Received: 27 August 2019 | Revised: 24 December 2019 | Accepted: 3 February 2020

DOI: 10.1111/jocn.15218

REVIEW

Journal of Clinical Nursing WILEY

The role of nurses and midwives in the provision of abortion care: A scoping review

Lydia Mainey RN, MPH, PhD Candidate[1,2] | Catherine O'Mullan PhD, MSc, BA Hons, Senior Lecturer[3] | Kerry Reid-Searl PhD, RN, RM, Professor[1] | Annabel Taylor PhD, Professor[1,2] | Kathleen Baird PhD, RM, Associate Professor[4,5]

[1]School of Nursing, Midwifery and Social Sciences, CQUniversity, Rockhampton, Queensland, Australia

[2]Queensland Centre for Domestic and Family Violence Research, Brisbane, Queensland, Australia

[3]School of Health, Medical and Applied Sciences, CQUniversity, Bundaberg, Queensland, Australia

[4]Griffith University, Meadowbrook, Queensland, Australia

[5]Gold Coast University Hospital, Southport, Queensland, Australia

Correspondence
Lydia Mainey, Academic, School of Nursing, Midwifery and Social Sciences, CQUniversity, Rockhampton, Qld, Australia.
Email: l.mainey@cqu.edu.au

Funding information
The primary author is an Australian PhD candidate funded through the Australian Government Research Training Program (RTP).

Abstract

Aims and objectives: To define the role and scope of the nurse and midwife within the global context of abortion.

Background: An estimated 56 million women seek abortions each year; nurses and midwives are commonly involved in their care (Singh et al., 2018, https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf). As new models of abortion care emerge, there is a pressing need to develop a baseline understanding of the role and scope of nurses and midwives who care for women seeking abortions.

Design: The review design was Arksey and O'Malley's five-stage methodological framework. The review follows the PRISMA-ScR checklist.

Methods: MEDLINE, CINAHL, Scopus and ScienceDirect were used to identify original research, commentaries and reports, published between 2008–2019, from which we selected 74 publications reporting on the nursing or midwifery role in abortion care.

Results: Nurses and midwives provide abortion care in a variety of practice. Three themes emerged from the literature: the regulated role; providing psychosocial care; and the expanding scope of practice.

Conclusions: The literature on nursing and midwifery practice in abortion care is broad. Abortion-related practices are potentially over-regulated. Appropriately trained nurses and midwives can provide abortions as safely as physicians. The preparation of nurses and midwives to provide abortion care requires further research. Also, healthcare organisations should explore person-centred models of abortion care.

Relevance to clinical practice: Abortion care is a common procedure performed across many healthcare settings. Nurses and midwives provide technical and psychosocial care to women who seek abortions. Governments and regulatory bodies could safely extend their scope of practice to increase women's access to safe abortions. Introduction of education programmes, as well as embedding practice in person-centred models of care, may improve outcomes for women seeking abortions.

KEYWORDS

abortion, nurse's role, nursing, scoping review

1 | INTRODUCTION

Access to safe abortion is considered a human right and has directly contributed to a steep decrease in maternal mortality and morbidity worldwide (Erdman, Depiñeres, & Kismödi, 2013). Still, women seek unsafe abortions in places where safe and legal abortion is inaccessible. For every 100,000 unsafe abortions performed in developed areas, 30 women will die from complications. In developing regions, this number rises to between 220–520 deaths per 100,000 (Ganatra et al., 2017). Estimates from a decade ago put the global economic impact of treating the complications of unsafe abortion at $US553 million per year (Vlassoff, Shearer, Walker, & Lucas, 2008).

This paper reports on a systematic scoping review of research on nursing or midwifery abortion care to define the role and scope of the nurse and midwife within the global context of abortion.

Nurses and midwives together form the largest group of professionals employed in healthcare services and potentially play an important role in abortion care worldwide (Levi, Simmonds, & Taylor, 2009; Singh, 2018; Sutherland, Fontenot, & Fantasia, 2014). The activities undertaken by individual nurses and midwives are regulated and standardised according to their scope of practice, which is determined by education and law (Nursing & Midwifery Board of Australia, 2016). Scope of practice is influenced by the context of practice, the nurse or midwife's confidence and competence, the health needs of the people and the policy requirements of the health service (Nursing & Midwifery Board of Australia, 2016). Internationally, there has been a call to enhance the reproductive rights of women by integrating self-managed medical abortions (m-tops) into the current abortion service model (Jelinska & Yanow, 2018) as well expand the scope of nurses and midwives to provide medical and surgical abortions (s-top) (Renner, Brahmi, & Kapp, 2013). Improved research is needed to inform the nurse/midwives' scope in emerging abortion care frameworks to improve practice, streamline service provision and improve the health and reproductive autonomy of women. Ultimately, this may increase the availability, access and affordability of abortion services. The first step in this process is to identify the main types and sources of evidence available to develop future research priorities.

2 | AIMS

This scoping review is part of a larger doctoral study exploring the experiences of nurses managing the care of women seeking abortions in the context of violence. This review aims to define the role and scope of the nurse/midwife within the global context of abortion care.

The review addressed the following overarching question:

1. What is the nurse or midwife's role and scope of practice within abortion care?

What does this paper contribute to the wider global clinical community?

- This review consolidates the literature regarding the nurse and midwife's role in abortion care. In doing so it highlights research and practice gaps.
- This review demonstrates that nurses and midwives are essential to the delivery of abortion care. However, there are political and educational barriers that prevent nurses and midwives from working to an extended scope of practice. Further research is required to determine the extent of evidence-based abortion practice taught across nursing and midwifery curricula.
- This review demonstrates that nurses and midwives can improve access to women in rural and remote areas. Further inquiry is needed to ensure that care is provided within a person-centred model of care.

3 | METHODS

3.1 | Protocol registration

This scoping literature review is not registered and is not associated with a pre-existing protocol. The authors did not find any published systematic review protocols on this topic in Prospero, OSF Registries, Joanna Briggs Institute or Research Registry. Nor did the database search unearth published reviews of a similar nature.

3.2 | Study design

We have employed Arksey and O'Malley's (2005) systematic five-stage methodological framework for scoping reviews to identify, analyse and synthesise the literature. The five stages are (a) identify the search question (outlined above), (b) identify relevant studies, (c) study selection, (d) charting the data and (e) collating, summarising and report the results. The review follows the Preferred Reporting Items for Systematic Review and Meta-Analysis Extension for Scoping Reviews (Tricco et al., 2018; Appendix S1).

3.3 | Eligibility criteria

To identify relevant studies (stage one), we selected the initial search terms using the SPIDER tool (Sample, Phenomenon of Interest, Design, Evaluation and Research type). While other search tools may have been appropriate, SPIDER is purported to be more efficient than other search strategy tools with qualitative and mixed-method research questions (Cooke, Smith, & Booth, 2012).

Sample—nurses or midwives
Phenomenon of Interest—abortion care
Design—any
Evaluation—nursing or midwifery practice
Research Type—qualitative, quantitative and mixed methods

Search terms were tested and modified iteratively to find relevant articles. We restricted abortion to elective abortions and not those conducted for foetal abnormalities. We deemed studies eligible if they were published from 2008 onwards, citing both qualitative and quantitative original research data and published in English. We also included discussion papers and reports where they directly related to the role of the nurse or midwife (refer to Table 1 for inclusions/exclusions).

3.4 | Information sources and data collection process

LM searched MEDLINE, CINAHL, Scopus and ScienceDirect databases from 2008–December 2019 to identify relevant articles. LM drafted the search strategy and further refined through team discussion. The MEDLINE search strategy is demonstrated below.

3.5 | Search

The final search strategy for MEDLINE can be found in Table 2.

3.6 | Selection of sources of evidence

The articles collected in the previous step were imported into EndNote and screened for duplicates. To select the studies (stage three), LM performed title and abstract screening on the articles collected in the previous step and tracked this process in an Excel spreadsheet. These results were discussed with CO. LM then read the full-text articles and assessed them against inclusion and exclusion criteria to confirm their eligibility in the scoping review. Study relevance and validity were evaluated by considering how helpful each article was in answering the overarching scoping review question. The reviewers did not conduct a critical appraisal of individual articles; this is not a requirement for scoping reviews (Arksey & O'Malley, 2005; Pham et al., 2014).

3.7 | Data charting process (stage four)

LM charted data from eligible studies using a standardised data abstraction tool designed for this study. We abstracted data on nursing or midwifery care and charted the article characteristics including author, study population, methodology and outcomes. This information is presented in Appendix S2.

4 | RESULTS

4.1 | Selection of sources of evidence

A total of 140 records were identified using the outlined search strategy. Citations were imported to EndNote and screened for duplicates. Thirty articles were removed. Next, titles and abstracts were scrutinised against the inclusion and exclusion criteria. Twenty-two articles were removed as they were found not to meet the study criteria: 12 articles did not focus on the nurse or midwife's scope of practice and 10 articles were unrelated to nurses or midwives (e.g. DNA-testing, healthcare economics, patient attitudes to a support person in theatre). Full-text articles were then read and assessed with respect to how they answered the overarching research question. Ten articles were excluded as they did not report on nursing or midwifery care. Four articles were unavailable. Seventy-four articles, considered relevant to the study, were included in the synthesis (Figure 1): 27 qualitative, 29 quantitative, 4 mixed-methods studies and 3 systematic reviews. Eleven articles were reports or commentaries.

4.2 | Characteristics of sources of evidence

Each study's aim, setting, method and findings are presented in Appendix S2.

4.3 | Results of individual sources of evidence

Individual sources of evidence are presented in Appendix S2.

4.4 | Synthesis of results (stage five)

While the studies differed in purpose, design, study population and geographical location, all had a focus of nursing or midwifery practise in abortion care. The (74) articles demonstrated variation in work settings, qualifications, training and regulated practice. Three themes emerged from the articles: (a) regulated role, (b) psychosocial care and (c) expanding scope. The first theme related to the legal and clinical context in which abortion care can be delivered by nurses and midwives, as well as the education required to undertake the role. The second theme referred to aspects of abortion care, beyond task-based nursing and midwifery care. The final theme represented articles about nurses and midwives assuming the responsibilities in abortion care, more traditionally controlled by physicians.

4.4.1 | Theme 1: The regulated role

The 74 studies demonstrate that abortion care is delivered across diverse health settings by nurses and midwives who have varying

TABLE 1 Inclusions/exclusions table

Criteria	Inclusion criteria	Exclusion criteria
Time period	January 2008 onwards (December 2019)	Before January 2008
Type of article	Original research article, reviews, published in a peer-reviewed article. In English; quantitative and qualitative or mixed methods. Discussion papers and reports directly related to the role of nurse/midwife in abortion care	Articles which reported views about the provision of abortion by nurses (i.e. conscientious objectors)
Study focus	Nursing and midwifery care of women who present for abortion	No reference made to the nursing care of women who present for abortion

TABLE 2 MEDLINE search strategy

1. MeSH descriptor: [Abortion, Criminal]
2. MeSH descriptor: [Abortion, Therapeutic]
3. MeSH descriptor: [Abortion, Induced] explode all trees
4. MeSH descriptor: [Abortion, Legal]
5. Termination
6. Terminat* near/3 preg*
7. Medical near/2 terminat*
8. Surgical near/2 terminat*
9. Medical near/2 abortion
10. Surgical near/2 abortion
11. Care near/3 abortion
12. NOT Object*
13. NOT Conscientious
14. OR/1–14
15. MeSH descriptor: [Nursing Care]
16. MeSH descriptor: [Nurse Practitioners]
17. MeSH descriptor: [Nurse Specialists]
18. MeSH descriptor: [Nursing]
19. MeSH descriptor: [Nurse's Role]
20. MeSH descriptor: [Nurses, Community Health]
21. MeSH descriptor: [Nurses]
22. MeSH descriptor: [Midwifery]
23. MeSH descriptor: [Nurse Midwives]
24. MeSH descriptor: [Nurse Clinicians]
25. 15 AND (OR/1–14)

degrees of education and training. Two subthemes were identified: (a) context and law, and (b) qualifications and training.

Subtheme 1—Context and law

Except where nurses and midwives worked in specialist abortion services, abortion care was just one aspect of the nurse or midwives' overall responsibilities. Nurses and midwives worked in obstetric and gynaecological wards, operating theatres, primary practice, community sexual and reproductive health centres, telemedicine clinics, pharmacies and stand-alone abortion clinic contexts across metropolitan rural and remote areas. The broad skill sets of nurses and midwives were seen as helpful in the provision of comprehensive abortion care (CAC; Freedman & Levi, 2014; Hulme-Chambers, Clune, & Tomnay, 2018; Taylor, Safriet, & Weitz, 2009; Yarnall, Swica, & Winikoff, 2009).

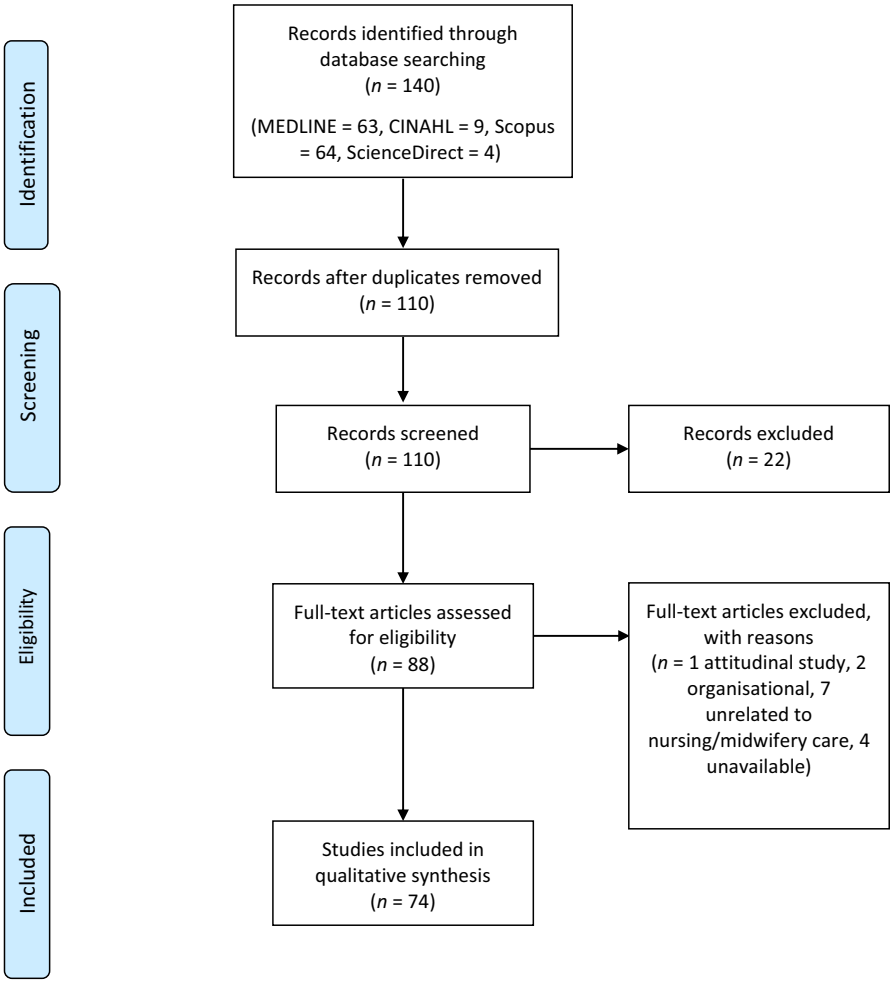
Nursing and midwifery work was largely influenced by the work context as well as national law and local policy. Table 3 provides an overview of the laws governing abortion globally and the associated effect on the provision of care by nurses and midwives. However, nurses and midwives did not always have a good understanding of the law (Oppong-Darko, Amponsa-Achiano, & Darj, 2017). Indeed, some countries interpreted laws ambiguously (Cleeve, Nalwadda, Zadik, Sterner, & Klingberg-Allvin, 2019), conservatively or enacted special laws restricting nurse/midwifery involvement (Biggs et al., 2019; Sheldon & Fletcher, 2017; Taylor et al., 2009).

The routine nursing and midwifery tasks described in the articles were pregnancy diagnosis and options counselling (Levi et al., 2009), pharmacological and nonpharmacological pain relief (Lindström, Wulff, Dahlgren, & Lalos, 2011), administration of anti-D, and antibiotic prophylaxis (Cappiello, Beal, & Simmonds, 2011), handling the products of conception (Andersson, Gemzell-Danielsson, & Christensson, 2014; Mauri, Ceriotti, Soldi, & Guerrini Contini, 2015; Michalik et al., 2019; Mizuno, 2011; Nicholson, Slade, & Fletcher, 2010), gestational dating, bimanual examination (Averbach, Puri, Blum, & Rocca, 2018) screening for domestic violence, postabortion contraception care (Purcell, Cameron, Lawton, Glasier, & Harden, 2016), referrals (Grace, 2016), health education (Cappiello et al., 2011; Halldén, Lundgren, & Christensson, 2011), counselling (Hulme-Chambers et al., 2018), prescription of abortion drugs (Simmonds, Beal, & Eagen-Torkko, 2017), administration of abortion drugs, manual vacuum aspiration abortions (MVA) (Berer, 2009; Bridgman-Packer & Kidanemariam, 2018; Paul, Gemzell-Danielsson, Kiggundu, Namugenyi, & Klingberg-Allvin, 2014), postabortion phone counselling (Dawson, Bateson, Estoesta, & Sullivan, 2016), peer education (Puri, Regmi, Tamang, & Shrestha, 2014; Puri, Tamang, Shrestha, & Joshi, 2015), care of or referral for postabortion complications (Hulme-Chambers et al., 2018; Yegon et al., 2019), screening and treatment of sexually transmitted infections and human immunovirus (Yegon et al., 2019) and management of postabortion complications (Cleeve et al., 2019; Paul et al., 2014; Yarnall et al., 2009; Yegon et al., 2019). These tasks were not ubiquitous. A qualitative longitudinal study suggested where policy allowed for specially trained nurses and midwives to provide abortions, access and quality of care improved; however, the changes to clinical operations and staffing created barriers (Battistelli, Magnusson, Biggs, & Freedman, 2018).

Subtheme 2—Qualifications and training

Qualifications and training required to provide abortion nursing and midwifery care were reported in 15 articles. They varied significantly

FIGURE 1 PRISMA 2009 flow diagram



across the studies and depended on the regulation of abortion generally and specialist clinical practices specifically, and the country setting. For example, the degree to which qualifications and training were necessary for MVA was not uniform. In Nigeria, MVAs were performed by generalist nurses who did not routinely receive formal education around the practice (Adinma, Adinma, Ikeako, & Ezeama, 2011). Ugandan midwives had similar experiences and performed MVAs for postabortion care with or without specific training and in emergencies would perform dilatation and curettage, and manual removal of placentas (Paul et al., 2014). Tanzanian nurses and midwives reported that they performed postabortion care with inadequate training and supervision (Yegon et al., 2019). Twenty per cent of Ethiopian mid-level healthcare workers reported training in safe abortion care despite the country having the fifth highest rate of maternal deaths in the world (Assefa, 2019). In contrast, Californian certified midwives, nurse practitioners and physician assistants underwent training, based on education programmes used for family practice residence, to perform MVAs. The health practitioners' confidence grew after they became competent and their ability to manage clinical issues increased with experience (Levi, Angel James, & Taylor, 2012; Levi et al., 2018).

In Nepal, nurses and auxiliary nurse midwives in the Rupandehi district received a 3-day training to provide unbiased counselling, MVA, m-top, management of minor complications and early identification and escalation of adverse conditions. Postintervention interviews revealed that nurses and auxiliary nurse midwives were confident about performing m-tops independently (Puri et al., 2014).

Recently, the International Confederation of Midwifery amended its competency standards for basic midwifery education, adding a new competency specific to individualised, culturally sensitive abortion-related care provision (Fullerton, Thompson, Severino, & International Confederation of, 2011). In accordance, the Nigerian Midwifery curriculum has been upgraded to improve postabortion care material. The intervention has increased the quality of instruction as well as the skills of graduates using MVA (Akiode, Fetters, Daroda, Okeke, & Oji, 2010). Ghanaian midwifery schools added CAC to the curriculum in 2007 (Rominski, Lori, Nakua, Dzomeku, & Moyer, 2016). In Poland, the midwifery degree is regulated nationally and requires theoretical and practical preparation of students to provide abortion care, though students feel abortion is inadequately covered in the curriculum (Michalik et al., 2019). A descriptive study carried out across 77 nursing and midwifery schools in Japan found little content devoted to the abortion procedure itself, favouring instead the legal aspects of abortion as well as family planning, emergency contraception, postabortion complications and psychological effects

TABLE 3 Abortion laws by country

Country	Law	Effect on nurses/midwives and women
Kenya	Abortion illegal except to save the woman's life. Postabortion care is legal	High mortality rate PAC currently only performed by physicians (Makenzius et al., 2017)
Nigeria	Criminal except in certain circumstances	High mortality rate Nurses and midwives can perform postabortion care (Adinma et al., 2011; Akiode et al., 2010; Fawole et al., 2012)
Ethiopia	Abortion is illegal except in the case of rape or incest, a risk to the woman's life or health, foetal malformation, maternal disability or age under 18 years up until foetal viability (28 weeks) (Assefa, 2019). Medical abortion beyond 9 weeks. CAC country model	Services have expanded but still unavailable for many women. Nurses able to provide first-trimester abortions (Bridgman-Packer & Kidanemariam, 2018)
Zambia	Abortion is legal on socio-economic grounds since 1994 (Kishen, Stedman, Kishen, & Stedman, 2010)	Midwives can perform medical and surgical abortions up to 12 weeks of gestation and postabortion care. CAC training was added to the midwifery curricula in 2007
Uganda	Abortion is only legal to save the life of the woman (Paul et al., 2014)	40% of admissions to emergency obstetric units are due to unsafe abortion. Specially trained midwives may perform postabortion care
Ghana	The liberalisation of abortion laws in 1985 to allow abortion in context of rape, defilement, incest, risk to the life or physical/mental health, risk of child suffering (Oppong-Darko et al., 2017). 2003 National Reproductive Health strategy includes access to safe abortion care	Unsafe abortion continues to be a public health challenge. Midwives authorised to provide early abortion (Oppong-Darko et al., 2017)
South Africa	Abortion on demand available up to 12 weeks under the Choice on Termination of Pregnancy Act, 1996	A registered nurse may lawfully perform first-trimester abortions (Kishen, Stedman, Kishen, & Stedman, 2010; Mamabolo & Tjallinks, 2010)
Mozambique	Abortion is legal	Maternal-child nurses provide comprehensive care including ultrasound, administration of misoprostol, MVA, follow-up and postabortion care (Yarnall et al., 2009)
Tanzania	Government committed to postabortion care (Yegon et al., 2019)	Nurses and nurse–midwives treat abortion complications using misoprostol, MVA and curettage. Also expected to provide contraception counselling
Poland	Legal if there is a risk to life, if the pregnancy results from an illegal act, or in the case where a foetal abnormality will impact independent life (Michalik et al., 2019)	Estimated 80–150 thousand illegal abortions annually. Midwives may conscientiously object to providing abortion care
England, Wales and Scotland	Abortion Act 1967 made abortion legal on request up to 24 weeks. The interpretation of the law is disputed, and some believe that surgical abortions could be performed by nurses and midwives as part of the healthcare team (Sheldon & Fletcher, 2017)	Abortion Act 1967—nurses may accept delegated instructions from a registered medical practitioner allowing for nurse-delivered termination services (Cherry & Sokolovs, 2008; Gallagher, Porock, & Edgley, 2010; Kishen et al., 2010; Lipp, 2011). Abortion almost exclusively provided through the National Health Service in hospital gynaecology departments however moving into community-based sexual and reproductive health centres. Misoprostol must be delivered in the healthcare setting
Northern Ireland	Abortion remains illegal (Kishen et al., 2010)	
France	Abortion legal if performed by a qualified medical doctor (Kishen et al., 2010)	Must be performed by a physician; however, nurses are regularly involved in abortion care
Italy	Law no 194 of 22 May 1978 abortion is legal 12 weeks. After 12 weeks, only legal under circumstances that preserve the woman's life or when malformations are detected that could risk the physical or mental maternal health	Registered nurses may conscientiously object to being part of the abortion but not the before/aftercare (Mauri et al., 2015)

(Continues)

TABLE 3 (Continued)

Country	Law	Effect on nurses/midwives and women
Sweden	Abortion is legal under the Swedish Abortion Act of 1974 up to 18 weeks and must be performed by a doctor	Performed by physicians but nurses or midwives are usually involved in caring for the woman (Andersson et al., 2014; Kishen et al., 2010; Kopp Kallner et al., 2015; Lindström et al., 2011)
Norway	Abortion Act of 1978 made abortion legal in the first trimester. Medical abortion was introduced in 1998	In some instances, the nurse can be delegated the whole medical abortion procedure by the physician. Usually, nurses have a more limited role (Kjelsvik et al., 2018)
Nepal	First-trimester abortions became legal in 2002. CAC initiated in 2004	Access to abortion care has increased for many women; however, those in remote areas still have limited access. One in seven maternal deaths is attributable to unsafe abortion (Kishen et al., 2010) Nurses and midwives (as well as auxiliary nurse midwives) can legally provide abortions (Andersen et al., 2016). Medical abortions can be provided up to 63 days of gestation in government-certified health facilities (Averbach et al., 2018)
India	Medical Termination of Pregnancy Act of 1972 up to 20 weeks of gestation	Access to abortion remains limited. Estimates that 3 unsafe abortions are performed to every 2 legal abortions. Carried out in registered facilities by gynaecologists or specially trained allopathic physicians (Jejeebhoy et al., 2011, 2012; Kishen et al., 2010)
Bangladesh	The law permits induced abortion to save the life of the woman. "Menstrual regulation" though vacuum aspiration is available up to 10 weeks of pregnancy	Vacuum aspiration is performed by family-welfare visitors (Kishen et al., 2010)
Kyrgyzstan	Abortion is legal on request without restriction up to 12 weeks' gestation and up to 22 weeks for economic and social reasons	Must be provided by an obstetrician–gynaecologist in public or private institution. Nurses and midwives are involved in the care of women undergoing abortions (Johnson et al., 2018)
Canada	1988 abortion was decriminalised entirely (Kishen et al., 2010)	Must be provided by a medical practitioner (Kishen et al., 2010)
USA	Abortion legal in many US states. Roe v. Wade 1973 enacted due to concern over untrained providers harming women. March 2016, Food and Drug Administration updated the labelling of mifepristone to allow midwives, nurse practitioners and physician's assistant to obtain and prescribe mifepristone without physician supervision (Simmonds et al., 2017). Physician-only laws in some states restrict the provision of abortion (Taylor et al., 2009)	2003 Assembly Bill (154) allows trained nurse practitioners, certified nurse–midwives and physicians assistants to perform aspiration abortions in California (Battistelli et al., 2018; Freedman et al., 2015; Freedman & Levi, 2014). Physician-only abortion law in Arizona (Jackson, 2011). Advance practice clinicians (APCs) provide abortions in Vermont and Montana since 1973; APCs perform medical abortions in 14 states and surgical abortions in six states (Kishen et al., 2010). Certified nurse–midwives can legally provide medical and aspiration abortions in the USA as determined by State law (Levi et al., 2012)
Mexico	Abortion legalised in 2007 (Olavarrieta et al., 2015)	Patient demand still outpaces service delivery. Most abortions are still illegal. Nurses could be trained and authorised to perform medical terminations (Olavarrieta et al., 2015)
Chile	Abortion legalised in 2017 in situations when the woman's life is at risk, for foetal abnormality and for pregnancies resulting from rape (Biggs et al., 2019)	Midwives have a limited role in abortion care as legally, only physicians can perform the procedure
Vietnam	Abortion legal since 1945 and can be performed by a doctor, doctor-assistant or trained midwife (Kishen et al., 2010)	Trained midwives can perform abortions (Kishen et al., 2010)
Japan	Abortion legal up until 21 weeks of gestation for justifiable reasons such as rape, physical health, socio-economic hardship (Mizuno, 2011)	People seeking abortions are cared for within maternity units. Midwives provide care for people undergoing abortions. Medical abortions are still rare (Mizuno, 2014). Nurses and midwives do not have the option to contentiously object (Mizuno, 2014)

(Continues)

TABLE 3 (Continued)

Country	Law	Effect on nurses/midwives and women
Cambodia	Abortion legal on any grounds in the first trimester and performed by a doctor, medical assistant or midwife at public or private health facilities (Kishen et al., 2010)	Authorised midwives can perform surgical abortions (Yarnall et al., 2009)
Myanmar	Penal code of 1,860 criminalises abortion unless it is performed to save the life of the woman	Unsafe abortion is common and contributes to 10% of maternal deaths countrywide and 50% of maternal deaths in conflict-affected areas (Sheehy, Aung, & Foster, 2015). Commonly performed by untrained traditional birth attendants. Few trained midwives (m-top)
Australia	Legislation differs between states. Restrictions on abortion in most states	Abortions must be performed by a medical doctor. Nurses and midwives assist in the care of the woman during the procedure (Dawson et al., 2016; Hulme-Chambers et al., 2018). Doctors who wish to become medical abortion providers must undergo online training through MS Health. Only pharmacists who are registered providers with the MS-2Step programme can dispense medication abortion drugs

Abbreviations: CAC, comprehensive abortion care; MVA, manual vacuum aspiration.

of abortion (Mizuno, 2014). Comparable results were found in a Canadian study which aimed to understand the curriculum coverage of abortion in nurse practitioner programmes. The national survey of nurse practitioner programme directors revealed 63% of programmes covered ethics of abortion, counselling and post-abortion care, and approximately half of the programmes covered first-trimester abortion procedures (Sheinfeld, Arnott, El-Haddad, & Foster, 2016).

The context of care presented unique educational needs for nurses and midwives. For example, labour and delivery nurses in Quebec, Canada, identified that they needed more knowledge of pre-abortion counselling to assess the woman's understanding of the procedure as well as more training on how to support women who had received abortions through the postpartum period (Parker, Swanson, & Frunchak, 2014). Lack of m-top training opportunities was seen as a barrier to nurse-led medical abortion in the primary health care setting in regional and rural Victoria, Australia (de Moel-Mandel, Graham, & Taket, 2019). A support network for abortion care nurses, established in Wales, provides ongoing professional development to its members to extend their knowledge, expertise and skills (Cherry & Sokolovs, 2008).

4.4.2 | Theme 2: Providing psychosocial care

Nine articles explored broader aspects of nursing and midwifery care referred to here as psychosocial care. English gynaecology nurses from a ward-based abortion service felt that psychological care was one of their major roles. They employed nonjudgemental counselling and interpersonal skills, though this proved challenging for the nurses if women presented for multiple abortions or had an abortion after fertility treatment (Nicholson et al., 2010). Nurses in UK abortion clinics described how they used therapeutic communication to reduce the controversy and shame around the stigmatised procedure (Fullerton et al., 2011) and joint decision-making around contraception uptake (Purcell et al., 2016). Developing the therapeutic relationship and establishing professional boundaries were two important elements of abortion care for labour and delivery nurses in Quebec, Canada (Parker et al., 2014). Nurses and midwives who provided care for women undergoing home abortions in Sweden explained that they adapted their care depending on the woman's need to cope or deal with loss, grief and sorrow associated with the procedure (Lindström et al., 2011).

An exploration of the experiences and perceptions of Swedish nurses and midwives caring for women undergoing late-term abortions found themselves being selective with the information they gave the woman about the procedure to increase comfort and responded to the woman's emotional and existential needs (Andersson et al., 2014). In a similar study conducted in Italy, midwives explained that caring for women undergoing late-term abortions required practical and psychological competence, excellent communication skills and empathy (Mauri et al., 2015).

A qualitative study of Norwegian nurses and doctors who cared for women ambivalent about their abortions explained that they employed a therapeutic use of self as well as intuition to assess the woman's ambivalence. They changed their language so as not to seem confrontational, remained neutral about the woman's choice and pragmatically prepared them for the procedure (Kjelsvik, Tveit Sekse, Moi, Aasen, & Gjengedal, 2018). A phenomenological hermeneutic analysis of midwives who provide abortion care to teenagers in Sweden uncovered that midwives used a variety of psychosocial techniques to engage young women and assist them to make decisions about abortion and contraception. Midwives felt that understanding the teen's social situation was an essential element that allowed them to refer her to a social worker and tailor their preventative care. They also created a space where the young woman could work through her feelings, consider the consequences of terminating or continuing the pregnancy and negotiate low-dosage contraceptives. They employed unconventional contact methods, such as calling the teen's friends when they missed appointments (Halldén

et al., 2011). Providing abortion care to Swedish women from immigrant backgrounds required midwives to adapt their care since some women did not see their bodies as their own, had a lack of understanding about sex and pregnancy, made decisions with their families and came from backgrounds that accepted honour-based violence (Larsson, Fried, Essén, & Klingberg-Allvin, 2016).

4.4.3 | Theme 3: Expanding scope of practice

Expanding the scope of practice to allow nurses and midwives to have a greater role in abortion care was the focus of 27 articles. Three subthemes emerged: (a) as safe as doctors, (b) pragmatism and (c) moving away from the hospital.

Subtheme 1—As safe as doctors

A 2009 summary of evidence article by Yarnall et al. (2009) found that mid-level providers (such as nurses and midwives), especially those who manage normal pregnancies, possess the requisite clinical skills to provide m-tops. Such skills include the administration of medications, assessment of gestational age, diagnosis of ectopic pregnancy, family planning counselling and the management of obstetric complications. A systematic review, by Barnard, Kim, Park and Ngo (Barnard, Kim, Park, & Ngo, 2015), compared the effectiveness or safety of abortion provided by mid-level providers against medical and s-tops performed by doctors. They identified eight studies (three of which were identified by our search protocol), including randomised control trials, prospective cohort studies and observational studies. The quality of evidence varied from high quality to very low quality. The combined data from the s-top rate found no difference between doctors and mid-level providers failure and complication rates. A systematic review by Renner et al. (2013) had similar findings, which is not surprising as the articles selected for the meta-analysis were similar. A 4-year prospective observational cohort study to assess the safety of first-trimester MVA performed by advanced nurses, midwives and physicians assistants across four services in California found that these health providers were no less safe than physicians (Freedman, Battistelli, Gerdts, & McLemore, 2015; Weitz et al., 2013; Weitz, Taylor, Upadhyay, Desai, & Battistelli, 2014). A cohort study conducted in Oregon, USA, compared the outcomes of 669 first-trimester MVA with immediate intra-uterine device insertion between nurse practitioners, certified nurse–midwives and physicians and found no differences in outcomes between provider type (Patil et al., 2016). A 3-month noninferiority trial to examine the effectiveness, safety and acceptability of nurse provision of early m-tops compared to physicians was conducted across three facilities in Mexico City (Olavarrieta et al., 2015). A total of 844 women were randomly assigned to a nurse or physician. Like the previous study, nurses were found to be no less safe than physicians. The study also found that there was no difference between physicians and nurses in determining gestation or the uptake of contraception postabortion. The women rated care provided by the nurse and physician groups as highly acceptable.

A randomised controlled equivalence trial in Sweden assessed nurse/midwife provision of first-trimester m-top where ultrasound was used as part of the protocol. The study found the effectiveness of m-top provided by nurses to be superior to doctors (though there were no differences in patient safety outcomes) (Kopp Kallner et al., 2015). A 12-month randomised controlled equivalence trial conducted across five districts in Nepal. It set out to (a) assess whether first-trimester m-tops provided by mid-level providers were as safe and effective as that provided by doctors and (b) assess the level of satisfaction women who received m-tops felt when the services were provided by trained nurses and auxiliary nurse midwives (independently from doctors) or doctors. The study found that safety and effectiveness were similar between groups (Warriner et al., 2011), and women's satisfaction was also similar between the groups (Tamang et al., 2017). A retrospective review of CAC service register at Tribhuvan University Teaching Hospital in Nepal also found that nurses were as competent as doctors in providing abortions but were underutilised (Sayami, 2019). Studies carried out in India (Jejeebhoy et al., 2011, 2012) concluded that nurses could assess gestation and complete abortions, and perform MVA as well as physicians. Abortion failure rates were equivalent to physicians.

A prospective cohort study carried out by Gebreselassie, Ustá, and Mitchel (Gebreselassie, Ustá, Andersen, & Mitchell, 2012) found that when nurses were consistently able to diagnose complete abortions using clinical history taking and physical examination as proficiently as gynaecologists using ultrasound. The same nurses had a moderate agreement with physicians diagnosing incomplete abortions and ongoing pregnancy. A nonrandomised implementation study of 32 nurses and midwives who provided medical termination to 554 women across four remote services in Kyrgyzstan found that there was a high level of complete abortions with no adverse events or safety issues and a high level of patient satisfaction (Johnson et al., 2018). A multicentre randomised controlled equivalence trial of 1,094 women with incomplete first-trimester abortions in Kenya found that women who were administered misoprostol by midwives to complete their abortions had slightly better outcomes than when administer by physicians (94.8% compared with 94.3%) (Makenzius et al., 2017). An open-label prospective study in Nigeria had similar findings where nurses performed first-line treatment for incomplete abortions using misoprostol (Fawole, Diop, Adeyanju, Aremu, & Winikoff, 2012).

Conversely, an Australian study, which investigated the expansion of general practice to provide m-top, found doctors were resistant to the exclusive provision of m-top by primary care nurses. Study participants felt that nurses lacked skill and experience, and their nursing care was of a lower standard than other countries with nurse-led m-top models of care (Newton et al., 2016). On the other hand, a study investigating the enablers and barriers to decentralising m-top service provision in Victoria found that some general practice providers utilised nurse-led integration models of abortion care. Unsurprisingly, general practitioners and primary care nurses felt that training by providers that had partnered with trusted rural organisations and being able to adapt resources used by rural services

facilitated the provision of abortion care (Hulme-Chambers et al., 2018). de Moel-Mandel Graham and Taket's (2019) Delphi study exploring a nurse-led model of m-top provision in rural and regional Victoria achieved a consensus that primary health care nurses could provide m-top in collaboration with general practitioners, refer for blood tests and ultrasound scans, interpret pathology, administer mifepristone and prophylactically manage pain. The panel also believed legislation changes were necessary to allow nurses to prescribe m-top medications. They could not reach consensus on nurses managing the m-top process autonomously or the responsibility of the general practitioner managing non-life-threatening complications. The barriers to a nurse-led model of care were training, support from general practitioners and other stakeholders (such as local health professionals), funding models, abortion stigma, and distribution of labour between doctors and nurses.

Subtheme 2—Pragmatism

Under-resourced countries, such as Nepal, Bangladesh, Myanmar and Uganda, pragmatically extend the scope of nurses and midwives, as well as incorporate other auxiliary health professionals (such as auxiliary nurses and female paramedics) to provide abortion or postabortion care (Andersen et al., 2016; Cleeve et al., 2019; K C et al., 2011; Puri et al., 2015). Nonetheless, in some under-resourced settings, such as areas of Uganda, midwives were forced to practice outside of their extended scope, with improvised equipment (Paul et al., 2014), in inadequate facilities and for low pay (Cleeve et al., 2019). The use of auxiliary nurses and midwives in abortion care, without specific training, should be approached cautiously. A mixed-method study describing the knowledge, attitudes and roles of auxiliary nurse midwives and other community health intermediaries in Karnataka, India, demonstrates that the health workers had limited understanding of abortion law, held negative views towards abortion and would not support women in their abortion decision-making (Nandagiri, 2019).

Subtheme 3—Moving away from the hospital

Expanding scope was described in other ways such as in Sweden, where a focus group of nurses and midwives foreshadowed the provision of home abortions. This shift, from the hospital to the home, would give control of the process to the woman. The nurses believed their role would change to be that of advocate, providing phone support and offering advice for pain relief (Lindström et al., 2011). A 12-month observational noninferiority study carried out in semi-urban and remote areas in two Nepali districts compared the safety and effectiveness of m-tops provided by trained auxiliary nurse midwives at six pharmacies and six health facilities (Rocca et al., 2018). M-top provided through pharmacies was as effective as provided through health facilities.

5 | DISCUSSION

This scoping review adds to the literature by consolidating a large body of international research in the field of nursing and midwifery abortion care. The evidence demonstrated that nurses and midwives provide a wide range of abortion-related services and are essential to abortion care delivery. From this review, we have learnt that the nurse and midwife's role in abortion may be over-regulated in many countries. The risk profile of abortion care, especially m-top, appears to be lower than many other roles advanced-practice nurses and midwives already perform. However, we learnt little about the education and training that midwives and especially nurses receive to provide abortion-related care. While some momentum has been made to determine the essential abortion care competencies by Hewitt and Cappiello (2015), further work is needed to establish the extent of abortion content taught across the international undergraduate nursing and midwifery curricula.

Furthermore, although this review illustrates that nurses and midwives are essential providers of abortion care, few articles provided a framework of person-centred abortion care. CAC, identified in four articles, is a framework which incorporates high-quality integrated services, safe induced abortion, treatment of complications, counselling, contraceptive and family planning services and decentralisation of services. It is affordable to both women and health systems and attends to other issues relevant to the woman's health (IPAS, 2011). However, we do not know whether nurses or midwives situate their practice activities within such a framework. Further research is therefore required in this area.

There was evidence that psychosocial care was a central element of abortion care, and this is not surprising given the stigmatised nature of the procedure. Treatment by healthcare staff is a consistent finding in overall satisfaction rates among women seeking abortions (Regmi & Madison, 2010; Taylor et al., 2013). Nevertheless, these findings were overshadowed by the volume of studies that focused on the nurse/midwife's task-based scope of practice.

There was consistent evidence that adequately trained nurses and midwives could work more autonomously, and within nurse-led care models to provide m-top and MVA in the first trimester as well as postabortion care. Legislation, however, acts as a barrier for nurses and midwives and presents a significant access threat to women living in regional or remote areas globally. In an era where safe, self-managed abortions are gaining traction, the current risk profile of the abortion medication, mifepristone, needs review to make it available in the midwifery and nurse practitioner formulary.

5.1 | Limitations

We undertook this review throughout 2019, and information contained in Table 3 may be outdated. Any recent changes to abortion law reform, not captured by the search strategy, are not displayed in this article. We completed our literature search after the first round of database searching. While this could indicate that some articles may have been missed, Nussbaumer-Streit et al. (2018) suggest that when 10 or more studies are combined, there is a reduced risk that conclusions may be false; we found 74 articles. They also found that combining two separate databases (we combined four) increases the

reliability of conclusions. The effectiveness of citation searching for reviews of qualitative data, especially on public health topics, has also been called into question by Cooper, Booth, Varley-Campbell, Britten, and Garside (2018). These topics usually generate large numbers of studies, the data are not needed for meta-analysis and there is difficulty in demonstrating the value of missed studies. Finally, Horsley, Dingwall, and Sampson (2011) recommend citation searching when the identification of all relevant studies through database searching is difficult. We believe that the inclusion of 74 articles indicates that most relevant studies have been identified. Further, the scoping review consolidated findings from varied research topics, study populations, methods and findings and generalisable conclusions should not be drawn from the study. As our search strategy was limited to English, some articles may have been missed.

6 | CONCLUSIONS

In this scoping review, we set out to map research on the nurse/midwife's role and scope of practice in abortion care. The literature was extensive, with many studies focussing on task-based duties and the feasibility of nurses and midwives providing abortions. Several studies explored nursing practices beyond task-based care. Future research should be directed towards abortion care education, nursing practice within the comprehensive care model and nurse-led models of care.

7 | RELEVANCE TO CLINICAL PRACTICE

The findings of this scoping review are relevant for clinical practice. Abortion care is a common procedure performed across many healthcare settings. Currently, nurses and midwives provide technical and emotional care to women who seek abortion care. Governments and regulatory bodies could safely extend the scope of practice to increase women's access to safe abortion care. Introduction of education programmes, as well as embedding practice in person-centred models of care, may improve outcomes for women seeking abortions.

CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

AUTHOR CONTRIBUTIONS

Design and implementation of the search strategy and analysis of the results: LM and CO; and writing of the manuscript: LM, CO, KRS, AT and KB.

ORCID

Lydia Mainey https://orcid.org/0000-0003-1438-8061
Catherine O'Mullan https://orcid.org/0000-0003-2882-3087
Kerry Reid-Searl https://orcid.org/0000-0001-5808-9296
Kathleen Baird https://orcid.org/0000-0003-0142-6962

REFERENCES

Adinma, J. I. B., Adinma, E. D., Ikeako, L., & Ezeama, C. (2011). Abortion treatment by health professionals in south-eastern Nigeria. *Journal of Obstetrics and Gynaecology*, *31*(6), 529–532. https://doi.org/10.3109/01443615.2011.580394

Akiode, A., Fetters, T., Daroda, R., Okeke, B., & Oji, E. (2010). An evaluation of a national intervention to improve the postabortion care content of midwifery education in Nigeria. *International Journal of Gynecology & Obstetrics*, *110*(2), 186–190. https://doi.org/10.1016/j.ijgo.2010.05.003

Andersen, K. L., Basnett, I., Shrestha, D. R., Shrestha, M. K., Shah, M., & Aryal, S. (2016). Expansion of safe abortion services in Nepal through auxiliary nurse-midwife provision of medical abortion, 2011–2013. *Journal of Midwifery & Women's Health*, *61*(2), 177–184. https://doi.org/10.1111/jmwh.12419

Andersson, I.-M., Gemzell-Danielsson, K., & Christensson, K. (2014). Caring for women undergoing second-trimester medical termination of pregnancy. *Contraception*, *89*(5), 460–465. https://doi.org/10.1016/j.contraception.2014.01.012

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*, *8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Assefa, E. M. (2019). Knowledge, attitude and practice (KAP) of health providers towards safe abortion provision in Addis Ababa health centers. *BMC Women's Health*, *19*(1), 1–10. https://doi.org/10.1186/s12905-019-0835-x

Averbach, S., Puri, M., Blum, M., & Rocca, C. (2018). Gestational dating using last menstrual period and bimanual exam for medication abortion in pharmacies and health centers in Nepal. *Contraception*, *98*(4), 296–300. https://doi.org/10.1016/j.contraception.2018.06.004

Barnard, S., Kim, C., Park, M. H., & Ngo, T. D. (2015). Doctors or mid-level providers for abortion. *Cochrane Database of Systematic Reviews*, (7), 1. https://doi.org/10.1002/14651858.CD011242.pub2

Battistelli, M. F., Magnusson, S., Biggs, M. A., & Freedman, L. (2018). Expanding the abortion provider workforce: A qualitative study of organizations implementing a New California Policy. *Perspectives on Sexual and Reproductive Health*, *50*(1), 33–39. https://doi.org/10.1363/psrh.12051

Berer, M. (2009). Provision of abortion by mid-level providers: International policy, practice and perspectives. *Bulletin of the World Health Organization*, *87*(1), 58–63. https://doi.org/10.2471/BLT.07.050138

Biggs, M. A., Casas, L., Ramm, A., Baba, C. F., Correa, S. V., & Grossman, D. (2019). Future health providers' willingness to provide abortion services following decriminalisation of abortion in Chile: A cross-sectional survey. *British Medical Journal Open*, *9*(10), e030797. https://doi.org/10.1136/bmjopen-2019-030797

Bridgman-Packer, D., & Kidanemariam, S. (2018). The implementation of safe abortion services in Ethiopia. *International Journal of Gynecology & Obstetrics*, *143*, 19–24. https://doi.org/10.1002/ijgo.12673

Cappiello, J. D., Beal, M. W., & Simmonds, K. E. (2011). Clinical issues in post-abortion care. *The Nurse Practitioner*, *36*(5), 35–40. https://doi.org/10.1097/01.NPR.0000396475.68812.06

Cherry, A., & Sokolovs, H. (2008). Setting up a support network for specialist nurses. *Nursing Times*, *104*(43), 29–30.

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. *Midwifery*, *77*, 71–77. https://doi.org/10.1016/j.midw.2019.06.004

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO. *Qualitative Health Research*, *22*(10), 1435–1443. https://doi.org/10.1177/1049732312452938

Cooper, C., Booth, A., Varley-Campbell, J., Britten, N., & Garside, R. (2018). Defining the process to literature searching in systematic

reviews: A literature review of guidance and supporting studies. *BMC Medical Research Methodology*, *18*(1), 85. https://doi.org/10.1186/s12874-018-0545-3

Dawson, A., Bateson, D., Estoesta, J., & Sullivan, E. (2016). Towards comprehensive early abortion service delivery in high income countries: Insights for improving universal access to abortion in Australia. *BMC Health Services Research*, *16*(1), 612. https://doi.org/10.1186/s12913-016-1846-z

de Moel-Mandel, C., Graham, M., & Taket, A. (2019). Expert consensus on a nurse-led model of medication abortion provision in regional and rural Victoria, Australia: A Delphi study. *Contraception*, *100*(5), 380–385. https://doi.org/10.1016/j.contraception.2019.07.004

Erdman, J. N., Depiñeres, T., & Kismödi, E. (2013). Updated WHO guidance on safe abortion: Health and human rights. *International Journal of Gynecology & Obstetrics*, *120*(2), 200–203. https://doi.org/10.1016/j.ijgo.2012.10.009

Fawole, A. O., Diop, A., Adeyanju, A. O., Aremu, O. T., & Winikoff, B. (2012). Misoprostol as first-line treatment for incomplete abortion at a secondary-level health facility in Nigeria. *International Journal of Gynecology & Obstetrics*, *119*(2), 170–173. https://doi.org/10.1016/j.ijgo.2012.06.012

Freedman, L., Battistelli, M. F., Gerdts, C., & McLemore, M. (2015). Radical or routine? Nurse practitioners, nurse-midwives, and physician assistants as abortion providers. *Reproductive Health Matters*, *23*(45), 90–92. https://doi.org/10.1016/j.rhm.2015.06.002

Freedman, L., & Levi, A. (2014). How clinicians develop confidence in their competence in performing aspiration abortion. *Qualitative Health Research*, *24*(1), 78–89. https://doi.org/10.1177/1049732313514483

Fullerton, J. T., Thompson, J. B., Severino, R., & International Confederation of, M. (2011). The International Confederation of Midwives essential competencies for basic midwifery practice. An update study: 2009–2010. *Midwifery*, *27*(4), 399–408. https://doi.org/10.1016/j.midw.2011.03.005

Gallagher, K., Porock, D., & Edgley, A. (2010). The concept of 'nursing' in the abortion services. *Journal of Advanced Nursing*, *66*(4), 849–857. https://doi.org/10.1111/j.1365-2648.2009.05213.x

Ganatra, B., Gerdts, C., Rossier, C., Johnson, B. R., Tunçalp, Ö., Assifi, A., … Alkema, L. (2017). Global, regional, and subregional classification of abortions by safety, 2010–14: Estimates from a Bayesian hierarchical model. *The Lancet*, *390*(10110), 2372–2381. https://doi.org/10.1016/S0140-6736(17)31794-4

Gebreselassie, H., Ustá, M., Andersen, K. L., & Mitchell, E. M. H. (2012). Clinical diagnosis of completeness of medical abortion by nurses: A reliability study in Mozambique. *Contraception*, *86*(1), 74–78. https://doi.org/10.1016/j.contraception.2011.08.012

Grace, K. T. (2016). Caring for women experiencing reproductive coercion. *Journal of Midwifery & Women's Health*, *61*(1), 112–115. https://doi.org/10.1111/jmwh.12369

Halldén, B.-M., Lundgren, I., & Christensson, K. (2011). Ten Swedish midwives' lived experiences of the care of teenagers' early induced abortions. *Health Care for Women International*, *32*(5), 420–440. https://doi.org/10.1080/07399332.2010.535937

Hewitt, C., & Cappiello, J. (2015). Essential Competencies in Nursing Education for Prevention and Care Related to Unintended Pregnancy. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, *44*(1), 69–76. https://doi.org/10.1111/1552-6909.12525

Horsley, T., Dingwall, O., & Sampson, M. (2011). Checking reference lists to find additional studies for systematic reviews. *Cochrane Database of Systematic Reviews* (8), MR000026. https://doi.org/10.1002/14651858.MR000026.pub2

Hulme-Chambers, A., Clune, S., & Tomnay, J. (2018). Medical termination of pregnancy service delivery in the context of decentralization: Social and structural influences. *International Journal for Equity in Health*, *17*(1), 172. https://doi.org/10.1186/s12939-018-0888-8

IPAS (2011). *What is woman-centred comprehensive abortion care?* Chapel Hill, NC: IPAS.

Jackson, C. B. (2011). Expanding the pool of abortion providers: Nurse-midwives, nurse practitioners, and physician assistants. *Women's Health Issues*, *21*(3 Suppl), S42–S43.

Jejeebhoy, S. J., Kalyanwala, S., Mundle, S., Tank, J., Zavier, A. J. F., Kumar, R., … Jha, N. (2012). Feasibility of expanding the medication abortion provider base in India to include ayurvedic physicians and nurses. *International Perspectives on Sexual and Reproductive Health*, *38*(3), 133–142. https://doi.org/10.1363/3813312

Jejeebhoy, S. J., Kalyanwala, S., Zavier, A. J. F., Kumar, R., Mundle, S., Tank, J., … Jha, N. (2011). Can nurses perform manual vacuum aspiration (MVA) as safely and effectively as physicians? Evidence from India. *Contraception*, *84*(6), 615–621. https://doi.org/10.1016/j.contraception.2011.08.010

Jelinska, K., & Yanow, S. (2018). Putting abortion pills into women's hands: Realizing the full potential of medical abortion. *Contraception*, *97*(2), 86–89. https://doi.org/10.1016/j.contraception.2017.05.019

Johnson, B. R., Maksutova, E., Boobekova, A., Davletova, A., Kazakbaeva, C., Kondrateva, Y., … Seuc Jo, A. H. (2018). Provision of medical abortion by midlevel healthcare providers in Kyrgyzstan: Testing an intervention to expand safe abortion services to underserved rural and periurban areas. *Contraception*, *97*(2), 160–166. https://doi.org/10.1016/j.contraception.2017.11.002

K C, N. P., Basnett, I., Sharma, S. K., Bhusal, C. L., Parajuli, R. R., & Andersen, K. L. (2011). Increasing access to safe abortion services through auxiliary nurse midwives trained as skilled birth attendants. *Kathmandu University Medical Journal*, *9*(36), 260–266.

Kishen, M., Stedman, Y., Kishen, M., & Stedman, Y. (2010). The role of Advanced Nurse Practitioners in the availability of abortion services. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *24*(5), 569–578. https://doi.org/10.1016/j.bpobgyn.2010.02.014

Kjelsvik, M., Tveit Sekse, R. J., Moi, A. L., Aasen, E. M., & Gjengedal, E. (2018). Walking on a tightrope—Caring for ambivalent women considering abortions in the first trimester. *Journal of Clinical Nursing*, *27*(21–22), 4192–4202. https://doi.org/10.1111/jocn.14612

Kopp Kallner, H., Gomperts, R., Salomonsson, E., Johansson, M., Marions, L., & Gemzell-Danielsson, K. (2015). The efficacy, safety and acceptability of medical termination of pregnancy provided by standard care by doctors or by nurse-midwives: A randomised controlled equivalence trial. *BJOG: An International Journal of Obstetrics & Gynaecology*, *122*(4), 510–517. https://doi.org/10.1111/1471-0528.12982

Larsson, E. C., Fried, S., Essén, B., & Klingberg-Allvin, M. (2016). Equitable abortion care – A challenge for health care providers. Experiences from abortion care encounters with immigrant women in Stockholm, Sweden. *Sexual & Reproductive Healthcare*, *10*, 14–18. https://doi.org/10.1016/j.srhc.2016.10.003

Levi, A., Angel James, E., & Taylor, D. (2012). Midwives and abortion care: A model for achieving competency. *Journal of Midwifery & Women's Health*, *57*(3), 285–289. https://doi.org/10.1111/j.1542-2011.2012.00182.x

Levi, A., Goodman, S., Weitz, T., AbiSamra, R., Nobel, K., Desai, S., … Taylor, D. (2018). Training in aspiration abortion care: An observational cohort study of achieving procedural competence. *International Journal of Nursing Studies*, *88*, 53–59. https://doi.org/10.1016/j.ijnurstu.2018.08.003

Levi, A. J., Simmonds, K. E., & Taylor, D. (2009). The role of nursing in the management of unintended pregnancy. *Nursing Clinics of North America*, *44*(3), 301–314. https://doi.org/10.1016/j.cnur.2009.06.007

Lindström, M., Wulff, M., Dahlgren, L., & Lalos, A. (2011). Experiences of working with induced abortion: Focus group discussions with gynaecologists and midwives/nurses. *Scandinavian Journal of Caring Sciences*, *25*(3), 542–548. https://doi.org/10.1111/j.1471-6712.2010.00862.x

Lipp, A. (2011). Stigma in abortion care: Application to a grounded theory study. *Contemporary Nurse*, *37*(2), 115–123. https://doi.org/10.5172/conu.2011.37.2.115

Makenzius, M., Oguttu, M., Klingberg-Allvin, M., Gemzell-Danielsson, K., Odero, T. M. A., & Faxelid, E. (2017). Post-abortion care with misoprostol - equally effective, safe and accepted when administered by midwives compared to physicians: A randomised controlled equivalence trial in a low-resource setting in Kenya. *British Medical Journal Open*, *7*(10), 1. https://doi.org/10.1136/bmjopen-2017-016157

Mamabolo, L. R. C., & Tjallinks, J. E. (2010). Experiences of registered nurses at one community health centre near pretoria providing termination of pregnancy services. *Africa Journal of Nursing and Midwifery*, *12*(1), 73–86.

Mauri, P. A., Ceriotti, E., Soldi, M., & Guerrini Contini, N. N. (2015). Italian midwives' experiences of late termination of pregnancy. A phenomenological-hermeneutic study. *Nursing & Health Sciences*, *17*(2), 243–249. https://doi.org/10.1111/nhs.12180

Michalik, A., Zdun-Ryżewska, A., Pięta, B., Basiński, K., Kiełbasińska, J., Mazurkiewicz, B., … Łukaszuk, K. (2019). Multicenter study on midwifery students' attitudes towards abortion and it's place in their future practice – Comparison of respondents at early and late stages of the university education. *Nurse Education in Practice*, *35*, 42–47. https://doi.org/10.1016/j.nepr.2019.01.003

Mizuno, M. (2011). Confusion and ethical issues surrounding the role of Japanese midwives in childbirth and abortion: A qualitative study. *Nursing & Health Sciences*, *13*(4), 502–506. https://doi.org/10.1111/j.1442-2018.2011.00647.x

Mizuno, M. (2014). Abortion-care education in Japanese nurse practitioner and midwifery programs: A national survey. *Nurse Education Today*, *34*(1), 11–14. https://doi.org/10.1016/j.nedt.2013.04.016

Nandagiri, R. (2019). "Like a mother-daughter relationship": Community health intermediaries' knowledge of and attitudes to abortion in Karnataka, India. *Social Science & Medicine*, *239*, 112525. https://doi.org/10.1016/j.socscimed.2019.112525

Newton, D., Bayly, C., McNamee, K., Bismark, M., Hardiman, A., Webster, A., & Keogh, L. (2016). '…a one stop shop in their own community': Medical abortion and the role of general practice. *Australian and New Zealand Journal of Obstetrics and Gynaecology*, *56*(6), 648–654. https://doi.org/10.1111/ajo.12507

Nicholson, J., Slade, P., & Fletcher, J. (2010). Termination of pregnancy services: Experiences of gynaecological nurses. *Journal of Advanced Nursing*, *66*(10), 2245–2256. https://doi.org/10.1111/j.1365-2648.2010.05363.x

Nursing and Midwifery Board of Australia (2016). *Registered nurse standards for practice*. Retrieved from https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/registered-nurse-standards-for-practice.aspx

Nussbaumer-Streit, B., Klerings, I., Wagner, G., Heise, T. L., Dobrescu, A. I., Armijo-Olivo, S., … Gartlehner, G. (2018). Abbreviated literature searches were viable alternatives to comprehensive searches: A meta-epidemiological study. *Journal of Clinical Epidemiology*, *102*, 1–11. https://doi.org/10.1016/j.jclinepi.2018.05.022

Olavarrieta, C. D., Ganatra, B., Sorhaindo, A., Karver, T. S., Seuc, A., Villalobos, A., … Sanhueza, P. (2015). Nurse versus physician-provision of early medical abortion in Mexico: A randomized controlled non-inferiority trial. *Bulletin of the World Health Organization*, *93*(4), 249–258. https://doi.org/10.2471/BLT.14.143990

Oppong-Darko, P., Amponsa-Achiano, K., & Darj, E. (2017). "I Am Ready and Willing to Provide the Service … Though My Religion Frowns on Abortion"-Ghanaian Midwives' mixed attitudes to abortion services: A Qualitative study. *International Journal of Environmental Research and Public Health*, *14*(12), https://doi.org/10.3390/ijerph14121501

Parker, A., Swanson, H., & Frunchak, V. (2014). Needs of labor and delivery nurses caring for women undergoing pregnancy termination. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *43*(4), 478–487. https://doi.org/10.1111/1552-6909.12475

Patil, E., Darney, B., Orme-Evans, K., Beckley, E. H., Bergander, L., Nichols, M., & Bednarek, P. H. (2016). Aspiration Abortion With Immediate Intrauterine Device Insertion: Comparing Outcomes of Advanced Practice Clinicians and Physicians. *Journal of Midwifery & Women's Health*, *61*(3), 325–330. https://doi.org/10.1111/jmwh.12412

Paul, M., Gemzell-Danielsson, K., Kiggundu, C., Namugenyi, R., & Klingberg-Allvin, M. (2014). Barriers and facilitators in the provision of post-abortion care at district level in central Uganda - a qualitative study focusing on task sharing between physicians and midwives. *BMC Health Services Research*, *14*, 28. https://doi.org/10.1186/1472-6963-14-28

Pham, M. T., Rajić, A., Greig, J. D., Sargeant, J. M., Papadopoulos, A., & McEwen, S. A. (2014). A scoping review of scoping reviews: Advancing the approach and enhancing the consistency. *Research Synthesis Methods*, *5*(4), 371–385. https://doi.org/10.1002/jrsm.1123

Purcell, C., Cameron, S., Lawton, J., Glasier, A., & Harden, J. (2016). Contraceptive care at the time of medical abortion: Experiences of women and health professionals in a hospital or community sexual and reproductive health context. *Contraception*, *93*(2), 170–177. https://doi.org/10.1016/j.contraception.2015.09.016

Puri, M., Regmi, S., Tamang, A., & Shrestha, P. (2014). Road map to scaling-up: Translating operations research study's results into actions for expanding medical abortion services in rural health facilities in Nepal. *Health Research Policy and Systems*, *12*, 24. https://doi.org/10.1186/1478-4505-12-24

Puri, M., Tamang, A., Shrestha, P., & Joshi, D. (2015). The role of auxiliary nurse-midwives and community health volunteers in expanding access to medical abortion in rural Nepal. *Reproductive Health Matters*, *22*(44 Suppl 1), 94–103. https://doi.org/10.1016/S0968-8080(14)43784-4

Regmi, K., & Madison, J. (2010). Ensuring patient satisfaction with second-trimester abortion in resource-poor settings. *International Journal of Gynecology & Obstetrics*, *108*(1), 44–47. https://doi.org/10.1016/j.ijgo.2009.08.005

Renner, R. M., Brahmi, D., & Kapp, N. (2013). Who can provide effective and safe termination of pregnancy care? A systematic review*. *BJOG: An International Journal of Obstetrics & Gynaecology*, *120*(1), 23–31. https://doi.org/10.1111/j.1471-0528.2012.03464.x

Rocca, C. H., Puri, M., Shrestha, P., Blum, M., Maharjan, D., Grossman, D., … Harper, C. C. (2018). Effectiveness and safety of early medication abortion provided in pharmacies by auxiliary nurse-midwives: A non-inferiority study in Nepal. *PLoS ONE*, *13*(1), 1. https://doi.org/10.1371/journal.pone.0191174

Rominski, S. D., Lori, J., Nakua, E., Dzomeku, V., & Moyer, C. A. (2016). What makes a likely abortion provider? Evidence from a nationwide survey of final-year students at Ghana's public midwifery training colleges. *Contraception*, *93*(3), 226–232. https://doi.org/10.1016/j.contraception.2015.11.007

Sayami, J. T. (2019). Trends in Comprehensive Abortion Care (CAC) and characteristics of women receiving abortion care in a tertiary hospital in Nepal. *BMC Women's Health*, *19*(1), 41. https://doi.org/10.1186/s12905-019-0739-9

Sheehy, G., Aung, Y., & Foster, A. M. (2015). "We can lose our life for the abortion": Exploring the dynamics shaping abortion care in peri-urban Yangon, Myanmar. *Contraception*, *92*(5), 475–481. https://doi.org/10.1016/j.contraception.2015.08.006

Sheinfeld, L., Arnott, G., El-Haddad, J., & Foster, A. M. (2016). Assessing abortion coverage in nurse practitioner programs in Canada: A national survey of program directors. *Contraception*, *94*(5), 483–488. https://doi.org/10.1016/j.contraception.2016.06.020

Sheldon, S., & Fletcher, J. (2017). Vacuum aspiration for induced abortion could be safely and legally performed by nurses and midwives. *Journal of Family Planning and Reproductive Health Care*, *43*(4), 260–264. https://doi.org/10.1136/jfprhc-2016-101542

Simmonds, K. E., Beal, M. W., & Eagen-Torkko, M. K. (2017). Updates to the US Food and Drug Administration regulations for mifepristone: Implications for clinical practice and access to abortion.

Journal of Midwifery & Women's Health, *62*(3), 348–352. https://doi.org/10.1111/jmwh.12636

Singh, S., Remez, L., Sedgh, G., Kwok, L., & Onda, T. (2018). *Abortion worldwide 2017: Uneven progress and unequal access*. Retrieved from https://www.guttmacher.org/sites/default/files/report_pdf/abortion-worldwide-2017.pdf

Sutherland, M. A., Fontenot, H. B., & Fantasia, H. C. (2014). Beyond assessment: Examining providers' responses to disclosures of violence. *Journal of the American Association of Nurse Practitioners*, *26*(10), 567–573. https://doi.org/10.1002/2327-6924.12101

Tamang, A., Shah, I. H., Shrestha, P., Warriner, I. K., Wang, D., Thapa, K., … Meirik, O. (2017). Comparative satisfaction of receiving medical abortion service from nurses and auxiliary nurse-midwives or doctors in Nepal: Results of a randomized trial. *Reproductive Health*, *14*(1), 176. https://doi.org/10.1186/s12978-017-0438-7

Taylor, D., Postlethwaite, D., Desai, S., James, E. A., Calhoun, A. W., Sheehan, K., & Weitz, T. A. (2013). Multiple determinants of the abortion care experience: From the patient's perspective. *American Journal of Medical Quality*, *28*(6), 510–518. https://doi.org/10.1177/1062860613484295

Taylor, D., Safriet, B., & Weitz, T. (2009). When politics trumps evidence: Legislative or regulatory exclusion of abortion from advanced practice clinician scope of practice. *Journal of Midwifery & Women's Health*, *54*(1), 4–7. https://doi.org/10.1016/j.jmwh.2008.09.003

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., … Straus, S. E. (2018). Prisma extension for scoping reviews (prisma-scr): Checklist and explanation. *Annals of Internal Medicine*, *169*(7), 467–473. https://doi.org/10.7326/M18-0850

Vlassoff, M., Shearer, J., Walker, D., & Lucas, H. (2008). *Economic impact of unsafe abortion-related morbidity and mortality: Evidence and estimation challenges* (Vol. *59*). Brighton, UK: Institute of Development Studies.

Warriner, I. K., Wang, D., Huong, N. T. M., Thapa, K., Tamang, A., Shah, I., … Meirik, O. (2011). Can midlevel health-care providers administer early medical abortion as safely and effectively as doctors? A randomised controlled equivalence trial in Nepal. *The Lancet*, *377*(9772), 1155–1161. https://doi.org/10.1016/S0140-6736(10)62229-5

Weitz, T. A., Taylor, D., Desai, S., Upadhyay, U. D., Waldman, J., Battistelli, M. F., & Drey, E. A. (2013). Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver. *American Journal of Public Health*, *103*(3), 454–461. https://doi.org/10.2105/AJPH.2012.301159

Weitz, T. A., Taylor, D., Upadhyay, U. D., Desai, S., & Battistelli, M. (2014). Research informs abortion care policy change in California. *American Journal of Public Health*, *104*(10), e3–e4. https://doi.org/10.2105/AJPH.2014.302212

Yarnall, J., Swica, Y., & Winikoff, B. (2009). Non-physician clinicians can safely provide first trimester medical abortion. *Reproductive Health Matters*, *17*(33), 61–69. https://doi.org/10.1016/S0968-8080(09)33445-X

Yegon, E., Ominde, J., Baynes, C., Ngadaya, E., Kahando, R., Kahwa, J., & Lusiola, G. (2019). The quality of postabortion care in Tanzania: Service provider perspectives and results from a service readiness assessment. *Global Health: Science and Practice*, *7*, S315–S326. https://doi.org/10.9745/GHSP-D-19-00050

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

How to cite this article: Mainey L, O'Mullan C, Reid-Searl K, Taylor A, Baird K. The role of nurses and midwives in the provision of abortion care: A scoping review. *J Clin Nurs*. 2020;29:1513–1526. https://doi.org/10.1111/jocn.15218