Optimizing the Nursing Role in Abortion Care: Considerations for Health Equity

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Abstract
Registered nurses (RNs) provide abortion care in hospitals and clinics and support abortion care through sexual health education and family planning care in sexual health clinics, schools and family practice. Nurse practitioners (NPs) improve access to abortion not only as prescribers of medication abortion but also as primary care providers of counselling, resources about pregnancy options and

abortion follow-up care in their communities. There is a need to better understand the current status of and potential scope for optimizing nursing roles in abortion care across Canada. In this article, we describe the leadership of nurses in the provision of accessible, inclusive abortion services and discuss barriers to role optimization. We present key insights from a priority-setting meeting held in 2019 with NPs and RNs engaged in medication abortion practice in their communities. As scopes of practice continue to evolve, optimization of nursing roles in abortion care is an approach to enhancing equitable access to comprehensive abortion care and family planning.

Introduction

Family planning includes a range of health services across the lifespan to assist individuals in planning pregnancies and managing unintended pregnancies, including counselling and provision of contraception, assisted reproductive technologies and abortion care. This care occurs in a variety of hospital and community settings. Abortion is a critical family planning service that was completely decriminalized in Canada in 1988. Medication abortion, approved by Health Canada in 2015 for administration using the drug combination 200 mg mifepristone/800 mcg misoprostol, is a safe, effective option and an alternative to aspiration abortion (Kapp et al. 2013; Løkeland et al. 2014). Medication abortion pills are taken orally at the patient's home. As such, medication abortion may be perceived as less physically invasive than aspiration abortion – it requires minimal contact with health services and, because fewer resources and equipment are required, it may be prescribed in primary care settings. As geographical issues are the most common barriers to abortion access in Canada, medication abortion can vastly expand access for those living in rural or remote communities (Norman et al. 2019).

Despite the potential value of medication abortion in advancing health equity, there are social, structural and policy issues in Canada preventing optimization of access. In this article, we focus specifically on barriers to optimizing the roles of registered nurses (RNs) and nurse practitioners (NPs) in abortion care and on how optimization of the nursing role can increase access to care and improve health outcomes and healthcare experiences. We describe their roles with regard to abortion care in Canada and their unique position to address health inequities. We then describe a priority-setting meeting held in 2019 and consider the role of the current nurse leadership in the implementation of medication abortion in Canada. We conclude with considerations for policy makers, stakeholders and researchers about how to support nurse leadership in abortion care to improve quality of and access to reproductive healthcare, especially for individuals and communities facing intersecting oppressions.

Disparities in Abortion Care

Access to abortion is a key factor for improving not only overall health but also the social and economic well-being of women and all people with a uterus. While there are no legal restrictions to abortion services in Canada, there are multiple intersecting factors that contribute to health disparities and the differing abilities of individuals to access abortion services safely and efficiently (Hardcastle 2019; Ross and Solinger 2017). An equity approach to social justice and health aims to identify and reduce health-related disparities caused by avoidable economic and social conditions (Braveman 2014; Marmot and Allen 2014; WHO 2008). Health equity is value-based and focuses on the equitable distribution of not only health services but also resources in society (Braveman 2014; Braveman and Gruskin 2003).

Viewed through a health equity lens, disparities in abortion access and family planning services are exacerbated by social and economic factors, including abortion stigma; class, individual and systemic racism; ability; gender identity and sexual orientation; and geographical location. Geographical disparities are well researched in Canada (Kaposy 2010; Norman et al. 2016; Sethna and Doull 2013); having timely access to a nearby provider improves clinical outcomes (Schummers and Norman 2019). People experiencing violence, poverty, racism, xenophobia, homophobia and/or transphobia face additional barriers to abortion care, including discrimination and trauma triggers in healthcare settings. Black communities report lower trust in healthcare providers (Halbert et al. 2006), which leads to lower patient satisfaction (Benkert et al. 2006). The impact of these barriers is under-researched in Canada – no data are available on access to abortion disparities by race or income, for example. In the US, black women have abortions at a rate four times higher than white women (Studnicki et al. 2020); it is not known how this translates in Canada. A population-based study using administrative immigration and healthcare data in Ontario found that induced abortion rates were two to five times higher among immigrants born in almost all regions of the world when compared to those born in the US, northern and western Europe, Australia and New Zealand. Additionally, immigrants from the Caribbean, West/Middle/East Africa and South America were most likely to have an abortion (Wanigaratne et al. 2020). US-based research has found that 8.4% of abortion patients are currently experiencing intimate partner violence (Saftlas et al. 2010), and abortion is more common among women in poverty (Dehlendorf et al. 2013). Furthermore, given the cultural and political stigmatization surrounding abortion (La Roche and Foster 2018; Shaw 2019), trust in providers is particularly important. Empowering, patient-centred care is crucial. It is possible that access to abortion outside of healthcare settings and in the comfort and privacy of one's home may improve equity in access.

Policy decisions may reinforce or mitigate social and economic factors that negatively impact abortion access. As an example of policy reducing equity – and its reversal – consider this: when Health Canada first approved mifepristone for use in Canada in 2015, only specially trained physicians were authorized to prescribe it. In 2017, Health Canada made a landmark decision to allow authorized health professionals, including NPs, to prescribe medication abortion (Government of Canada 2017). Prior to these changes, nearly all abortion was provided as an aspiration (surgical) procedure in a major city (Norman et al. 2016), severely limiting access for those living in rural or remote regions (Devane et al. 2019; Munro et al. 2020). Expanding authorization to NPs has the potential to vastly increase the number of patients who can receive timely abortion care because RNs and NPs provide essential primary care services in rural and remote settings (Martin-Misener et al. 2020) and are dedicated to meeting the needs of underserved communities. Furthermore, sex-based data show that most NPs are women (CIHI 2021a), potentially increasing the comfort of women and gender-diverse and transgender patients in discussing abortion, a highly stigmatized health service.

Nursing, Family Planning and Health Equity

There are over 300,000 RNs in Canada, including over 6,000 NPs, making nurses not only the largest healthcare workforce but one of the largest workforces in the country overall (CIHI 2021b). RNs and NPs play a key role in family planning education, counselling and collaborative care provision in schools, emergency departments, sexual and reproductive health clinics, specialized clinics, public health and primary care (CIHI 2021a). As primary care providers, NPs – and in some provinces such as Quebec and Manitoba, RNs – may prescribe a range of contraceptive options: long-acting reversible contraceptives, including the copper and hormonal intrauterine devices and the subdermal etonogestrel implant; barrier methods (diaphragms); and combined hormonal methods such as the birth control pill, ring or patch. That RNs and NPs play an integral role in abortion remains hidden.

NPs have been found to provide equivalent primary care to physicians (Kippenbrock et al. 2019), and outcomes from first-trimester medication abortion provided by NPs are comparable to those of physicians (Kishen and Stedman 2010). Patients are often more satisfied with family planning services provided by NPs (Goldberg et al. 2017; Harper et al. 2013). As nurses and NPs often are the primary first-contact healthcare professionals among hard-to-reach and underserved communities, the presence of nurses in abortion care can increase the availability of abortions in rural and remote areas (Andrews et al. 2005; Laurent 2002; MacLeod et al. 2004) and communities including Black, Indigenous and People of Colour (BIPOC) and two-spirit, lesbian, gay, bisexual, transgender, queer, intersex and asexual (2SLGBTQIA+) individuals (CNA 2017b; Hulme

et al. 2015). Beyond increasing access to these services, central to the identity and ethos of nurses is engaging with patients from a compassionate perspective that considers the whole person and the needs of their families (McCaffrey and McConnell 2015).

Nurse leadership in abortion care has the potential to further improve access and models of care; however, nurses are underutilized, and their roles and contributions are under-researched and under-supported by their institutions, in curriculum and in continuing education (Lebold and MacDonnell 2020; Paynter et al. 2019). Previous research has focused on trends in nursing education about contraception and abortion care (Harper et al. 2013; Sheinfeld et al. 2016) and increasing nurses' leadership in addressing the social determinants of health (Scheffer et al. 2019). The lack of research about nursing roles in abortion contributes to the lack of public visibility and understanding of nurses as care providers, which has implications for patient access: not knowing whom to turn to for care is a significant barrier (Aiken et al. 2018; Paynter et al. 2019). Nurses who are willing to provide abortion care and lead advocacy efforts for equitable, accessible reproductive services face barriers to working to full scope. These include professional hierarchies and institutional barriers that impede the ability of nurses to fulfill these roles and implement these services despite their training, abilities and scopes of practice (Gould et al. 2007; Heale 2012; Sangster-Gormley et al. 2011).

Nurses in Canada, including NPs, are largely remunerated on a salary basis funded by provincial, territorial and regional health authorities, as well as through federal and private funding (Tikkanen et al. 2020). This funding model enables nurses more time per patient when compared to a fee-for-service physician remuneration model (Glauser 2019). This structure is beneficial to abortion care, in that it facilitates longer appointments to hear patients' stories, provide appropriate counselling and build trust. This is especially important for marginalized and oppressed groups who face structural and systemic barriers to care – such as youth, the BIPOC community, the 2SLGBTQIA+ community, sex workers and those experiencing homelessness, violence and abuse – who may have lower trust in their providers and the health system broadly.

The involvement of nurses and their commitment to health equity "are essential to making a significant impact in national health indices" (Lathrop 2013: 42). Nurses are ideally positioned to address health equity because of public trust in the nursing profession (Reinhart 2020), codes of ethics (CNA 2017a) and education emphasizing advocacy and patient-focused care (Lathrop 2013). Studies have found unrealized political efficacy among nurses, despite the size of and respect for the profession (O'Rourke et al. 2017). Researchers have critiqued the gaps in nursing education with respect to not only inadequate content on abortion but

also lack of attention to sexism, racism, gender binarism and heterosexism in nursing that prevents the profession from engaging in transformational work for health equity (Burnett et al. 2020; Coleman 2020; Paynter et al. 2019; Thornton and Persaud 2018).

Nurses and other healthcare professionals may recognize and accept the consequences of the social and structural determinants of health for individuals and communities; however, their effects and ways to address them can be overwhelming (Andermann 2016; Lathrop 2020). It is not always clear how to intervene with patients who experience multiple intersecting social and structural barriers to healthcare and well-being amid staff shortages, burnout and a pressure to reduce readmissions and implement patient-centred care (Beagan and Ells 2007; Lathrop 2020). Structural hierarchies in health organizations may subjugate nurses' voices and discourage political engagement among nurses. For example, nurse Carolyn Strom faced discipline from the Saskatchewan Registered Nurses Association for speaking out on social media about patient mistreatment in long-term care (Sciarpelletti 2020). While she was vindicated, the experience elucidates potential disciplinary consequences for nurses who raise questions about healthcare systems, which may discourage fellow nurses from using their positions for political and social change. Despite the relative reported feelings of safety among physician abortion providers in Canada (Dressler et al. 2013; Norman et al. 2013, 2016), nurses may be reluctant to publicize their involvement in abortion care because of fears of violence, harassment or disapproval. Understanding these dynamics is essential to optimizing nurse leadership in abortion care. In the next section, we describe a 2019 priority-setting meeting with respect to nurses' roles in medication abortion. We present key insights from this meeting and describe ongoing barriers to and opportunities for supporting nurse leadership for reproductive health equity.

Nurse Leadership in Medication Abortion: A National Dialogue

The Contraception and Abortion Research Team-Groupe de recherche sur l'avortement et la contraception (CART-GRAC) is a national research team whose goal is to support health services and policies to ensure equitable access to high-quality family planning throughout Canada (https://cart-grac.ubc.ca/). In September 2019, CART-GRAC organized a meeting in Toronto, ON, funded by a Canadian Institutes of Health Research Planning and Dissemination Grant (CIHR, PCS-165031), engaging RNs, NPs and knowledge users. The theme was "Optimizing the Nurse Role in Abortion Care." The objective of the meeting was to identify ways to improve access to high-quality abortion care by understanding the current scope of practice of NPs and RNs, their practice communities and patient and family health needs. Organizers invited nurses working in sexual and reproductive health clinics, family practices and NP-led clinics across Canada.

The agenda included working groups among participants and presentations on optimizing the nursing role in abortion care. We identified lessons learned from the early period of implementation of mifepristone in Canada, ongoing barriers and potential opportunities and research priorities for healthcare providers.

Nineteen people attended the meeting: eight NPs, three RNs and eight CART-GRAC members. CART-GRAC members included physicians, nurses, an administrator, social workers and trainees who work in research settings. Attendees represented four provinces: British Columbia, Ontario, Prince Edward Island and Nova Scotia. Fourteen attendees participated in person, and five participated virtually.

The meeting included a combination of presentations and facilitated discussion groups with attendees. The meeting began by outlining the goals and aims for the day, followed by round-table introductions. Next, attendees learned of the current landscape of medication abortion in Canada, the evolution of Health Canada regulations and restrictions on mifepristone and research in progress on healthcare professionals' experiences during the first two years of mifepristone use in Canada. Next, a knowledge user partner (co-author JR) outlined provincial and territorial authorizations for NPs' and RNs' prescribing practice and for the provision of mifepristone. Two NP attendees who were early adopters of medication abortion in their practices – one in a northern community rural setting and one in a large urban setting – presented on the implementation of medication abortion in their practices, the successes, ongoing challenges and lessons learned. Attendees were then divided into groups of four to six people, with a member of CART-GRAC facilitating an open-ended discussion and taking notes about nurse attendees' priorities regarding research about medication abortion and its potential practice implications. Afterwards, all the groups came together to share discussion points and research priorities. Lastly, closing remarks were given by one of the co-organizers, and final thoughts were welcomed from attendees.

We organized the ideas generated from the meeting into three interconnected themes about nurse leadership and mifepristone implementation in Canada, based on meeting notes taken throughout the day by multiple members of the CART-GRAC, an audio recording of the entire meeting and detailed notes taken during the research priority-setting portion of the discussion. The three themes were as follows: (1) reducing barriers for marginalized and underserved patients; (2) communication and relationship building; and (3) collaboration between medical and allied health professionals (e.g., physicians, pharmacists, midwives).

Reducing Barriers for Marginalized and Underserved Patients

Participants described their development of strategies and resources to improve

access to and the experience of medication abortion for underserved patients. For example, participants were intentional about reducing the number of required appointments and minimizing travel. This was true for all patients, but especially important for those with a history of trauma who were uncomfortable in hospital environments and those without reliable transportation. Participants communicated with other professionals, such as pharmacies with respect to medication stocks, to prevent patients from unnecessary travel and encountering delays. Nurses completed follow-up care by phone. In addition, nurses utilized translation and interpretation services and created plain-language patient information forms.

Communication and Relationship Building

The participants prioritized communication and relationship building as strategies needed for the successful introduction of medication abortion into their practices and communities, from consultation to follow-up care. Examples included phoning pharmacies to ensure that mifepristone was in stock at their location before directing patients to a particular pharmacy location, connecting with health professionals who provide other aspects of care (e.g., ultrasound services) and sharing information and advice with other medication abortion care providers. This sharing of information and advice facilitated the medication abortion process, which can involve several appointments and interactions with multiple providers (e.g., NPs, RNs, physicians, social workers, clinic staff, pharmacists, ultrasound technicians, phlebotomists and laboratory technicians). Nurses also used communication and relationship building to assess whether these other providers would support their patients' decisions and provide non-judgmental services.

While Health Canada swiftly removed several initial restrictions to the prescription of medication abortion (e.g., only physicians authorized to prescribe and physicians required to watch the patient ingest the first dose), these changes were poorly communicated, leaving inconsistencies and missteps in the delivery of abortion care (Munro et al. 2020). Attendees described encountering misinformation about mifepristone regulation in their communities and its impact on their patients. For example, one NP described a pharmacist who refused to dispense the medication to a patient because they believed physician approval was required. This is evidence that inaccurate provider knowledge of current regulations around mifepristone impacted the abortion process. To care for their patient, the NP needed to educate the pharmacy with the most up-to-date information on medication abortion to prevent future delays in dispensing to patients. In another scenario, a participant described how, despite the ultrasound requisition form indicating "for pregnancy termination," the ultrasound technician congratulated the patient on their pregnancy. To prevent future incidents that could cause patient distress, the NP communicated with the diagnostic imaging department

that this was inappropriate, emphasizing that abortion is a very common outcome of pregnancy. The NP drew on this experience to share with attendees an appropriate approach to labelling requisitions for ultrasounds and blood work, which may have a greater potential to avert this sort of miscommunication.

Collaboration between Medical and Allied Health Professionals

Participants emphasized the importance of working as an interprofessional team in medication abortion care. For example, while NPs may prescribe, RNs provide counselling, education and resources about abortion and contraception and conduct follow-up care. Several NPs collaborated with midwives who provide other aspects of family planning care but are not yet authorized to provide abortion services. Medical laboratory assistants and social workers complemented nursing clinical care, reducing wait times for patients. Several NP participants expressed support for the removal of restrictions so that RNs and midwives could prescribe medication abortion.

Research Priorities

Small group representatives shared key discussion points with the larger group, identifying the following research priorities: (1) understanding a diversity of patient experiences with medication abortion; (2) interventions for expanding access to medication abortion, especially for those facing complex barriers and intersecting oppressions (e.g., patient information tools in multiple languages); (3) developing and evaluating new tools and training resources for providers; (4) increasing nurses' participation and leadership at conferences on reproductive health and family planning; and (5) strategies for educating the public about the NP role as prescribers of medication abortion.

Discussion

Findings from the CART-GRAC nurse priority-setting meeting for medication abortion demonstrate that nurses are passionate about improving medication abortion services and see the importance of advancing equity for their patients. Themes from this meeting suggest that RNs and NPs are already engaged in leadership to improve abortion care for their patients, including networking and educating other health professionals to provide patient-centred care, creating easy-to-understand visual patient information pamphlets and increasing the efficiency of appointments. Meeting insights also demonstrate that nurses are eager to optimize their roles in medication abortion by better understanding patient needs through the creation of interprofessional provider tools and education resources, by improving public awareness of medication abortion and nurses' roles in abortion care and by increasing the presence of nurses in abortion research. Participants in this meeting represented four Canadian provinces; empirical

studies that examine nurses' roles in abortion care should include participants from all provinces and territories.

In a realist review of literature on the social determinants of health, Andermann (2016) identified actions that can be taken by health professionals, including nurses at the patient, practice and community levels to mitigate health inequities: (1) approach patients about their social histories in a sensitive way, provide advice and facilitate access to appropriate resources; (2) improve access and quality of care for underserved patients by, for example, providing bus fare and child care to attend appointments and interpreter services and extending clinic hours, as well as hiring social support navigators; and (3) partner with community groups, public health and local leaders and advocate for social and policy changes. Furthermore, Lathrop (2020) argued that health equity requires that nurses commit to examining their own implicit biases that affect their understanding and actions (The Joint Commission 2016).

Reflecting on the research of CART-GRAC and insights from the nurse priority-setting meeting, we make the following additional recommendations for researchers, educators and policy makers to optimize the nursing role in abortion care. First, we encourage researchers to examine the role of nurses in abortion services and identify ways to support and strengthen these roles in practice. Research will support public and interdisciplinary understandings of nurse leadership in abortion and direct development of policies and clinical guidelines that optimize the nursing scope (Mainey et al. 2020).

Second, we recommend that nursing schools enhance advocacy and leadership training to better prepare nurses for leadership roles in health equity and policy change. For nurses to realize their potential in this field, they must be supported through appropriate academic preparation. This includes outreach to encourage and mentor more people from equity-seeking populations to become NPs, increasing representation of communities from within the profession. Increasing nurse leadership in abortion services will build the foundation for educational leadership to train future generations of nurses in this important area of practice. Incorporation of abortion care and family planning in nursing education supports demystification of abortion and sexual and reproductive health and its implementation across primary care (Paynter et al. 2019). Nursing education that supports the development of nurses' advocacy skills may meaningfully shift the social structures that determine health and health equity. Health equity training can improve cultural safety for patients by better preparing nurses for the realities of their patients' lives and encouraging reflection on their positions of power as healthcare providers.

Finally, we recommend that policy makers/stakeholders pursue changes that support NPs, RNs and midwives to take on leadership roles in abortion care. A scoping review of the international literature found that governments and regulatory bodies could safely extend RN and midwife scopes of practice to increase safe access to abortion (Mainey et al. 2020). Our priority-setting meeting with nurses uncovered how partnerships and communication with other members of the healthcare team, such as physicians, pharmacists, midwives, social workers and technologists, supported the effective implementation of medication abortion in their practices. Dismantling clinical hierarchies, advancing abortion, advocacy and leadership training in nursing education and addressing structural barriers in health services will support optimization of nurse leadership in abortion care (Goldsberry 2018) and reproductive health equity in Canada (Box 1).

Box 1. Highlights for optimizing the nursing role in abortion care

- Due to their presence in rural and remote settings and their dedication to meeting the needs of underserved communities, optimizing nursing roles (RNs, NPs) in abortion care has the potential to vastly increase the number and diversity of patients who can receive timely abortion care.
- Nurses are leaders of inclusive and accessible abortion care, but their roles are underutilized and under-researched.
- To implement medication abortion in their practices, findings from the 2019 meeting indicate that nurses are engaged in reducing barriers for marginalized and underserved communities, increasing communication and education about current guidelines and patient care and collaborating with medical and allied professionals in order to implement medication abortion in their practices.
- Optimizing the nursing role requires funded studies to explore nursing and abortion care for schools to enhance their curriculum to better prepare nurses to be leaders of abortion care, for policy changes that expand RNs', NPs' and midwives' scopes of practice and for the reduction of professional and structural hierarchical barriers in health services.

Conclusion

This article addressed gaps in knowledge about nursing roles in abortion care by describing a national knowledge exchange dialogue on medication abortion with RNs, NPs and members of the CART-GRAC research team. We found that nurses provide leadership to facilitate the implementation of accessible and effective medication abortion in their practice by reducing structural barriers for patients, educating healthcare providers on current policies and protocols and supporting interprofessional teamwork. Prioritizing nursing roles and nurse leadership within policy, research and nursing education in abortion care would benefit patients and support health equity.

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