (2011) acknowledged judging women undergoing abortion despite having claimed to be non-judgemental towards them. South African nurses highlighted self-control and concealing their emotions as the core of professionalism when providing abortion care (Teffo and Rispel, 2020). This suggests that ceasing to judge women undergoing abortion could be difficult for midwives/nurses, but that it was imperative that this did not become an excuse to provide lower-quality care.

External hostility and internal battles

Team relationships can be challenging

According to nine studies in this review, midwives'/nurses' relationship with their colleagues provided them with moral support, improved their knowledge and provoked feelings of belonging (Andersson et al., 2014; Gallagher et al., 2010; Garel et al., 2007; Mauri et al., 2015; Mayers et al., 2005; Parker et al., 2014; Simmonds, 2018; Teffo and Rispel, 2020; Young and Bennett, 2002). However, the relationship between abortion midwives/nurses and other providers is not always pleasant. Three studies, all located in South Africa, identified that midwives/nurses had to deal with hostile working environments (Mamabolo and Tjallinks, 2010; Teffo and Rispel, 2020, 2017). Hostile behaviour from other healthcare workers towards midwives/nurses could include degrading labeling, such as 'children/baby killers' (Mamabolo and Tjallinks, 2010; Teffo and Rispel, 2017), rude interruptions in their consulting rooms (Teffo and Rispel, 2020), and constant questioning of their morality (Teffo and Rispel, 2017). Accepting that those outside the intimate relationship of midwife/nurse and the woman seeking an abortion could see their role as controversial, midwives/nurses in seven studies of this review reported being very cautious about to whom they reveal that abortion care was part of their job (Chiappetta-Swanson, 2005; Cleeve et al., 2019; Gallagher et al., 2010; Gmeiner et al., 2000; Hanna, 2005; Teffo and Rispel, 2020, 2017).

Regarding the relationship between midwife/nurse and physicians, Danish midwives felt powerless in the face of a physicians' influence on midwives' work domain (Christensen et al., 2013). Canadian nurses felt that some physicians even neglected their job regarding abortion care, placing the midwife/nurse in an untenable position (Parker et al., 2014). It was argued, therefore, that it was important to identify which physician was accountable for the care of which woman at the beginning of the shift. It was believed that this could prevent them from ignoring their responsibilities (Parker et al., 2014). Likewise, South African nurses also perceived that physicians often refused to assist abortion or shifted their responsibilities onto the nurses (Mayers et al., 2005; Teffo and Rispel, 2017).

Working with insufficient resources

Midwives/nurses in several studies reported that they had to provide abortion care with insufficient medication, personnel, space, formal debriefing sessions, infrastructure, equipment, and even unsupportive managers and physicians (Andersson et al., 2014; Christensen et al., 2013; Cleeve et al., 2019; Mamabolo and Tjallinks, 2010; Mayers et al., 2005; Moel-Mandel et al., 2019; Parker et al., 2014; Simmonds, 2018; Teffo and Rispel, 2017). Furthermore, Ugandan midwives agreed that the lack of resources could have a negative impact on the quality of care provided (Cleeve et al., 2019). Some midwives/nurses in Sweden thought that having more resources could allow them to spend more time with women or allow them to debrief (Andersson et al., 2014). According to Brazilian nurses, prioritising resources for abortion care could allow, for instance, to have a designated area for women undergoing abortion where their privacy could be protected (Santiago-Strefling et al., 2015). Despite the lack of resources, midwives/nurses display their creativity to provide the best care they can. For example, nurses in Chiappetta-Swanson (2005) reconditioned a multipurpose room to prepare the fetus before showing it to the parents. Likewise, when provided with unsuitable containers in which to put the fetus to transfer

it to the morgue, nurses took the time to find a more appropriate one (Chiappetta-Swanson, 2005). Nurses in this study considered that having to drop the fetus into a container was undignified, "Where is the dignity? Because of the shape of the container you have to drop the fetus in—it's like a plop!" (p.104). There is a broad perception among the participants of the studies included in this review that abortion care provision requires constant training related to counselling, pain management, psychological support, communication, legislation, ethics and clinical management (Andersson et al., 2014; Chiappetta-Swanson, 2005; Garel et al., 2007; Lindstrom et al., 2007; Mauri et al., 2015; Mauri and Squillace, 2017; Mayers et al., 2005; Moel-Mandel et al., 2019; Parker et al., 2014; Susila, 2012; Young and Bennett, 2002). Furthermore, four studies highlighted the importance of having guidelines to follow (Christensen et al., 2013; Mauri and Squillace, 2017; Susila, 2012; Young and Bennett, 2002). When these were lacking, nurses in Chiappetta-Swanson (2005) developed routines to help them to provide safe, effective and efficient care.

Coping strategies

Coping strategies are necessary when witnessing women dying or suffering adverse consequences of abortion (Cleeve et al., 2019) or when faced with the contradictions of being a midwife/nurse (Cignacco, 2002; Gallagher et al., 2010; Lipp, 2011; Nicholson et al., 2010; Yang et al., 2016; Young and Bennett, 2002). For example, having to attend a birth directly after inducing an abortion (Yang et al., 2016) or caring for women who felt abortion meant losing their baby, while for some others, the fetus had no further meaning to them (Young and Bennett, 2002). Nurses in Parker et al. (2014) decided to put personal judgements aside and respect woman's decisions as an internal coping strategy. A more extreme measure of responsibility detachment was seeing themselves as someone who conducts a role and placing the responsibility of the decision on the woman and the physician who prescribed the abortion (Mayers et al., 2005). Other midwives/nurses reported reminding themselves of the consequences for women when denying abortion access (Aniteye and Mayhew, 2013; Gallagher et al., 2010; Nicholson et al., 2010). In Teffo and Rispel (2020), being respectful of their personal time away from work, including measures like turning the mobile phone off, was also a way to protect themselves from work stress. South African midwives reported feeling trapped at their work due to the unwillingness of other colleagues to do the job (Mayers et al., 2005). Under this context, they used emotional detachment as a coping strategy (Mayers et al., 2005). Likewise, some Italian midwives/nurses preferred to approach their work mechanistically (Mauri and Squillace, 2017). Canadian nurses developed a standardised routine to face abortion care due to fetal anomalies in order to manage their internal emotional battles (Chiappetta-Swanson, 2005). Among English and Welsh nurses, another coping strategy reported was to avoid being present at the surgical room when the abortion was being conducted (Gallagher et al., 2010). Hanna (2005) noticed that nurses with a positive perception of abortion focused on providing immediate abortion care. In contrast, those with a more negative perception of abortion tended to overthink about how the woman they cared for would continue to demand abortion care (Hanna, 2005). Ghanaian midwives reported referring women to other providers when experiencing conflicts between their beliefs and their duty to provide abortion care (Aniteye and Mayhew, 2013). Another good clinical practice point reported by Canadian nurses to cope with working stress was rotating who was caring for women undergoing abortion, "so it's not always the same nurse that's going to be… doing terminations all the time" (p.483) (Parker et al., 2014).

Discussion

Thirty-one articles from the five continents related to midwives' and nurses' experiences implementing abortion care were identified for this review. Nevertheless, there was a lack of studies about experiences from low and middle-low income countries. Multiple reasons could explain this situation. These countries may have more restrictive laws regarding abortion, such as being illegal under any circumstance, and may not have conducted studies about this topic, or may not have publications in journals or platforms addressed by this search, or used a language different from English or Spanish. Despite the reasons, the lack of data continues to affect countries belonging to the Global South (Collyer, 2018).

Even when morally challenged, midwives and nurses working in abortion care in this review recognise women as their primary clients. Efforts are declared to be made by midwives/nurses to avoid acting judgementally towards a woman's decision-making. However, technological advances such as the increasing availability of non-invasive prenatal screening and fetal viability at lower gestational weeks could continue to morally challenge healthcare workers when providing abortion care. A qualitative study conducted in the USA (Megregian et al., 2020) found that despite the multiple ethical challenges faced by midwives, their training in ethical decision-making was almost non-existent. Considering this, close attention should be paid to midwives'/nurses' ethical instruction during undergraduate training and continuing education (Botes, 2000; Ejder Apay et al., 2020; Honkavuo, 2021; Toro-Flores et al., 2019). In this review, midwives/nurses requested training in legislation, ethics, and prenatal diagnosis, which suggests a need for a more profound understanding of abortion beyond its clinical management. In the light of this, periodic discussion and dissemination of midwifery and nursing codes of ethics (International Confederation of Midwives, 2008; International Council of Nurses, 2012) should be encouraged by their respective professional associations. In clinical practice, it could be relevant to include ethical decision-making frameworks and clinical ethics committees related to abortion units to help healthcare workers provide ethical care as recommended by WHO (World Health Organization, 2015). Likewise, empirical research about ethical decision-making among midwives and nurses regarding abortion should be strengthened (Fleming et al., 2018).

Worldwide, around seven in ten healthcare workers are women (World Health Organization, 2019) and 1 in 4 midwives considered their poor working conditions were related to gender inequality and discrimination against women (World Health Organization, 2016). Midwives'/nurses' experiences in this review suggests they often care in motherly-like style, suffer with the woman undergoing abortion, and judge women negatively when undergoing repeated abortion. Midwives/nurses in this review are also challenged by healthcare system hierarchy where physicians are sometimes in a better position to make decisions about abortion care. This situation could lead to midwives/nurses narrowing their professional role instead of actively supporting women's decision-making (Larsson et al., 2009; Lotan, 2019). Occupational stigma related to abortion among midwives and nurses and the situations described in this review could benefit from using intersectionality lenses as it allows simultaneous analysis of more categories including providers' gender and ethnicity (Turan et al., 2019).

The insufficient funding, lack of support and silent discrimination that many midwives/nurses in this review report are expressions of the invisible way stigma power operates (Link and Phelan, 2014; The Partnership for Maternal, Newborn & Child Health, 2019). Being labelled by other staff members, feeling that their job is less important, and witnessing how no one wants to cover shifts in abortion wards are other ways of how abortion stigma taints abortion providers and keeps them at a lower

level of occupational prestige (Adesse et al., 2016; Ashforth and Kreiner, 1999). Midwives and nurses in this review display psychological disengagement, design routines and guidelines and protect their time away from work. Similar coping strategies among other workers in stigmatised occupations have been found in research (Ashforth and Kreiner, 1999; Kreiner et al., 2006). Midwives and nurses in this review face similar challenges when providing abortion care. This finding suggests that despite midwives' and nurses' professional differences and being usually identified as compassionate carers, abortion stigma prevails over other identity categories (Ashforth and Kreiner, 1999).

Among the strengths of this review, are the rigor with which it was conducted, inclusion of literature from different geographical locations, and use of two search strategies. This review also has limitations. The search was conducted in eight databases which might result in missing some relevant studies published elsewhere. Other relevant studies could have been missed due to the eligibility criteria of this review, such as articles published in languages different from English and Spanish. Among the included studies, non-binary and male midwives'/nurses' experiences were not represented. Likewise, this review retrieved no data about non-female people undergoing abortion. Future research should focus on addressing these literature gaps, and to studying the power structures within the healthcare system that reproduce abortion stigma among providers. Likewise, it becomes relevant to study how midwives'/nurses' professional identity is shaped by abortion as these review findings suggest midwives/nurses who become abortion providers still experience occupational stigma.

Conclusion

Each context where abortion policies are implemented is unique and requires an appropriate evaluation of their policy implementation process. In this review we highlight the major concerns for midwives and nurses when implementing an abortion policy worldwide. Effort should be made to increase midwives' and nurses' practical and ethical competencies required to provide abortion care. Guidelines aiming to support policy implementation should consider how abortion affects healthcare providers and suggest appropriate measures to reduce negative effects and other barriers that, in the long term, could jeopardize the policy implementation process.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Ethical approval

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Supplementary materials

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