“Doing the wrong thing for the right reason”

Australian nurses’ and midwives’ experience providing abortion care to people victimised by gender-based violence

by

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Thesis
Submitted in fulfillment of the requirements for the degree of

Doctor of Philosophy
Central Queensland University

School of Nursing, Midwifery and Social Sciences
Professor Emeritus Kerry Reid-Searl, Dr Cathy O’Mullan

PREFACE

Doctoral Thesis Declarations

Candidate's statement

By submitting this thesis for formal examination at CQUniversity Australia, I declare that it meets all requirements as outlined in the Research Higher Degree Theses Policy and Procedure.

Statement authorship and originality

By submitting this thesis for formal examination at CQUniversity Australia, I declare that all of the research and discussion presented in this thesis is original work performed by the author. No content of this thesis has been submitted or considered either in whole or in part, at any tertiary institute or university for a degree or any other category of award. I also declare that any material presented in this thesis performed by another person or institute has been referenced and listed in the reference section.

Copyright statement

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Dedication

To all the people who do what they must to stay safe, and to all the nurses and midwives who support them.

To Participant 2, who threw caution to the wind. Thank you for trusting me with your story. Your interview changed everything in the most exciting way. I started this PhD for me, but I finished it for you.

Content advice

This thesis contains material that may be confronting and disturbing to some people. Participant recollections may cause sadness or distress, or trigger traumatic memories, particularly for survivors of gender-based violence. For some people, these responses can be overwhelming. If you need to talk to someone, support is available. In Australia please call:

1800 Respect – 1800 737 732

Sexual Assault Counselling Australia – 1800 211 028

Lifeline – 13 11 14

Ethics Approval

CQUniversity Human Research Ethics Committee approved this project (HREC0000021264). The period of approval is from 04/12/2018 to 31/10/2024. Please refer to Appendix A for further details.

List of papers included in the thesis

Paper 1

Mainey, L., O'Mullan, C., Reid-Searl, K., Taylor, A., & Baird, K. (2020). The role of nurses and midwives in the provision of abortion care: A scoping review. *Journal of Clinical Nursing*, *29*(9–10), 1513–1526. https://doi.org/10.1111/jocn.15218

Paper 2 (under review)

Mainey, Lydia, O'Mullan, Catherine, Reid-Searl, Kerry. (Under review). Using intersectionality to increase the social justice reach of constructivist grounded theory: A worked example. *Australian Journal of Advanced Nursing.*

Paper 3

Mainey, L., O'Mullan, C., & Reid-Searl, K. (2022). Working with or against the system: Nurses' and midwives' process of providing abortion care in the context of gender-based violence in Australia. *Journal of Advanced Nursing*, 1–13. https://doi.org/10.1111/jan.15226

Paper 4

Mainey, Lydia, O'Mullan, Catherine, Reid-Searl, Kerry. (2022). Unfit for purpose: A situational analysis of abortion care and gender-based violence. *Collegian.* https://doi.org/10.1016/j.colegn.2022.01.003

Paper 5 (under review)

Mainey, L., O'Mullan, C., & Reid-Searl, K. (under review). Reproductive power and justice: An Australian social worlds/arenas analysis of abortion and gender-based violence care. *Nursing Inquiry*.

Paper 6 (under review)

Mainey, L., O'Mullan, C., & Reid-Searl, K. (under review). Resistance in health and healthcare: Applying Essex conceptualisation to a multi-phased study on the experiences of Australian nurses and midwives who provide abortion care to people victimised by gender-based violence. *Bioethics*.

List of additional published papers relevant to the thesis

Abortion-related

Downing, Sandra, Dean, Judith, **Mainey, Lydia**, Balnaves, Mary-Claire, Peberdy, Lisa, Peacock, Ann, & Cappiello, Joyce. (2020). Reflections: Unintended pregnancy prevention and care education - are we adequately preparing entry-to-practice nursing and midwifery students? *Australian Nursing & Midwifery Journal, 27*(1), 32–33.

Downing, S., Balnaves, M.C., **Mainey, L.**, Peacock, A., Cappiello, J., Peberdy, L. & Dean, J. (under review). Unintended pregnancy prevention and care - pivotal but passed over in curriculum: a descriptive cross-sectional survey of nursing and midwifery faculty. *Collegian.*

Gender-based violence-related

O'Mullan, C., Hing, N., Nuske, E., Breen, H., & **Mainey, L.** (2022). Strengthening the service experiences of women impacted by gambling-related intimate partner violence. *BMC Public Health*, *22*(1), 1–13. https://doi.org/10.1186/s12889-022-13214-9

O'Mullan, C., Hing, N., Mainey, L., Nuske, E., & Breen, H. (2021). Understanding the determinants of gambling-related intimate partner violence: perspectives from women who gamble. *Violence against women*. https://doi.org/10.1177/10778012211051399

Hing, N., O'Mullan, C., Nuske, E., Breen, H., **Mainey, L.,** Taylor, A., ... & Jackson, A. (2021). Gambling-related intimate partner violence against women: a grounded theory model of individual and relationship determinants. *Journal of Interpersonal Violence*. https://doi.org/10.1177/08862605211037425

Hing, N., O'Mullan, C., **Mainey, L**., Nuske, E., Breen, H., Taylor, A. (2021). Impacts of male intimate partner violence on women: A life course perspective. *International Journal of Environmental Research & Public Health*, *18*, 8303. https://doi.org/10.3390/ijerph18168303

Hing, N., O'Mullan, C., Breen, H., Nuske, E., & **Mainey, L.** (2021). How gambling by a male partner contributes to intimate partner violence against women: a gendered perspective. *International Gambling Studies*, 1–19. https://doi.org/10.1080/14459795.2021.1973534

Hing, N., Nuske, E., Breen, H., O'Mullan, C., Mainey, L., & Thomas, A. (2021). Problem gambling and economic abuse against women: an adaptive grounded theory analysis. Addiction Research & Theory, 1–11. https://doi.org/10.1080/16066359.2021.1962847

Hutchinson, Marie, Doran, Frances, Brown, Janie, Douglas, Tracy, East, Leah, Irwin, Pauletta, **Mainey, Lydia** . . . Yates, Karen. (2020). A cross-sectional study of domestic violence instruction in nursing and midwifery programs: Out of step with community and student expectations. *Nurse Education Today, 84*, 104209. https://doi.org/10.1016/j.nedt.2019.104209

Doran, Frances, Hutchinson, Marie, Brown, Janie, East, Leah, Irwin, Pauletta, **Mainey, Lydia**, . . . Yates, Karen. (2019). Australian nursing and midwifery student beliefs and attitudes about domestic violence: A multi-site, cross-sectional study. *Nurse Education in Practice, 40*, 102613. https://doi.org/10.1016/j.nepr.2019.08.007

List of conference presentations

Podium Presentations

Mainey, L., O'Mullan, C., & Reid-Searl, K. (abstract accepted, August 2022). F*ck the system: Abortion anarchy in Australia. Reproductive Rights and Abortion Conference, Brisbane.

Mainey, L., O'Mullan, C., & Reid-Searl, K. (2021). “Given the right set of circumstances, I’ll break the rules every time”: A situational analysis of abortion anarchy in Australia. 2021 Joint Australasian Sexual Health and HIV&AIDS Conferences, Virtual. (Winner ASHM Early Career Award)

Mainey, L., O'Mullan, C., Reid-Searl, K., Baird, K., & Taylor, A. (2019). Nursing and midwifery practices in the provision of comprehensive abortion care. Unplanned Pregnancy Conference, Brisbane.

Keynote Address

Mainey, L., O'Mullan, C., & Reid-Searl, K. (2022). Intersectionality and abortion care: Time to reimagine the future. Abortion Access and Equity – Finding a Way in Central Queensland Webinar hosted by Brittany Lauga (Member for Keppel), Online.

Mainey, L., O'Mullan, C., & Reid-Searl, K. (2021). How nurses and midwives increase abortion access, equity, and agency in the delivery of abortion care. Reshaping Abortion Care Webinar hosted by Marie Stopes Australia, Online.

Poster Presentations

Mainey, L., O'Mullan, C., Reid-Searl, K., Baird, K., & Taylor, A. (2019). Do nurses and midwives practice comprehensive abortion care? A global perspective. Joint Australasian Sexual Health and HIV&AIDS Conference, Perth.

Mainey, L., O'Mullan, C., Reid-Searl, K., Baird, K., & Taylor, A. (2019). Doctoral study design: domestic violence, sexual assault, and abortion – experience of nurses and midwives. STOP Domestic Violence Conference Gold Coast.

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List of acronyms and initialisms

ANROWS	Australia's National Research Organisation for Women's Safety
CbyC	Children by Choice
CDA	Critical Discourse Analysis
CGT	Constructivist Grounded Theory
DV	Domestic Violence
GBV	Gender-Based Violence
GP	General Practitioner
GT	Grounded Theory
MSA	Marie Stopes Australia
NMHRC	National Health and Medical Research Council
PBS	Pharmaceutical Benefits Scheme
RHH	Resistance in Health and Healthcare
RFT	Racial Formation Theory
SA	Situational Analysis
SXA	Sexual Assault
TGA	Therapeutic Goods Administration
WCA	Work Complexity Assessment

SYNOPSIS

When a woman[1] is assaulted, abused, or killed, it is usually at the hands of a male partner or family member. As well as fatal and non-fatal injuries, chronic health conditions and risky behaviours, gender-based violence (GBV) can often lead to unplanned pregnancies. Hence abortion is a predictable outcome for this population.

Nurses and midwives are intrinsically involved in the care of pregnant people victimised by GBV and could be instrumental in early intervention, support, and coordination of support services. However, limited research has been conducted on how this occurs within abortion care. Service provision across a range of Australian sectors such as health, women's safety, and law enforcement could benefit from understanding how nurses and midwives provide abortion care to people victimised by GBV.

The overarching aims of this thesis project are:

- To explain the process through which Australian nurses and midwives provide abortion care to people victimised by GBV.
- To explore how the elements of the broader situation affect the provision of abortion care to people victimised by GBV.

This study was conducted across Australia and used an extended multiple method Constructivist Grounded Theory (CGT) design. I[2] conducted semi-structured interviews with Australian nurses and midwives who had at least 12 months of experience providing abortion care.

The thesis contains six chapters, including six interrelated publications, which follow a cohesive narrative addressing the study aims. In Paper 1, situated at the end of the introductory chapter, I contextualise the role of nurses and midwives in abortion care to

[1] Not everyone who seeks an abortion identifies as a woman. For this reason, I use the term "pregnant people" where possible. At times I am restricted to using the term "woman/women" by the cited literature, the words of my research participants or clarity.

[2] In this thesis I use first person to clarify the research process and to embrace my position within, and influence over, this Constructivist study.

assist my readers in understanding the scope of the research topic. This published paper, a scoping literature review, uses Arksey and O'Malley's five-stage methodological framework. The review demonstrates that abortion care is a common procedure performed across many healthcare settings and shows that nurses and midwives provide technical and psychosocial care within their roles. The review also highlights that the scope of practice of nurses and midwives within abortion care is probably unnecessarily restrictive. Notably (and foreshadowing the findings of this thesis study), it exposes a lack of person-centred models of abortion care.

Paper 2 appears in the methodology chapter and is under review in a peer-reviewed nursing journal. In Paper 2, I describe the novel approach I have used to undertake this study – a multiple method study design combining Constructivist Grounded Theory (CGT), Situational Analysis (SA) and intersectionality. I address the usefulness of this approach in extending the social justice research of CGT and SA, sensitising researchers to processes of health care resistance within oppressive systems.

Paper 3 is one of three papers that appear in the findings chapter. This paper, accepted for publication in a peer-reviewed nursing journal, is a CGT study which explains the process through which Australian nurses and midwives provide abortion care to people affected by gender-based violence. I report that the research participants undertook a process described as *working with or against the system* to facilitate person-centred abortion care.

Paper 4 is a SA study, accepted for publication, that describes the situational elements of the Australian healthcare environment affecting abortion care for people victimised by gender-based violence. I report that research participants believe that patients are *mostly uncatered for*. They describe a workforce unprepared to provide abortion care generally, and gender-based violence interventions more specifically. Clinicians found that their pro-life colleagues centred their own needs over patients and revealed that the workplace environments placed clinicians' and patients' safety at risk.

Paper 5 is a Social Worlds/Arena study that uses a CGT approach to map groups that operate at the nexus of abortion and GBV. The analysis focusses on four important worlds – *Smuggler*, *Navigator*, *Marie Stopes Australia*, and the *Family Safety Framework* – which resist systemic oppression and attempt to incorporate gender-based violence responses into their work to increase abortion access. My findings call attention to pro- and anti-abortion worlds that influence abortion care in Australia and emphasise the importance of streamlined, safe and confidential pathways for people who disclose gender-based violence.

In Paper 6, situated in the discussion chapter, I use a theoretical conceptualisation of *Resistance in health and healthcare* to tell a unifying and cohesive story about the significant findings from the thesis project. I use vignettes from the multiple method extended CGT study findings for demonstrative purposes. Finally, I discuss the potential for *Resistance in health and healthcare* as a postmodern feminist research tool to reclassify some nursing and midwifery practices as political. This paper is under review in a peer-reviewed bioethics journal.

In the concluding chapter, I summarise how I met the study aims, discuss the implications of the findings and offer recommendations to guide and inform future practice and research.

CHAPTER 1: INTRODUCTION

Chapter 1 contains three sections. Section 1 is a background to the study in which I examine the socio-political landscape of abortion in Australia as well as gender-based violence and its relationship to abortion. As part of Section 1, I include a published scoping literature review of 75 articles (Paper 1) describing the role of nurses and midwives in abortion care. In Section 2, I provide a rationale for the thesis study. Finally, I describe the thesis structure in Section 3.

Section 1: Background

Socio-political background of abortion

White anthropologists such as Cowlishaw (1981) and Kaberry (2004) postulate that abortion practices predated the colonial invasion of Australia and contributed towards the relatively stable precolonial birth rate. There are various accounts of Aboriginal people using methods, such as abdomen pummelling and hot stoning, to end their pregnancies (Berndt, 1951; Billington, 1960; Goodale, 1971, as cited in Cowlishaw, 1981; Kaberry, 2004; Meggitt, 1962; Warner, 1937). During the 18th and 19th centuries, abortion was the standard remedy for unplanned or untimed pregnancies (Carmichael, 1996) and Aboriginal, middle-class, and working-class people self-managed abortions or relied on the services of midwives and other lay-health workers (Baird, 2013; Kaberry, 2004; Morgan, 2012). Abortifacients, such as ergot, were widely accessible and advertised to the poorer classes as birth control (McCalman, as cited in Morgan, 2012).

At the turn of the 20th century, as Australia was developing its *white* national identity, population growth became a key government strategy to support defence and development; motherhood was promoted as the ultimate vocation for women (Baird, 2006). Yet, the population was in steady decline and, along with contraception and girls' academic schooling, politicians viewed abortion as a direct threat to nation-building and left us open to

the “Asian invasion” from the north (Baird, 2006). In 1903, the *Commission on the Decline of the Birth Rate* heard evidence of the widespread availability of abortion (Carmichael, 1996). In response, Australian States and Territories (independently responsible for health and criminal law) enacted legislation similar to Articles 58 and 59 of the *Offences Against the Person Act 1861 (UK)*, making abortion, or the procurement of an abortion drug, a serious crime unless carried out by a medical officer and only to preserve the life and health of the woman or for foetal abnormalities (de Costa et al., 2015; Rankin, 2011). Over the centuries, particularly in the last decade, abortion law reform has occurred across the country, and it is now decriminalised in all regions except Western Australia. However, because the States and Territories are individually responsible for health legislation, abortion law reform has resulted in inconsistent laws and abortion access for pregnant people in Australia (de Costa et al., 2015; Sifris & Belton, 2017). Despite the decriminalisation of abortion, anti-abortion politics continues at the State and Federal levels with populist conservative parties, such as the Katter’s Australian Party and One Nation Party, running on anti-abortion platforms (Francis, 2020; Johnson, 2020).

The Australian Commonwealth controls some aspects of health care law, such as universal health care coverage (Medicare and the Pharmaceutical Benefits Scheme) and the Therapeutic Goods Administration (TGA) (de Costa et al., 2015). Some politicians have attempted to leverage these arms of the government to reduce access to abortion. For example, in 1979, four years after the introduction of Medicare, Member of Parliament Stephen Lusher unsuccessfully moved to restrict Medicare rebates for abortion (Pringle, 2005). In 2008 another unsuccessful motion was made in the Federal Senate to remove the rebate for second-trimester abortions. In 2013, Senator John Madigan proposed a bill to remove Medicare rebates for sex-selective abortion despite a lack of evidence to suggest sex-selective abortion is a common practice in Australia (Children by Choice, 2019).

Commonwealth imposition in abortion care also played out in 1996 when the Howard Government agreed to Christian Senator Brian Harradine’s bid to amend the *Therapeutic*

Goods Act 1989 (Cwlth), giving the Minister for Health and Aging[3] the right to veto abortifacient drugs being imported into Australia (Petersen, 2010). In exchange, Senator Harradine provided his vote on the privatisation of the national telecommunications company. Under this amendment, the importation, monitoring, registration and listing of the abortion drug mifepristone (commonly referred to as RU486) was subject to ministerial approval. The consequence was a de facto ban on medical abortions as no applications to import and market were made by pharmaceutical companies (Petersen, 2010; Sawer, 2012). In 2005, in direct response to the denial of medical abortion to Australians (Dowse, 2009), a cross-party collaboration, spearheaded by four female senators, sponsored a private senators bill to lift the ministerial veto on RU486 (Sawer, 2012). They won by an overwhelming majority, helping people, particularly those in rural and remote areas, gain access to legal abortions (Baird, 2013).

Unlike other sexual and reproductive health procedures, we do not collect standardised national data on abortion in Australia (Children by Choice, 2017). Official rates were last estimated in 2005 from a flawed dataset (Grayson et al., 2005) and before medical abortion was legal. However, estimates from South Australian data, collected under the *Criminal Law Consolidation Act 1935,* suggest around one in four Australian women will have an abortion in their lifetime (Scheil et al., 2016). These relatively high rates of abortion among Australians are not necessarily evidence of reproductive autonomy but likely emerge from intersecting forms of oppression. In countries with more liberal reproductive health policies, easier abortion access and robust welfare systems, rates are half that of Australia's (Children by Choice, 2017).

The high take-up of abortion in Australia is likely because the alternative choice, motherhood, is unfeasible for many people (Baird & Millar, 2020). The underpinning neoliberal ideology of the Australian welfare state places individuals' primary responsibility to the economy (Wolfinger, 2014). Images of immorality, poverty and the welfare queen have

[3] At the time this position was occupied by Tony Abbott, a Rhodes Scholar who, as a young adult, had entertained priesthood, briefly joining the Roman Catholic seminary.

been used in Australia and abroad (Thakkilapati, 2019; Wolfinger, 2014) to denigrate single mothers and promote the perception that they cheat the system. These stereotypes have persisted over time; from the forced adoptions of illegitimate children in the 1940s to 1970s (Community Affairs Reference Committee, 2012), to more recent discourses such as the 2017 article published in the Courier Mail, beginning “Single mothers have been crying poor, but are raking in tens of thousands of dollars in welfare” (Wolfinger, 2017).

These stereotypes relate to Australian women's migration from home and into the workforce, downgrading parenting to just one activity that women perform, leading to punitive welfare policy (Wolfinger, 2014). The Australian Government’s responses to COVID-19 are illustrative of this phenomenon. By keeping schools and child-care open during the initial stages of the pandemic, essential workers, primarily women, could remain productive (McLaren et al., 2020). Many of these people continue to transport their children to school or care while at the same time bearing the burden of running the household (McLaren et al., 2020).

Disability is another social category that intersects many lines in the abortion arena. In their submission to the 2007 Law Reform Commission on Abortion, the Victorian Women with Disability Network noted the stereotyping of disabled people as asexual leads to: disbelief regarding their pregnancies and delayed abortion access and abortion coercion from family members, health practitioners and paid carers/guardians; stereotyped attitudes towards the person’s ability to consent; as well as pressure to terminate a foetus with a disability (Victorian Women with Disabilities Network, 2007).

Of course, highly intrusive reproductive practices are not limited to those with disabilities. Much has been uncovered regarding the practices aimed at Indigenous women and women of colour globally, such as the forced sterilisation programs in Canada and the United States (Pereira, 2015; Ryan et al., 2021). In Australia, from 1910 to 1970, Aboriginal children were kidnapped, exploited and neglected under the guise of various government assimilation policies (Wilson & Waqanaviti, 2021). Discriminatory and punitive policies targeting Aboriginal and Torres Strait Islander mothers continue today. For example, the

ParentsNext program forces full-time Aboriginal mothers to complete mandatory tasks (which prevent them from going about the business of parenting) in exchange for welfare assistance, thus pushing single parents further into poverty and perpetuating the stereotype of the neglectful Aboriginal parent (Human Rights Law Centre, 2019).

Gender-based violence and its association with abortion

GBV, particularly domestic violence (DV) and sexual assault (SXA), contribute significantly to the global burden of disease for women and girls (Ellsberg et al., 2008). The term *gender-based violence* applies to sexual, reproductive, physical, psychological, or financial abuse of people who are targeted because of their gender. The function of GBV is to diminish the power and social status of the victim (McCloskey, 2016). DV (intimate partner violence in particular) and SXA are the most pervasive forms of GBV (Heise et al., 2002). As there is no universal definition of DV, for this study I define it as behaviour designed to coerce and control a current or ex-partner, child, stepchild, elder or another family member through intimidation and fear (Australian Bureau of Statistics, 2013). This behaviour may include physical violence, sexual abuse, sexual or reproductive coercion, emotional abuse, verbal abuse and intimidation, economic and social deprivation, personal property damage, and abuse of power (Australian Bureau of Statistics, 2013). In the Australian context, DV is a strong risk factor for depression, miscarriage, preterm birth, abortion and homicide and increased exposure to other risk factors such as smoking and drug and alcohol use (Ayre et al., 2016). Data from the 2016 Australian Personal Safety Survey indicate that since the age of 15, one in four women in Australia has experienced DV (Australian Institute of Health and Welfare, 2021). A recent Australian study indicates that the COVID-19 pandemic appears to have coincided either with the onset of DV or an increase in frequency or severity of ongoing DV (Boxhall & Brown, 2020).

Like DV, the definition of SXA is not ubiquitous and, for this study, will be understood as forced or coerced sexual acts on a person, against their will and without consent (NSW Government, 2016). SXA may co-occur within the context of DV or outside of the family

(Australian Bureau of Statistics, 2013; Jewkes et al., 2002; NSW Government, 2016). SXA rates are difficult to determine due to the reluctance of victims to report the assault or access support services (Australian Bureau of Statistics, 2013). However, data from the 2016 Australian Personal Safety Survey indicate that SXA rates are increasing, with one in five women reporting SXA since age 15 (Australian Institute of Health and Welfare, 2021). Tarczon and Quadara (2012) report that 12% of children experience SXA before the age of 15, with 90% of the abuse perpetrated by a person known to them. Female children who experience childhood SXA are more likely to experience intimate partner sexual violence and other forms of DV in adulthood (Cox, 2015). The United Nations name DV and SXA as violations of human rights most predominantly perpetrated against women (United Nations Women, 1992).

A substantial body of literature highlights the association between GBV (particularly DV, SXA) unplanned/untimed pregnancy, and abortion (Gee et al., 2009; McCloskey, 2016; Oberg et al., 2014; Taft & Watson, 2007; Tinglöf et al., 2015). A World Health Organisation (WHO) multi-country study on women's health and DV found it was a strong risk factor for unintended pregnancy and abortion (Pallitto et al., 2013). While this study was conducted primarily in low and middle-income countries, an earlier Australian study by Taft and Watson (2007) found that Australian women who accessed abortions were three times more likely to be affected by DV or SXA than those who did not end a pregnancy electively. Women who presented for multiple abortions or late-term abortions had even higher rates (Aston & Bewley, 2009; Gee et al., 2009; Hall et al., 2014). Common reasons for accessing abortion in the context of GBV include childhood sexual abuse (most commonly date rape) (Bleil et al., 2011; Silverman et al., 2004), forced sex by intimate partners (Messing et al., 2014) and reproductive coercion (control and sabotage of birth control and pressure to have an abortion) (Miller & Silverman, 2010). A small number of people seek abortion in the context of rape; however, it is more common for abortion to be associated with a cumulative experience of GBV (McCloskey, 2016).

Australian (and global) estimates of abortion and GBV implicitly refer to the experiences of cisgender, heterosexual women, which excludes transgender, nonbinary, and gender-expansive populations. However, emerging research from the United States suggests high rates of gender-based violence among trans people, with an estimated prevalence ranging from 7% to 89% (Wirtz et al., 2020). Abortion rates of transgender, nonbinary and gender-expansive Australians have not been measured, though research from the United States suggest that around 20% of trans pregnancies end in abortion (Moseson et al., 2020).

People who seek abortions in the context of GBV face higher levels of marginalisation, increasing their vulnerability within the health care system. First, the general loss of autonomy associated with GBV renders victims susceptible to staff domination and structural abuse (Brüggemann & Swahnberg, 2013). Second, structural or staff-enacted abortion stigma, designed to shame and restrict access, further oppresses victims (Biggs et al., 2020). Finally, this spectrum of abuse is compounded by intersectionality, such as race (Wilson & Waqanaviti, 2021), gender expression (Moseson et al., 2020), class (Wolfinger, 2017), disability (Victorian Women with Disabilities Network, 2007) and geographic lines (Doran & Hornibrook, 2016).

I commenced this doctoral study in 2016, the year after Rosie Batty was appointed Australian of the Year. Batty, whose 11-year-old son Luke was murdered by his father (her former partner) campaigned to address the systemic failures (Valentine & Breckenridge, 2016) and stigmatising community attitudes towards GBV (New South Wales Nurses Association, 2015). Her advocacy changed the narrative around family violence in the media, reframing it as a gender issue and a national problem (Hawley et al., 2018). This “critical discourse moment” (Carvalho, 2008; Chilton, 1987, as cited in Hawley et al., 2018, p. 2305) transformed the discussion regarding GBV from a private issue that happened behind closed doors to a gendered phenomenon, caused by men’s attitudes towards women. Consequently, women’s right to be believed and taken seriously when they disclosed GBV is “now done soberly and seriously” (Trioli, 2015, as cited in Hawley et al., 2018, p. 2305).

Since 2016, a further three Australian women, Saxon Mullins, Grace Tame and Brittany Higgins, buoyed by the international #MeToo movement, used their lived experience of GBV to advocate for legal and structural reform around consent, victim gag laws, and bullying, sexual harassment and SXA within the Parliament of Australia (Australian of the Year Awards, 2021; Kate Jenkins, 2021; Milligan, 2018; Oldfield & McDonald, 2021).

Batty's advocacy for GBV policy and structural reform was supported by nurses and midwives out of concern for patients impacted by GBV (New South Wales Nurses Association, 2015). Her momentum was a strong impetus in establishing the 2015 Victorian Royal Commission into Family Violence which, among other things, highlighted how to improve early intervention, support people victimised by DV and better coordinate community and government response (State of Victoria, 2016). Her advocacy also contributed to the National Plan to Reduce Violence against Women and their Children which initiated research and advocacy organisations, Australia's National Research Organisation for Women's Safety (ANROWS) and Our Watch (Valentine & Breckenridge, 2016).

Despite the strong links being drawn between abortion and GBV, important stakeholders within the GBV movement failed to recognise abortion as a time when pregnant people could be offered additional support. For example, The Special Taskforce on Domestic and Family Violence in Queensland (2015) handed its report and recommendations to the Premier which highlighted that pregnancy increased a person's risk of victimisation and was a strategic time for midwives and specialist obstetricians to speak to patients about DV. However, the Taskforce overlooked abortion as a strategic time to intervene. In doing so it missed an opportunity to drive meaningful change for potentially marginalised groups of people.

The role of nurses and midwives in the provision of abortion care

To preface my conceptualisation of the role of nurses and midwives in the provision of abortion care (a scoping review), I first explain the tension that exists within GT regarding

the timing of literature reviews. Following this, I provide a rationale for the inclusion of a scoping review in my doctoral thesis and then the scoping review itself.

A doctoral thesis conventionally commences with a thorough review of the literature. The review serves to demonstrate the candidate's knowledge in the field of inquiry, help them avoid replicating research and provide background information for ethics boards (Charmaz, 2014; Clarke et al., 2018; Nagel et al., 2015; Ramalho et al., 2015). However, for grounded theory (GT) researchers, the literature review is a source of epistemological and methodological tension. As GT students, we are compelled to create distance between ourselves and the extant literature so as not to influence our emergent or constructed theory (Charmaz, 2014; Glaser et al., 1967; Kenny & Fourie, 2015).

An epistemological argument endures within the field of GT itself regarding the purpose and sequencing of the literature review. At its origin, this is a debate concerning the researcher's position within the research (Ramalho et al., 2015). Classic GT, which emerged from the positivist paradigm, emphasises objectivity where theory emerges unhindered by researcher preconceptions. Accordingly, the literature review is undertaken after the data analysis is complete to facilitate a theory uncontaminated by the researcher's bias (Glaser et al., 1967). Alternatively, followers of Straussian GT (Strauss, 1990), which is positioned in pragmatism, contend that true researcher objectivity is unachievable. Straussian GT endorses a restrained and sceptical engagement with the literature throughout the research process. Its intent should be to develop the sensitising concepts (a pragmatist approach of handling prior beliefs about the research topic (Morgan, 2020)) to inform the construction of the theory (Ramalho et al., 2015). CGT's epistemological position of researcher centrality also renders objectivity untenable. Charmaz (2014) suggests that a series of short literature reviews be interspersed throughout the CGT thesis. This ensures the researcher is not theoretically blinded or creatively stifled by the literature (Charmaz, 2014, p. 308). For CGT, it is the purpose of the literature review, not the timing, that is of highest importance (i.e. to contextualise the journal publication or locate the methodology chapter) (Charmaz, 2014; Kenny & Fourie, 2015).

In complete contrast, SA, a methodological extension of CGT, views prior knowledge of the substantive field as essential and asserts that GT projects should be situated within the literature (Clarke et al., 2018). Like Straussian GT and CGT, those employing SA do not subscribe to researcher objectivity. Further, SA contends that a thorough literature review reduces unnecessary research replication and indicates sources to be used for data analysis (Clarke et al., 2018, pp. 36–37).

When using the multiple method framework, one must remain faithful to each methodology (Morse, 2010). In thinking through this conundrum, I came up with a workable solution, a scoping review of the role of nurses and midwives in the provision of abortion care. As you will see in the next chapter, I position myself as an insider within the abortion sector. I am not naïve to the (scarce) literature or clinical practise related to abortion and GBV. My supervisors and I judged that this gave me adequate knowledge of the field to avoid an in-depth literature review. However, during the confirmation of candidature process, it became clear that I had not explained the role of nurses and midwives in abortion care in enough detail. Examiners were more interested in specific GBV clinical tasks, such as screening and referral, without understanding important contextual factors such as clinical setting, national abortion law, psychosocial dimensions of care and the fight for an expanded scope of practice. Therefore, I conducted a scoping review to map and provide an overview of the research on the role of nurses and midwives in the provision of abortion care. It is produced without significant abstraction or synthesis to avoid theorising in a particular direction. Marie Stopes Australia cited this paper in their submission to the Joint Select Committee on Coercive Control, Parliament of New South Wales (Appendix B).

Paper 1: The role of nurses and midwives in the provision of abortion care: A scoping review

Synopsis

In Paper 1 I provide readers with a broad understanding of the role of nurses and midwives in the provision of abortion care. I used Arksey and O'Malley's approach scoping literature reviews to search MEDLINE, CINAHL, Scopus and ScienceDirect to identify original research, commentaries and reports, published between 2008–2019. I identified 74 publications reporting on the nursing or midwifery role in abortion care. The review findings emphasise that nurses and midwives have varying levels of abortion care education and training yet provide abortion care across diverse settings and contexts. Psychosocial care was seen as a major component of abortion care. Despite being as safe as doctors in the procurement of abortions, national laws and local policies that govern nursing and midwifery practice were interpreted ambiguously, conservatively or special laws were enacted to restrict their involvement in direct abortion care.

Declaration of co-authorship and co-contribution

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

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Nature of candidate's contribution, including percentage of total

In conducting the study, I was responsible for conceptualisation, methodology, analysis, writing and administration. This publication was written by me, and my contribution was 70%.

Nature of co-authors' contributions, including percentage of total

My co-author Catherine O'Mullan contributed to the paper by analysis, reviewing and supervising (15%). My co-author Kerry Reid-Searl contributed to the paper by reviewing and supervising (7.5%). My co-author Kathleen Baird contributed to the paper by reviewing (3.75%). My co-author Annabel Taylor contributed to the paper by reviewing (3.75%).

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REVIEW

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

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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 mid- wives 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, health- care 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 psycho- social 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

1513

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 abor- tion 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 re- search is needed to inform the nurse/midwives' scope in emerg- ing abortion care frameworks to improve practice, streamline service provision and improve the health and reproductive au- tonomy 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 pre- vent nurses and midwives from working to an extended scope of practice. Further research is required to deter- mine 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

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 ques- tion. Ten articles were excluded as they did not report on nursing or midwifery care. Four articles were unavailable. Seventy-four ar- ticles, considered relevant to the study, were included in the syn- thesis (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 comprehen- sive 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 ar- ticles were pregnancy diagnosis and options counselling (Levi et al., 2009), pharmacological and nonpharmacological pain re- lief (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

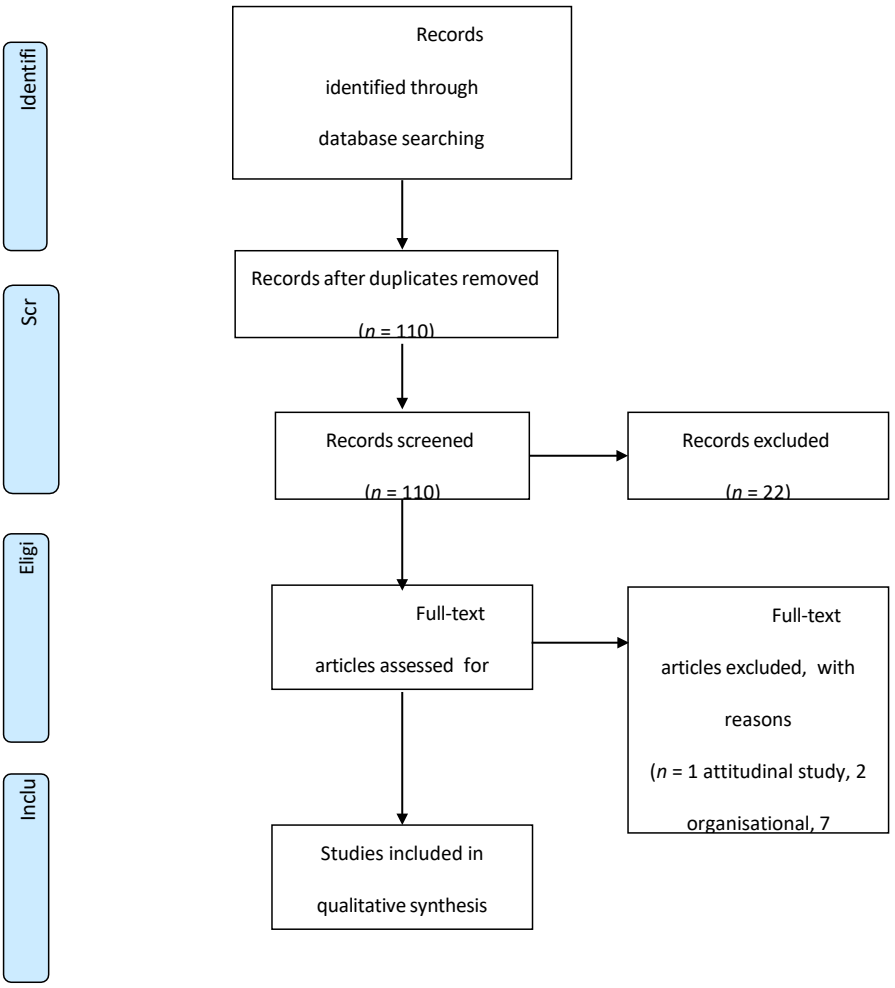

FIGURE 1 PRISMA 2009 flow diagram

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 iden- tification 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 mid- wifery 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)
	Criminal except in certain	High mortality rate Nurses and midwives can perform postabortion care (Adinma
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)
M	Abort	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
	Abortion remains illegal (Kishen	
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, ap- pears 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.

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SUPPORTING INFORMATION

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

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Section 2: Study rationale

Over the last decade, abortion law reform has swept across Australia; as of 2021, except in Western Australia, abortion is no longer a crime (Children by Choice, 2021). This is a significant victory for reproductive justice and paves the way for abortion services to transition from private clinics, which provide the majority of abortions (Australian Institute of Health and Wellfare [AIHW] et al., 2005), to local public hospitals and primary care centres. Decriminalisation of abortion also presents an exciting opportunity to increase abortion access and create services that are safe for marginalised people. Reorientation of abortion delivery in Australia will be significantly informed by research that: (i) documents the processes of providing nursing and midwifery abortion care to people affected by GBV; (ii) theorises how the broader situation impacts on this process of care; (iii) incorporates intersectionality, turning a critical lens on power. Progressing our understanding on these fronts is critical if improvements are to be made in the quality of abortion service delivery in Australia.

The long-term health outcomes for any person victimised by GBV are poor. GBV can influence health directly (e.g. injury or self-harm), or indirectly such as through limiting a person's earning capacity, social connections and access to health care (Ayre et al., 2016). GBV also increases exposure to other risk factors such as smoking and drug and alcohol use. It is associated with poor mental health and perinatal outcomes, chronic diseases, and sexually transmitted infections and unplanned pregnancy (Ayre et al., 2016; Taft & Watson, 2007; World Health Organization, 2021). Abortion is a relatively common and predictable intervention for victims of GBV who find themselves pregnant (Grose et al., 2021; Hall et al., 2014; Taft & Watson, 2007).

The evidence surrounding clinical care of victims of GBV is complex and contested and translation of research to policy and practice has lagged (Cameron et al., 2020). Physical assessment, clinical care of injuries and symptoms (Du Mont et al., 2014), documentation of the history of abuse, injuries or symptoms (Du Mont et al., 2014;

Sutherland et al., 2014) or screening/enquiry and referral to support or legal services (Ben Natan et al., 2012; Colarossi et al., 2010; Perry et al., 2015) are commonly researched clinical tasks associated with GBV. Interventions may also include counselling and validating the person's experience (Spangaro et al., 2010), or conducting risk assessments (Snider et al., 2009).

Within abortion care specifically, the body of knowledge regarding GBV care is controlled and limited, emerging predominantly from single-site, mixed method surveys or content analysis studies from North America with a focus on mandatory screening (Colarossi et al., 2010; Perry & Daniels, 2016; Sutherland et al., 2014; Wiebe & Janssen, 2001), targeted screening (O'Doherty et al., 2015) and routine enquiry (Perry et al., 2016). The findings of these studies highlight the tension within the wider DV and SXA fields around these types of assessments and the preparedness of clinicians to respond to disclosures. While informative, these studies overlook the importance of the relationships between the health care environment, practices of individuals, and the socio-political construction of the abortion arena on the care of victims of GBV.

This thesis extends current knowledge beyond the clinical tasks of GBV screening and referral in the abortion setting as this is not the only time a clinician may provide meaningful care to a person affected by GBV. I have focussed on Australian nurses and midwives, who perform a range of roles across the continuum of abortion care – from the diagnosis of unplanned/untimed pregnancies, through to post-abortion care. These health professionals are essential to abortion access and service delivery (Mainey et al., 2020), and are strongly positioned to provide meaningful support to people victimised by GBV. In contrast to the descriptive and exploratory single-site studies outlined above, the CGT and SA study design enabled me to (i) explain the phenomenon of interest (the process of providing abortion care in the context of GBV) from the perspectives of the research participants (Birks & Mills, 2015) and (ii) theorise how the broader situation (including power and politics) impacts on this process of care.

Unlike previous single-site studies, I have adopted Ipas' comprehensive definition of abortion care which is care delivered across a continuum from the diagnosis of pregnancy through to aftercare (Turner & Huber, 2013). Therefore, the findings of this thesis offer the perspectives of nurses and midwives from diverse clinical backgrounds across the Australian healthcare sector. I have also approached the research from a social justice perspective using an intersectional feminist lens with a focus on care delivered to people who are at high risk of falling through the cracks.

Section 3: Structure of thesis

Below, I present the structure of my thesis by publication. It is a linear and logical piece of work contained within six chapters. Six papers, "published", "accepted", or "under review" in peer-reviewed journals, are embedded within the relevant chapters. The association between each paper and the study aims are presented in Table 1.

Chapter 1 provides a background to the research area and a scoping literature review (Paper 1) to situate the topic in the broader socio-political abortion, GBV and clinical domains. It then offers the study rationale and presents the thesis structure.

In Chapter 2 I explain how I am situated in the thesis study. First, I tell a short satirical story called "Family Planning", then I discuss my positionality and explain how I have demonstrated reflexivity throughout the project.

In Chapter 3 I present the research aims and questions. Next, I discuss my intersectional feminist research lens and explain why I chose the extended CGT study design. I then explain the postmodern and constructivist paradigms and symbolic interactionism theoretical principles that underlie CGT. Following this, I present the two-phased multiple method extended CGT study design which combines CGT and SA. This chapter also includes a methodology paper (Paper 2) in which I explain the usefulness of combining CGT and SA to research intersectional health issues.

Chapter 4 presents three findings papers. Paper 3 aligns to the first research aim. It is a CGT study and reveals that research participants participate in *working with or against*

the system to provide person-centred abortion care. Paper 4 aligns to the second research aim. It is a situational mapping study and reveals that people who seek abortion in the context of abortion care are *mostly uncatered for.* Paper 5 also aligns to the second research aim. It is a social worlds/arenas mapping study that charts the complex network of groups that collaborate, collide, and exert power over access to abortion and women's safety.

Chapter 5 presents Paper 6 which tells a unifying story about the three findings papers. The theoretical code *Resistance in health and healthcare in the abortion arena* is presented and defended.

In Chapter 6 I summarise the thesis study and explain how I have met the study aims. Then I discuss the implications of the thesis project for future political activism, clinical practice and research, and offer 23 recommendations. I present the limitations of the study and provide a conclusion to the thesis.

Conclusion

Decriminalisation of abortion across most of Australia presents an exciting opportunity to increase abortion access and create services that are safe for vulnerable people such as those impacted by GBV. Nursing and midwifery staff are, and will continue to be, at the forefront of abortion service delivery. Reorientation of abortion delivery in Australia will be significantly informed by research that documents their processes of care and the situational factors that impact on care. Thus, this thesis and the papers contained herein, make a major contribution to this topic by explaining the process through which Australian nurses and midwives provide abortion care to people affected by GBV and mapping the elements of the broader health care situation that affect the provision of abortion care in the context of GBV.

This thesis comprises six chapters and six papers published, accepted or under review in peer-reviewed journals. As a point of difference to other research conducted in the substantive area, this thesis extends beyond the clinical tasks of screening for GBV and referral to support services. It offers the perspectives of clinicians from diverse clinical

backgrounds, explains their process of care as well and theorises how the broader situation impacts on care. In the following chapter, I will reveal my position within the thesis study through a short satirical story, a discussion of my positionality and explanation of my reflexivity throughout the project.

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CHAPTER 2: POSITIONALITY AND REFLEXIVITY

The previous chapter introduced the socio-political background of abortion in Australia and the association between GBV and abortion. I also presented a scoping literature review of the role of nurses and midwives in the provision of abortion care. Next, I offered the study rationale. Finally, I presented an overview of the thesis and explained how each of the six journal articles contributed to a cohesive thesis narrative. In this chapter, I analyse my social identity through a mapping exercise and a satirical short story. Next, I discuss my positionality and the positionality of my supervisors. Finally, I demonstrate how I have practised reflexively throughout this thesis study.

Family planning

Forward

I do not find it comfortable reflecting on my identity or lived experience. Intergenerational GBV surrounds me, and I constantly grapple with it. For me, this involves a pit crew of professionals (GPs, counsellors, psychologists), antidepressant medication and avoiding retraumatisation. Social Identity Mapping (Jacobson & Mustafa, 2019), which I discuss in the next section, was a perilous activity and brought up feelings of shame and anger. Considering that 66 to 85% of higher education students report traumatic event exposures (Carello & Butler, 2014), we need to take care of ourselves and each other when undertaking these types of activities. Learners who experience trauma tend to seek to control their environment for self-protection (Wolpow et al., 2009, as cited in Davidson, n.d.). I do this through writing satire. We also require flexibility from the academy in approaching assessment items (Davidson, n.d.).

As an academic, I align myself with Marcusian thinking; I value a separation between routinised and unthinking work and introspection, often facilitated through creative pursuits

(Brookfield, 2002). As Marcuse upholds, contemplation of the creative “shatters the reified objectivity of established social relations and opens a new dimension of experience: rebirth of the rebellious subjectivity” (Marcuse, as cited in Brookfield, 2002, p. 269).

“Family Planning” is a short satirical story I wrote in reaction to Social Identity Mapping (Table 1). After revisiting old traumas through the mapping process, I wanted to deliberate on them creatively, controlling my narrative through humour. I hope you enjoy it.

Family Planning

I always told myself that when I turned 30, I’d become a parent. Not accidentally like so many of my school friends, but wholly committed to the task. I would conceive orgasmically. God damn it, I would glow through the pregnancy. Maybe I’d eat my placenta. It seemed like a 30-year-old would be ahead of the rat race, having both the financial security and free time to deep dive into parenting. That’s why I put it off for so long. Then I turned 30, and instead of children, I discovered family planning. Or, rather, I rediscovered family planning.

I grew up under the Hawke Government, which brought unprecedented progress for women in Australia. Blow jobs were no longer a mandatory requirement for work promotions. Policymakers, who usually steered clear of the biological sciences, discovered four mammalian species, *Singulas Motherans*, *Womanus Indigenous*, *Womanus Migrantus*, and *Womanus Disabilus*. And, finally, it was easier to collect child support and the pension than to plot the murder of a spouse for his life insurance[4]. The women I grew up around loved Bob Hawke and were united in raising their daughters to believe that they could do anything. One even introduced me as a future Australian Prime Minister. Come whining to one of

[4] Under Hawke, sex discrimination became unlawful, Indigenous, and migrant women and women with disability were recognised in policy, older women were supported through pension reform and child maintenance payments were guaranteed. Ryan, S. (2019, May 16). “Women of Australia, be grateful for what Bob Hawke did”: Susan Ryan, Labor's first female minister. *The Guardian: Australian Edition*. https://www.theguardian.com/australia-news/2019/may/16/women-of-australia-be-grateful-for-what-bob-hawke-did-susan-ryan-labors-first-female-minister.

these mothers, and she'd likely say, "Tsk, is this how Murphy Brown[5] would act?" or "You think the World Health Organisation employs dobbers?" I think of those mothers of the 1980s and 90s, the first generation that wasn't forced to resign when they became pregnant. Believing they could have it all but working day and night to pay off their children's braces, swimming lessons and drama classes.

I've known about unplanned pregnancy as far back as I can remember. Afraid the Catholics were turning me into a fundamentalist, my mother, a midwife, explained it to me each time we passed the "Right to Life" billboard on our trips to the beach. Her cousin in the Netherlands had an abortion when she was 14, and this was discussed with the straightforward pragmatism her family, the Dutch, are known for, along with other topics such as euthanasia, prostitution, and bowel movements.

The Catholic school pulled out all the stops to frighten us against contraception and abortion. In one "human relation" class, zealous peripatetic teachers (co-opted from suspect not-for-profit organisations) passed around small silicon foetuses like they were collectable miniature troll dolls or micromachines that were so popular at the time. "Oh look, mine's got fingers and toes". Sex was only heterosexual, penetrative, missionary, and marital. To emphasise this last point, drawings of sex in our textbooks showed people wearing nothing but wedding bands. And teachers stressed sex was necessary to endure for making children – which were always a precious gift from God.

In the '80s and '90s, we were latchkey kids, unsupervised in the afternoons until our parents came home from work. This gave all children two solid hours to snoop around for hidden treasures like a copy of *The Joy of Sex*, porn stashes and adult movies. Then, in 1996 we got a computer with an internet connection which offered endless learning material and is how, according to my mother, "your brother learnt to type one-handed."

What we discovered in those afternoons led me to believe that adults were sex maniacs which didn't match my teachers' curriculum. "If adults are doing it all the time," I

[5] Murphy Brown is a fictional investigative journalist from the television series of the same name. She was known for her wit, sarcasm and ambition.

wondered, surveying the crowd at Sunday Mass, “where are all the children?” Curiosity got the better of me, and, aged 10, I asked a friend’s mother why she didn’t have any more children. She smirked and made a chopping motion with her fingers, the international sign for “scissors”. Now frightened that people were chopping the heads off new-born babies, I went to my mother for clarification and, in clinical detail, she explained the concept of a vasectomy.

It turns out that the plumbing of male genitals was too much for my 10-year-old brain, and grasping for something more familiar, I connected it with our dog. And on returning to school the next day, I confidently informed my friend that her father had been castrated. That night my parents received a hostile phone call from my friend’s parents, who frankly lacked the imagination to see how I had arrived at my conclusion. Thus, I learnt the perils of speaking freely about long-acting contraception.

Had my mother not found all this laughable, she might have moved us to the government school with its more liberal views on sex. Instead, she went about teaching us the pragmatics of reproduction. Her midwifery books were dusted off and handed over so that we could pore over pages of what appeared to be messy agony. Black and white photographs of vaginas that looked like something out of the movie Alien, frozen screams, and secretions that didn’t bear thinking about in too much detail.

My mother’s enthusiasm for sex and reproduction ended with injecting knowledge and fear. After that, she operated on the principle that pregnancy presented a clear and present danger to my future political aspirations. The pill failed, condoms broke, accidents happened. When I was on the cusp of puberty, the family packed up and moved to a farm. Fearing that not even the 40-kilometre trek to town would corral my raging teenage hormones, my mother enrolled me in three-hour piano lessons twice a week with an Irish sadist. A strict curfew was enforced, all razors were hidden for fear I would start shaving my legs and armpits, and my acne was left untreated. A prisoner is what I was. And on a still afternoon, you could hear me arguing with my parents, pleading for both Clearasil and to hang out with friends.

Before turning 14, I put boys in the same category as dogs and ferrets. Fun to play with for a while, but you couldn't overlook the odour. I certainly never thought about them being attracted to me. It was only when my hormones really took hold behind the prison bars of hairy legs and acne that life became fraught and filled with self-consciousness. Some guys asked me out, but they tended to be into the same things I was – musicals, debating, other guys. Show me a teenage boy who preferred duets over Durex, and my mother would enthusiastically encourage a sham romance.

So, when it came to having a real boyfriend, I was traumatised and cynical. At recess in the school yard, I would scowl at my clear-skinned classmates preening and flirting with each other. Even my Eisteddfod friends had moved on to second and third base. Then it occurred to me that one of us would have to be the spinster. Maybe even a nun. For no matter if I remained single or not, I was liberated. I was out of the race, and all I had to do was throw myself into studies and extra-curricular activities to take my place in the complex social hierarchy of Catholic high school.

At 17, my attitude towards sex changed and coincided with moving to the State school and meeting Stephen, a conventionally handsome, intelligent, and virile classmate who asked me out. After that, my mother's surveillance was sent into overdrive, apparating at social events, ringing parents to check on sleeping arrangements if there was a sleepover, and generally trying to cause maximum social damage. On one occasion, when I was released from high security to attend a party, I looked on horrified as, on the stroke of 10, my mother pulled up in her Mazda mini-van and strolled into our party in her homemade flannelette nightgown. "Hello Mrs Mainey," my new friends said, grinning at me, "would you like a drink?"

"Oh no you don't," I said, dragging her by the sleeve to the van.

"Mum, this is not normal. Why aren't you like this for the boys?" I asked as we drove home.

"Because", she sighed, "your brother can't get pregnant." According to my mother, a few sips of wine cooler after sunset led straight down a path that ended at the doors of the

maternity ward. Should I have put a cactus between my legs, worn chainmail and committed to a blood alcohol test, she still wouldn't have let up.

My brothers fared much better under fascism and were largely left alone. The "strictly no alcohol" policy was relaxed to "no alcohol on weekdays" and finally to "please don't turn up drunk to school events again". Girlfriends were allowed too. The boys were taken to the supermarket and shown where to buy condoms; my youngest brother's girlfriend moved in with us in grade 11.

My mother's hypervigilance, while neurotic, was not entirely disproportionate. At 36, she experienced an unplanned pregnancy that spun her world – and by extension, mine – off its axis. The farm was heavily mortgaged, the threat of poverty, caused by what turned out to be a 10-year drought, hung heavily over my parents' heads, there were marriage troubles, and abortion was illegal in Queensland. Within weeks of giving birth, she returned to permanent nightshifts. And my father, exhausted from his day job, working on the farm, and (let's face it) who took a backseat on parenting duties anyway, slept through his son's cries. So, aged 11, I became the de-facto mother, attending to the nightly feeds and changes. And while I honestly loved spending those quiet nights with my baby brother, this was not the life my mother wanted for me. So maybe she had a right to be less than enthusiastic about supporting a pregnant teenager.

Meanwhile, our hometown of Rockhampton gained the inglorious title of Murder Capital of Queensland. In the 1990s, a spate of sexual assaults and murders shook the regional community. A stranger raped a school friend as she walked home from the same party where Mum had embarrassed me. Rockhampton hosted a maximum-security male prison on its outskirts, and prison breaks were regular. As far as my brothers and I were concerned, police chases through the school yard added some interest to our otherwise mundane lives, but if prisoners were not back behind bars by evening, I was sleeping in my parents' bedroom. "But what if they are gay?" I used to think, seething at being kept awake by my father's room-shaking snores.

When I told my mother I would manage an abortion clinic, she said, "Excellent, Lyd'". *Lyd* is short for Lydia, and this is the phrase she uses whenever she thinks I'm bettering myself.

"I'm thinking about joining a choir."

"Excellent, Lyd."

"I'm going travelling for a year."

"Excellent, Lyd."

It's not my mother's approval that troubles me, but the hope that her rules haven't changed. She likes that I'm managing an abortion clinic, so maybe she'll be okay with me not having children.

When I told her I was doing a PhD instead of having children, she said, "But I can come and babysit." When I said that my partner didn't want children either, she asked, "But if it happens, it happens, right?" And when I reminded her that my brother had provided her two perfectly good grandchildren, she countered, "But it's always different with a daughter's children."

I recently listened to an interview of female politicians who recounted the misogyny they experienced on the job and decided it was a stroke of luck that I failed my political science subject and then dropped out of my Arts degree. Later, when I was analysing my interview data, I thought of Julia Gillard, the first Australian female Prime Minister, then my mother, and then I was carried back to the abortion clinic. September 2014: the doctor's plane was delayed by heavy spring fog, which can hang over Rockhampton until lunchtime. All patients had been admitted and were waiting together in a grey, windowless room with grey chairs and grey carpet.

The lousy part of working in the clinic was that we were busy and didn't spend much time supporting patients. While they were in theatre and recovery, certainly, but then our conversations were short and mainly dealt with medications and aftercare. We flitted between theatre and recovery, so we didn't get to observe much else. A group of people, for

example, sitting in a circle on the waiting room floor, telling each other their abortion story, laughing, crying, and telling each other they would be okay.

Positionality

Declaring positionality in the context of research is an act of transparency that assists people who read and critique our work to understand better how it is produced, analysed, and interpreted. In line with the theoretical principles of symbolic interactionism (Blumer, 1969) which I explain in more detail in the next chapter, our experiences and interpretations of the world change depending upon how, when and where we are positioned within it. This *positioning* directs our research interests, influences how we approach the research and impacts how we interpret the data (Jacobson & Mustafa, 2019). Aspects of our identities, such as race, gender and profession, as well as our contexts (consider pre-COVID versus today), determine what data we privilege, what we disregard and what we do with our findings (Guest, 2018). To put it simply, who we are influences our research outcomes and thinking this through assists researchers to discover and plan around potential areas of challenge and ease in the research process (Jacobson & Mustafa, 2019).

This qualitative study combines CGT and SA and is conducted through an Intersectional Feminist lens. In CGT, the goal is to construct a theory that explains a temporal sequence that leads to change (Charmaz, 2014). The underlying assumption of both CGT and SA is that this explanation is filtered through the experiences of the researcher/s and offers an “interpretive portrayal of the studied world, not an exact picture of it” (Charmaz, 2014, p. 17).

On the doctoral thesis journey, I have become excited about Intersectional Feminism. This seems logical when viewing my Social Identity Map (Table 1). Intersectional Feminism originates from the experiences of Black and indigenous women whose identities are shaped by multilevel forces such as racism and imperialism, which drive complexity and influence inequality (Crenshaw, 1990). More recently, it has been used to analyse how hidden power relations shape the health experiences of people on the margins (Kassam et al., 2020). As a

woman interested in social justice issues, I was already aware of the stigmatised nature of abortion and GBV within the health sector. And because I am inherently interested in real world issues (a pragmatic foundation of CGT and SA that I discuss in more detail in the next chapter), my experience working in abortion care highlighted the access issues faced by people living in rural and remote locations (particularly Indigenous Australians) as well as people with inadequate access to funds to pay for abortion (such as people affected by financial abuse or lower socio-economic status). Dialoguing with the Trans community, interacting with the broader literature on reproductive justice and listening to the research participants' accounts underscored the interconnectedness of abortion with other forms of oppression (I provide more detail in Paper 2 on this topic).

To identify as an emerging intersectional feminist scholar means that I am bound to think reflexively about my social position and role and the power I hold over the research process (Hankivsky, 2014). It also requires reflexivity about other people's influence on the research project. So this requires understanding my supervisor's positionalities as well.

The Social Identity Map (Jacobson & Mustafa, 2019) is a tool that helps researchers unpack the intertwined layers of complexity involved in their social identity and be reflexive about their positionality. I have used Social Identity Mapping (Table 1) to analyse my positionality. For reasons discussed above, I shall not discuss the results in too much detail; suffice it to say I am highly attuned to social justice and gender equity issues. In particular, I am drawn to topics considered taboo.

Cathy is the supervisor with whom I have worked most closely during my doctoral studies. She is neither a nurse nor a midwife, but her previous career was in sexual health. Cathy now researches women's health issues (amongst other things) and identifies that she has a developing yet complex relationship with what she calls "the F word" – feminism:

> …there are times when I was an out and proud Feminist. At other times I have shied away from describing myself as a Feminist – partly because of my upbringing (best to stay "quiet about these women's libber things" and "not cause a scene", as my Irish Catholic mother would say); partly because of the stereotypes

> and misconceptions associated with the F word. I have been “assured” many times that I don’t look like one – whatever “one” looks like.

Cathy can recall times when her positionality has manifested in her research work, such as her doctoral thesis, which explored women’s experiences of coping with the sexual side effects of antidepressant medication:

> A brilliant piece of feminist research humbly translated as “women are entitled to satisfying sex lives, and we won’t be told otherwise, especially by male doctors who think it’s all in our heads”. The examiner highlighted the fact that this was obviously a feminist piece of research, but I had had not positioned myself as a feminist, or even used the term “feminism”. “Was there a reason I had avoided using this term in my thesis?” she had asked…If the truth be known, I raised this with my supervisors at the start of my journey… it was pretty evident that my journey would be so much easier if I stayed away from the F word. Other colleagues agreed, and when I searched for journal articles in my field, I could see their point – not many people went there, not many people stuck the F label on their forehead and wore it with pride.

I have known Kerry since I was 19. In my first year of university, she was one of my nursing lecturers, and from 2014 to 2020, she was a senior colleague at CQUniversity. I have worked as Kerry’s assistant, she has included and mentored me on research projects, and we have co-published journal articles and textbook chapters. We have also done multiday hikes together. Despite not working as intensively with Kerry on this thesis, we have layers of trust and understanding, and I have felt completely comfortable disagree with her at certain times during the thesis project.

Kerry, whose father died when she was in primary school, watched her mother take control of running the household. By extension, Kerry also felt responsible for the family’s survival. This edifice of female agency came crashing down when Kerry’s mother met her new partner, who stripped their power away. These formative experiences both fostered

Kerry's belief in the capability of women and caused her to retaliate against threats to anything she has set out to achieve in life.

While Kerry identifies with feminism, during this thesis project, we have often disagreed over the language of feminism. She has found some of my work confronting and for fear that I am becoming a feminist trope, has suggested I soften some of my assertions and recommendations so as not to overreach my findings and make my work more conciliatory. Kerry's advice continues to elicit a range of reactions in me which usually begin with me digging a foxhole to defend my position, reminding myself of the reach of qualitative research and reflecting on who this research is for and the language that best suites them. This is discussed in more detail in Chapter 3 and Paper 2.

Reflexivity

Reflexivity is intentional self-awareness and encompasses ongoing analysis of our subjective responses, dynamics between researchers and research participants, and the research process (Finlay, 2002). Unlike reflection, which is distant and takes place after an event, reflexivity is more immediate and action-oriented (Finlay, 2002). In other words, when we are reflexive, we consider how our lived experiences influence our current understandings, decisions, and actions and then decide what action to take next. It is an ongoing cycle throughout the whole research process. Below are some of the critical moments of reflexivity that occurred during the thesis journey.

Immediately it was evident that my previous role as a clinician and manager in the abortion sector was likely to influence the entire thesis study. From my experience in the sector (positionality), I interpreted an unmet need regarding GBV that the organisation could not address. Therefore, I decided to research the phenomenon; but first I wanted to dialogue with GBV experts to advance my knowledge on its relationship with unplanned pregnancy (reflexivity). I raised my questions at Domestic Violence conferences but came away believing the experts felt GBV-related abortions were a minor concern, affecting only a small population. However, I knew it was a significant issue from my interest in the topic and

engagement in the literature (positionality). So, I chose to disregard this feedback, found midwives who were a better source of knowledge (reflexivity), and continued with my doctoral degree.

My positionality sometimes collided with Kerry and Cathy. For example, early in the project, we had a robust discussion about whether “abortion” or “termination of pregnancy” was the most appropriate term. There is some evidence that health care providers prefer the term “termination of pregnancy” and use it euphemistically due to the perceived harshness and stigma associated with “abortion” (Kavanagh et al., 2018). However, I wanted to avoid perpetuating stigma, so I decided to use abortion.

Despite no longer working in abortion care, I am well-regarded in the industry (positionality). I reconnected with Marie Stopes Australia (MSA) and Children by Choice (CbyC), asking them to recruit research participants through their networks (reflexivity). These organisations are pro-choice, and by extension, their networks are likely pro-choice, too (positionality). In fact, everyone who advertised my project was pro-choice, which likely affected the findings. For transparency, I have reported my recruitment strategy in Papers 2, 3, 4 and 5 (reflexivity).

The research findings may have been different had someone without experience in abortion care or experience of working in metropolitan, regional and remote contexts conducted the semi-structured interviews or performed the analysis. My clinical and cultural insight into the reality of abortion care, and issues that impact regional and remote practice (positionality), helped me feel that I could relate to the people I interviewed. Sharing our passions and frustrations seemed to increase our trust for one another, to the point that people disclosed transgressive practices to me. Sometimes participants asked, “You’re not recording this are you?” before revealing something illegal. When this occurred, I would revisit the Participant Information Sheet details with them and advise them that they were recorded, but transcripts are anonymised, and their details are kept confidential (reflexivity).

I set out to minimise the power differential with participants so they did not feel coerced into speaking about anything that caused them discomfort (reflexivity). For example,

I tried to use the language that they used and sometimes this involved swearing which is demonstrated in the following quote from my interview with Participant 8: “And were you thinking, ‘shit, I could get in trouble here’. Or were you just like, ‘no, this is beyond this (trouble), this is the right thing to do?’”

On reflection, I may have surprised some participants when I asked them about rule breaking. CGT is an iterative research method, and new interview questions are added based on information received in the previous interviews (Charmaz, 2014). Participants had registered for an interview about their experiences of providing abortion care to people who had experienced GBV, *not* their experiences of breaking the rules, which is where the analysis and theoretical coding were leading me. While no one seemed upset by the question, I would have prepared them at the beginning of the interview if I had my time again. I will take this lesson into future research projects (reflexivity).

My experiences of abortion care also influenced the way I interpreted and then analysed the interviews. Initially, I had some hunches about the findings, and I was worried these could cloud the interviews and the analysis. Redundancies are built into CGT which allows the researcher to pursue hunches (and then drop them in the absence of confirming data) (Charmaz, 2014), I was nervous that I had latched onto preconceptions that participants were not aware of what to do in the case of GBV and did not have the time to respond to GBV. On the advice of a colleague, I conducted a self-interview to record my experiences. This act alone helped me to put my ideas aside. When I conducted the analysis, I returned to my interview transcript to see if my hunches influenced codes. In the later stages of the study, as I developed the focussed codes, I integrated my data into the analysis to fully claim my role as a co-constructor of experience and meaning (Birks et al., 2019).

In terms of the thesis, my academic position attunes me to nursing and midwifery concerns – not biomedical or workflow concerns (positionality). I teach nursing students and continuously review the standards, codes, and guidelines that underscore nursing and midwifery in Australia. This position is a point of difference; much of the recent Australian

abortion research (some which directly relates to nursing) was not conducted by nurses or midwives and has overlooked the social justice aspect of our work, which arises from these codes and guidelines.

Among other things, Charmaz (2014, p. 43) encourages novice researchers who use CGT to look for unusual or surprising actions in the data and consider what strikes as most noteworthy, interesting and telling. From my experiences, and because I used intersectional feminism as a sensitising concept (see Paper 2) there were two significant surprises; some participants had clear GBV policies and procedures that they followed, other participants knowingly broke the rules. However, I am confident that someone with different experiences may have found other data more noteworthy and surprising. Take, for example, my communication with a reviewer of Paper 3:

> Reviewer: I would feel the nurses' and midwives' struggling when providing abortion care after reading the results section…I believe "the process of providing abortion care in the context of gender-based violence" is also a dynamic, back-and-forth, and struggling process for the nurses and midwives. The attributes of struggles were not clearly presented.
>
> Me: I have gone back to the data and thought about your code "struggling back & forth". I don't believe it stands on its own. Many participants said they didn't think too much about breaking the rules and just went for it. However, within the category "being backed into a corner" there is a place for "struggling".

My position as an abortion advocate, most recently as part of the Far North Queensland Pro-Choice coalition that worked on the Queensland abortion law reform campaign, means that I am wary of words like "struggle" that might be taken out of context to promote conscientious objection. Therefore, codes like "struggling back and forth" must earn their way into the analysis, which I did not feel it did (reflexivity).

In academia, I have collaborated on research projects concerning GBV and abortion. This has contributed to being regarded by some as an "expert" in the area. This supposed expertise benefits the thesis project by opening doors. For example, at the end of 2021,

MSA invited me into an (unpaid) collaborative relationship to implement the recommendations of this research into their service. Translation of abortion and GBV knowledge into practice is notoriously slow (Cameron et al., 2020); leveraging my positionality to change practice is reflexive. However, this relationship with MSA conceivably presents conflicts of interest. Since MSA helped me recruit participants from inside the organisation and is offering to work with me to implement my findings, I could feel pressured to “play down” research findings that might paint MSA in a critical light. Conceivably MSA could end our working relationship if they are unhappy with the research findings or if I am involved in advocacy work that does not meet their interests.

My Social Identity Map suggests it is unlikely that I will play down the research findings or feel corralled by any organisational agenda. My attitudes towards social justice, advocacy and identifying as a “positive disruptor” implies it is more likely that MSA might be unhappy with Paper 5, which discusses the tension between its business model and philosophy of care. To that end, I meet regularly with MSA stakeholders to update them about my research findings.

Finally, in reading the journal articles in this thesis, you will see that I grapple with the term “woman-centred care”. I prefer to use “person-centred care” to disrupt the man-woman binary, but the research participants more commonly used “woman-centred”. This is an ongoing fight between constructing theory through my intersectional feminist lens and grounding it in the data.

Conclusion

Locating this doctoral thesis study to my positionality has been challenging but illuminating. Social Identity Mapping has demonstrated that I am highly attuned to social justice and gender-equity issues, particularly taboo topics. In the short satirical story, “Family Planning”, I revealed some social experiences that have compelled me to undertake the study. I have also provided examples of how I have demonstrated reflexivity throughout the

thesis process. Other examples of reflexivity appear throughout this thesis. The next chapter explains the research methodology and situates positionality as an axiological component.

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Table 1: Researcher's Social Positioning

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 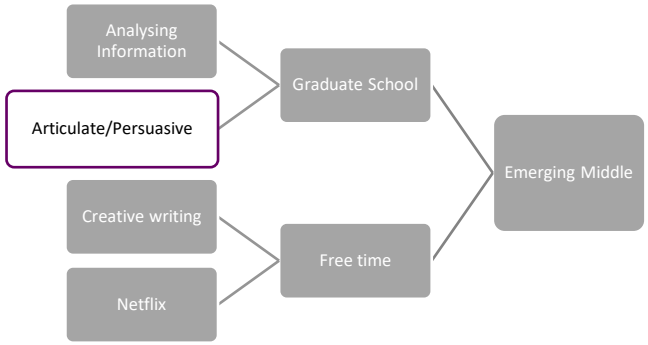
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 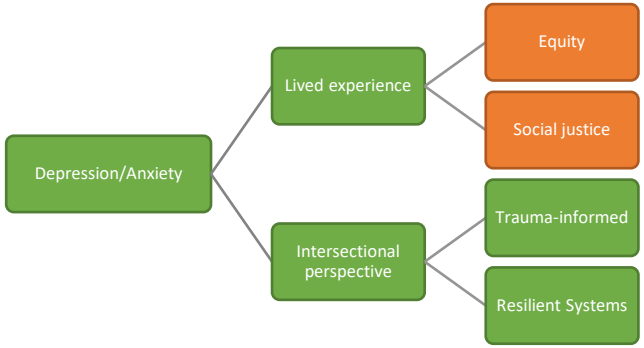
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 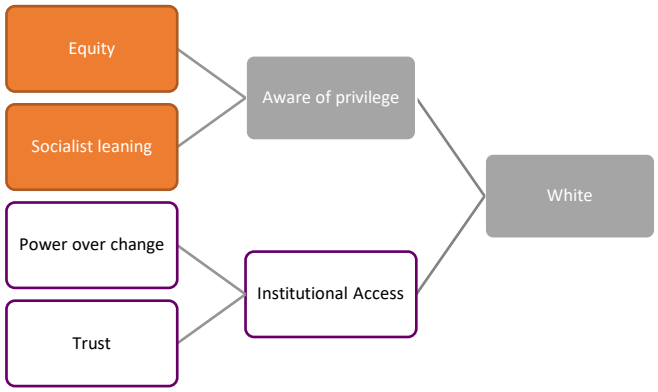
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 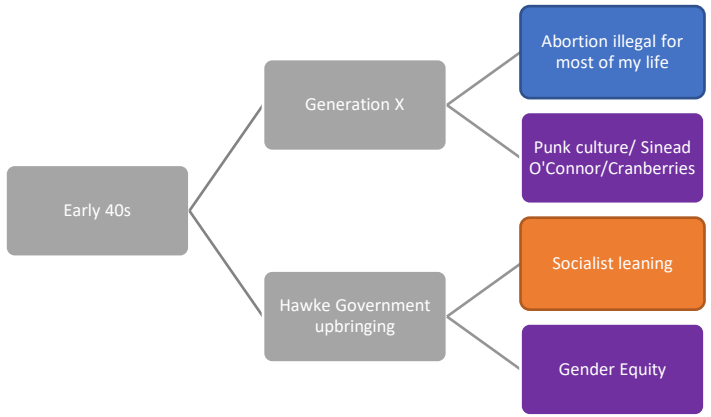
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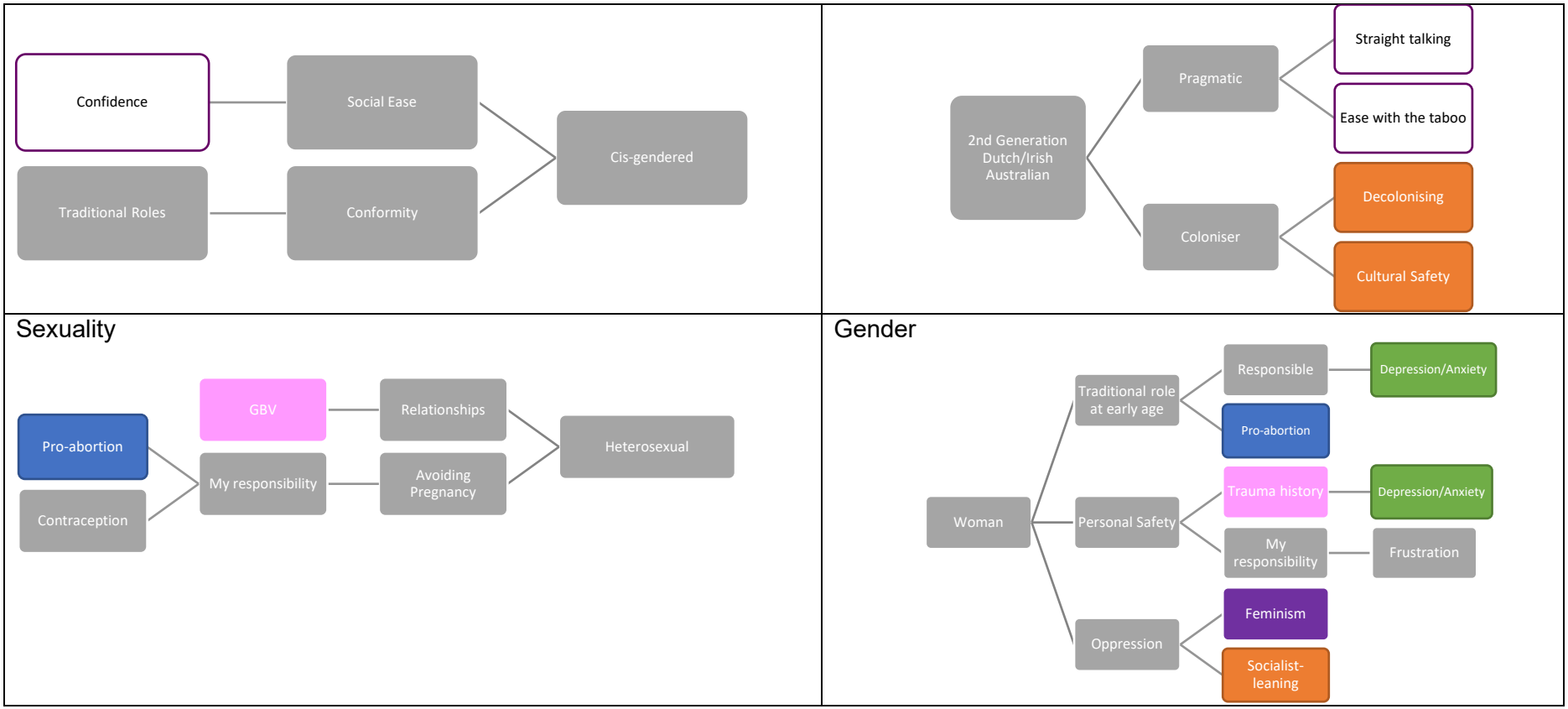
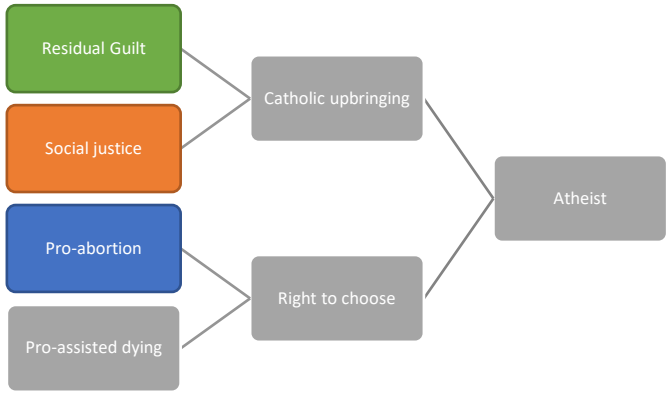

Confidence
Social Ease
Traditional Roles
Conformity
Cis-gendered
2nd Generation Dutch/Irish Australian
Pragmatic
Straight talking
Ease with the taboo
Coloniser
Decolonising
Cultural Safety
Sexuality
Pro-abortion
Contraception
GBV
My responsibility
Relationships
Avoiding Pregnancy
Heterosexual
Gender
Woman
Traditional role at early age
Responsible
Depression/Anxiety
Pro-abortion
Personal Safety
Trauma history
Depression/Anxiety
My responsibility
Frustration
Oppression
Feminism
Socialist-leaning

Religion



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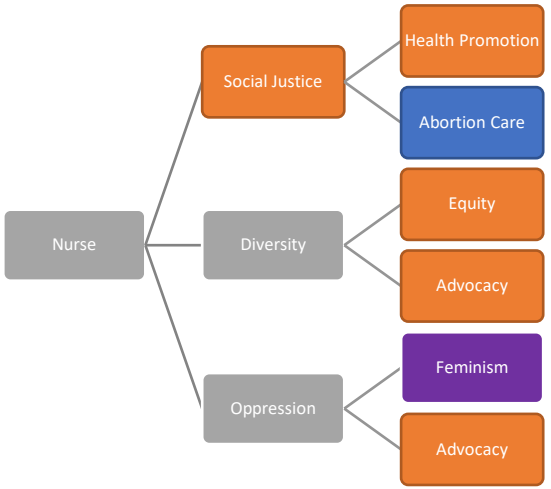

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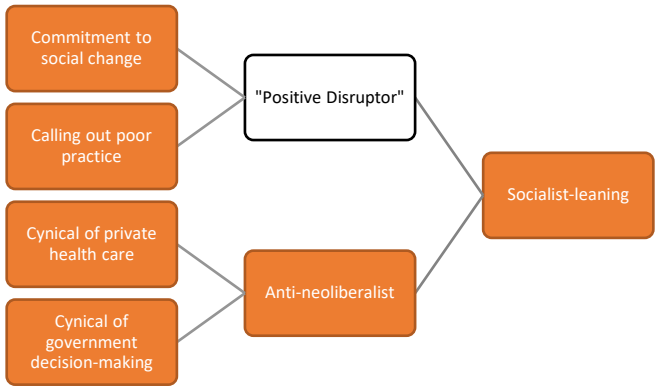
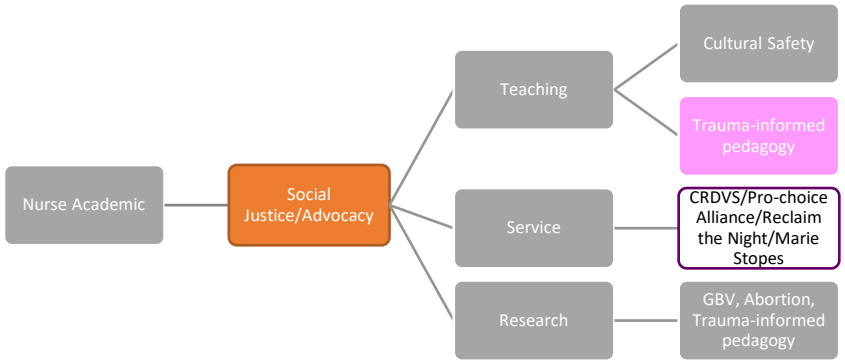


Profession 2



CHAPTER 3: METHODOLOGY

The previous chapter explained my positionality as it relates to the thesis project. This chapter will first link my positionality to the research lens, paradigms, and theoretical principles of the thesis study's methodology. Next, I will briefly discuss the use of theoretical frameworks in GT studies, followed by a description of the two-phased, simultaneous, multiple method CGT study used to organise and conduct the thesis project. Finally, in Paper 2 (under review in a peer-reviewed journal), I explain why this research design aligns with intersectional feminism.

Research aims

To recap, this study has two aims:

- To explain the process through which Australian nurses and midwives provide abortion care for people in the context of GBV.
- To map the elements of the broader health care situation that affect the provision of abortion care to people affected by GBV.

Research questions

I crafted the following questions to meet the study aims:

- How do Australian nurses and midwives provide abortion care to people victimised by GBV?
- How does the broader health care situation affect the way in which Australian nurses and midwives provide abortion care to people victimised by GBV?

Research lens, paradigms, and theoretical principles

Abortion and GBV are topics considered taboo, often veiled in secrecy, inherently related to power, and shaped through identity politics. Through analysing my positionality, I discovered that social justice and intersectional feminism strongly influence my identity,

drawing me to research taboo topics, from diverse viewpoints, and compelling me to view research as advocacy work. In philosophical terms, this is axiology, or what I believe is valuable or worth doing (Melville et al., 2019). This thesis study aligns with my axiology. It is feminist research which intends to be beneficial to nurses, midwives, and pregnant people – particularly those marginalised by GBV. It seeks to legitimise the perspectives of nurses and midwives from diverse contexts and liberate their suppressed knowledge. Furthermore, it aims to highlight the official and unofficial power structures within the broader abortion and GBV arenas.

My first study protocol was driven by naïve axiology: I wanted to produce work that could affect policy change. Consequently I developed an explanatory mixed methods research design combining a survey with quantitative statistical analysis, and interview with thematic analysis (Clarke & Braun, 2013). This approach was sold to me as having the most reach for policy development and change. However, the more I came to realise I was interested in *how* – the process – nurses and midwives provided abortion care to people victimised by GBV, and what broader factors impact this process, the less confident I grew in the mixed methods approach.

In discussing this with non-nursing or midwifery academics and doctoral students, I felt they assumed by “process” I meant a sequence of clinical tasks confined to addressing GBV (i.e. screening and referral). I felt that they fundamentally misunderstood the highly contingent nature of our work and that a disclosure of GBV could have a broader impact on the process of abortion care. Moreover, they seemed to conflate our work with the biomedical model, not understanding that nursing and midwifery practise is underpinned by different philosophies of care which place greater emphasis on person/woman-centredness and social justice (International Council of Nurses, 2012). I also felt that non-nurses or midwives were unaware of the agency and autonomy that we have over our work. This insight helped me distil my axiological position, which clarified my research aims and pointed me in an ideological direction towards third-wave feminism.

Third-wave feminism combines the feminist postmodernism paradigm and the lens of intersectionality (Price, 2017). Together they oblige researchers to bring the “other” into the research process, empower oppressed groups (Evans et al., 2014), take a multi-axis approach towards identity and use methods that examine power structures and politics (Price, 2017). So, I then turn to Fairclough’s (1995) rendering of Critical Discourse Analysis (CDA) whose primary concern is how power is exercised through language. CDA takes an analytically dualist approach, focussing research on the relationship between social processes (the *how*) and social structures (Fairclough, 2005). CDA showed great potential for meeting the intersectional feminist concern of analysing the power in the abortion arena but I was not sure that the process through which nurses and midwives provide abortion care for people affected by GBV would be power based. This worldview seems incredible now and demonstrates my growth as a feminist scholar through this thesis project. As you will see in the next chapter, my assumption was incorrect; I could have legitimately used CDA in this study to meet my *axiological* objective.

Axiology leads to ontology – the way people conceptualise knowledge, reality and truth (Howell, 2013). My ontological position is best described through the way I teach. I believe that students are continuously learning (i.e. building knowledge, reality, and truth) through their interactions with other people and objects in their environments. I observe that the construction of knowledge is expedited and enriched through group study. I usually find that each study group places greater importance on some subject matter over other matter because individual students with their own experiences and world views influence the study direction. Therefore, study groups build knowledge that is slightly (and sometimes wildly) different to other groups.

Ontologically speaking, this means I am ambivalent towards universal “truth”, and take a relativist stance on realism, meaning that knowledge, reality, and truth are constructed locally and based on shared experiences (Howell, 2013). With the benefit of hindsight, I align myself with social constructivist ontology because I believe groups or societies create realities (Kukla, 2000). Had I understood this at the beginning of this thesis

journey I may have selected a different methodology such as participatory action research (Baum et al., 2006). Instead, I selected the constructivist ontological paradigm which has similarities with social constructivism; it also accepts a relativist stance, asserting that there are multiple constructed realities (Denzin & Lincoln, 2011) which can be constructed through consensus (i.e. groups) (Howell, 2013). However, constructivism also contends that reality is constructed by individuals, including the researcher, who are influenced by cultural and social factors. In taking this stance it embraces the *situatedness* (i.e. the unavoidable influence) of the researcher within the research (Clarke et al., 2018; Howell, 2013).

In simple terms, epistemology is the theory of knowledge and deals with how knowledge is gathered and from which sources. Understanding epistemology also assists in the selection of an appropriate methodology and methods for their study (Howell, 2013). Constructivism accepts that reality is always an interpretation and research findings are always the researcher's interpretation of the situation (Creswell, 2013; Morse et al., 2016). That is, the knowledge generated from the research cannot exist independently from the researcher; it is absolutely dependent on the researcher (Guba & Lincoln, 1989, as cited in Howell, 2013). Therefore, methodologies that align with constructivism assumes the researcher's subjectivity in the interpretation of the data. So, unlike objectivist methodologies, which may seek to produce grand theory, constructivism aims to achieve levels of understanding and allows space for multiple realities (Guba & Lincoln, 1989, as cited in Howell, 2013).

Figure 1 presents the alignment of my axiology, ontology, and epistemology.

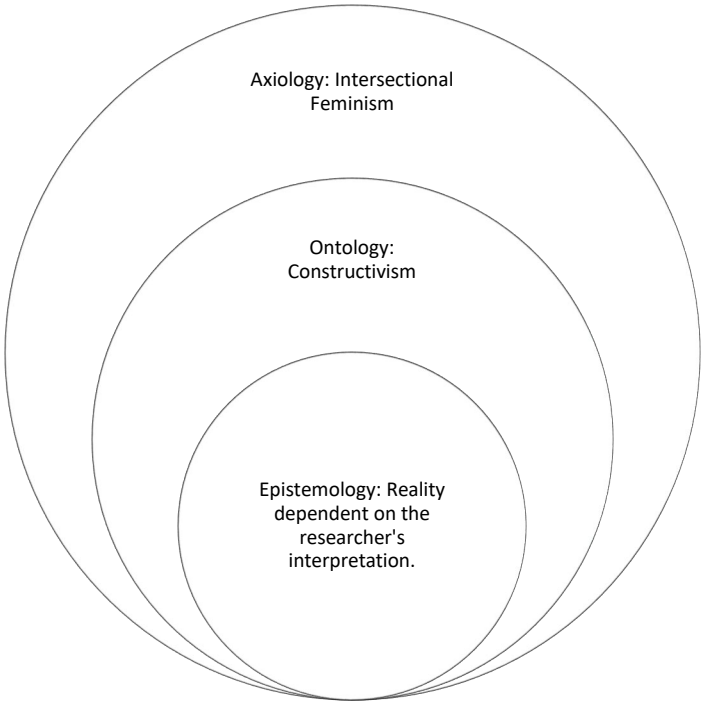


Figure 1: Alignment of axiology, ontology, and epistemology

In 2018, my secondary doctoral supervisor and I joined a research team using Adele Clarke's Situational Analysis (SA) (2018), a constructivist methodology, to examine the relationship between gambling and intimate partner violence against cis-gendered women. In familiarising ourselves with SA we realised that Clarke drew upon Foucauldian CDA to "engage questions of power" (p.80) and uncover minority views and marginalised positions in the situation (Clarke et al., 2018). Moreover, Clarke et al. (2018) explained that one could combine SA with CGT to also analyse a basic social process; a process of care, for example.

At face value, the combined CGT and SA approach met my research aims to explain a process and explore the broader situation (particularly the power within the situation). CGT and SA are in the constructivist paradigm, aligned with the postmodernism of third-wave feminism and claimed to embrace the complexity of multiple situated realities (Charmaz, 2014; Clarke, 2003; Clarke et al., 2018), allowing for an intersectional feminist lens into the research design.

CGT and SA are second generation GT methodologies, influenced by feminism, postcolonial theory, anti-racism, amongst many other factors (Clarke, 2009). Second generation grounded theorists took original GT (Glaser et al., 1967), with its objective epistemology, and applied postmodernism (Clarke, 2005; Noerager Sterns, 2009) and poststructuralism (Clarke, 2012). Strauss and Corbin (1990) paved the way for this new generation by shifting GT into the realm of pragmatist ontology (Charmaz, 2014).

The focus of pragmatism is problem-solving; it is concerned with the links between beliefs and actions of individuals as they attempt to solve the empirical problems of their everyday lives (Morgan 2020, Morse et al., 2021). Pragmatists accepts that people hold multiple and changeable views about their experiences, which are shaped through language and multiple perspectives. In other words, pragmatists see reality as rather indeterminant and conditional (Mead, 1934, as cited in Charmaz, 2009; Bryant & Charmaz, 2019; Morse et al., 2021). To this end, they eschew questions about reality, instead placing importance on the nature of experience and joint actions (Morgan, 2020).Strauss's work was also heavily influenced by Herbert Blumer's (1969) symbolic interactionism. Strauss and Corbin emphasised symbolic interactionism in their rendering of GT (Charmaz, 2014) and this has carried into second generation GT. Symbolic interactionism has several underlying assumptions. First, human actions, shared meanings, interpretations and habits construct the self, the situation and society (Charmaz, 2014; Schwalbe, 2020). In other words, reality is constructed through actions and does not exist on its own. Next, interpretations and interactions with humans and non-humans are reciprocal (Charmaz, 2014). Thus, we act based on our interpretation of the world and it reacts based on its interpretation of our actions. Symbolic interactionism also contends that we use language and symbols to form and share meanings (Charmaz, 2014; Schwalbe, 2020). Finally, it contends the present informs interpretations of the past, and vice versa (Charmaz, 2014; Schwalbe, 2020). Strauss, Charmaz and Clarke have drawn from Blumer's five directives of symbolic interactionism in their own versions of GT. These are: (i) to understand the perspectives of other people; (ii) to focus on interactions through which people create and change meanings;

(iii) to analyse action; (iv) to view social organisation as interlinking action; (v) to regard social organisation historically, as if coordinated across time and space (Blumer, as cited in Schwalbe, 2020).

The second generation of grounded theorists, which include Charmaz and Clarke, are all women, who aimed to provoke GT towards promoting social justice to improve the diverse lives of women (Clarke, 2012). Charmaz, followed by Clarke, diverged from Strauss and Corbin's GT by introducing the relativist stance and subjectivity of constructivism and declared "that conducting and writing research are not neutral acts" (Charmaz, 2009, p. 130). So, while I continue to emphasise the interpretation I unavoidably bring to the findings of this doctoral project, this is done for reflexive reasons. I believe the findings and results of *all* research projects are inevitably steered by the position of the researchers. Taking a relativist stance does not mean my interpretation of the research data is left unchecked and unquestioned. Like Charmaz, I do not agree with the centrality of individual consciousness that radical subjectivism or individual reductionism subscribe to (Charmaz, 2009). CGT continues to follow the rigorous process of GT (inductive logic, comparative analysis, and theoretical analysis), and adds reflexivity which it takes "into explicit and continuous account" (Charmaz, 2009, p. 133). In doing so, CGT researchers: (i) aim to locate participants stories in participants' beliefs and perspectives; (ii) interpret the assumptions that underlie these beliefs and perspectives; (iii) situate these beliefs and perspectives in the larger social structures which participants may not be aware of (Charmaz, 2009). This is extended upon by SA, which moves the analysis away from the individual to the situational level, uncovering structural processes and relationships which may be hidden (Charmaz, 2014).

Theoretical framework

The theoretical framework is used to position a study in a particular discipline or discourse (Clarke, 2012) and, traditionally, is selected before collecting data. Thus, the theoretical framework informs what and how data are collected and analysed (Creswell, 2013). However, unlike traditional quantitative research, inductive qualitative methodologies,

such as GT, often do not use a theoretical framework at the beginning of the research project (Charmaz, 2014). As will be expanded upon later, GT is constructed from the data and should not be excessively influenced by outside factors such as the theoretical framework (Birks & Mills, 2015; Charmaz, 2006). Instead, the theoretical framework is constructed through the analysis and locates the argument arising out of the analysis in the relevant discourses (Charmaz, 2014). This will be elaborated in the section "theoretical coding" and is presented in Paper 6.

Research design

The design for this thesis study was a two-phase, simultaneous, qualitative, multiple methods approach (Morse, 2016) combining CGT and SA. While Clarke et al. (2018) advise they are complementary and can be used together, Morse's (2016) principles for conducting multiple method studies were used to verify the research design. First, I determined that the complexity of the topic required analysis at multiple levels: to truly assume to explain the processes through which nurses and midwives provide abortion care to people affected by GBV, it was important to also understand the dense complexities of the environments in which they work. Next, the theoretical "thrust" (Morse, 2016, p. 148) of the study was determined to be *inductive*. Phase A, CGT was confirmed to match the overall[6] theoretical inductive thrust. Phase B, SA, was selected because its analysis focussed on the broader situation (Clarke et al., 2018) and also matched the inductive thrust of the study and aligned with the overarching ontology and epistemology.

Morse (2016) asserts that both components of the multiple methods study must remain faithful to their underlying methodology. When researchers face epistemological tensions between methods, or issues in merging the data and analysis, they often use a sequential multiple methods design (Morse, 2016). However, CGT and SA methods come

[6] In addition to induction, GT and SA undertake the process of abduction. Because abduction generally moves in an inductive direction, it is considered as an *inductive* theoretical thrust for the purpose of the multiple methods selection. Morse, J. M. (2016). *Mixed method design: Principles and procedures* (Vol. 4). Routledge.

from the same origin, Straussian GT, and work well together at the level of analysis (Clarke et al., 2018). Therefore, on the advice of the candidature examiners, I chose to conduct the phases simultaneously[7]. Figure 3-2 presents a diagram of the multiple methods approach I set out to undertake.

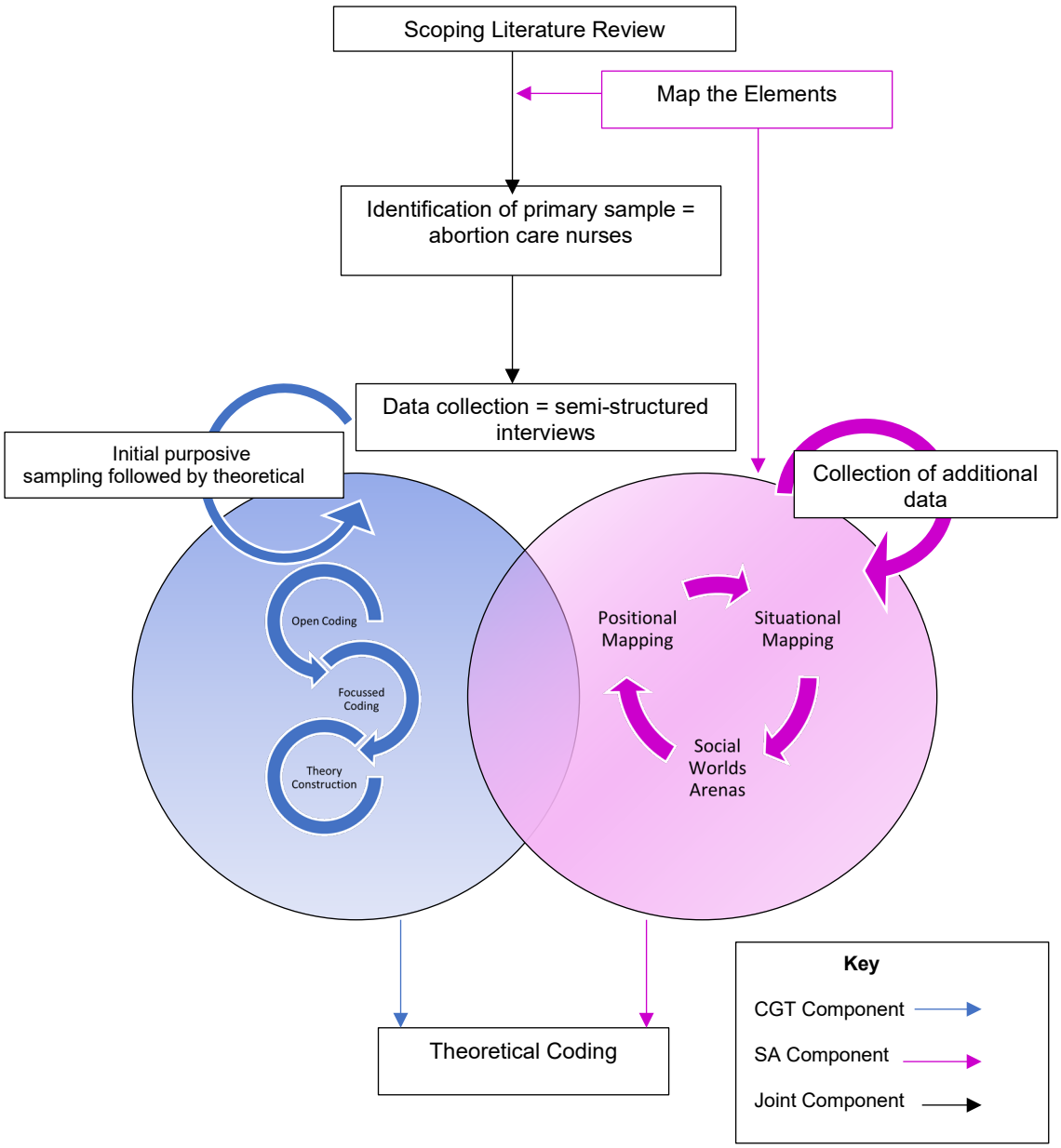


Figure 3-2: Multiple methods design

For clarity, I will explain the CGT project first, followed by SA; however, initially this was a simultaneous study.

[7] With hindsight it would have been better to conduct the study sequentially. I explain this later.

Phase A: Constructivist Grounded Theory

This short section describes CGT methodology and methods used for Phase A of this thesis project. I provide a brief overview of CGT to reaffirm its suitability for the study and explain CGT analysis. A comprehensive explanation of ethics, recruitment and data collection is contained in Paper 3.

CGT is an extension of Glaser's original positivist and Strauss' pragmatist approach to grounded theory (Glaser & Strauss, 1967) and takes an inductive, comparative, emergent and open-ended approach to analysis (Charmaz, 2014). CGT emphasises flexibility of method and highlights the inextricable position that the researcher plays within the research and accepts their interpretation of the analysis (Higginbottom & Lauridsen, 2014; Nagel et al., 2015). Explicitly locating the researcher within the research fosters reflexivity about their actions, decisions and interpretations (Charmaz, 2014). Within nursing, CGT is frequently used and is often applied to understand experiences and social behaviours to enhance patient care (Higginbottom & Lauridsen, 2014). Thus, CGT was well-suited to contribute towards answering the research question 1:

- How do Australian nurses and midwives provide abortion care to people victimised by GBV?

Phase A addressed the following research aim:

- To explain the process through which Australian nurses and midwives provide abortion care for people in the context of GBV.

CGT analysis occurs at the level of meanings, actions and practices of research participants (the legacy of pragmatism) and aims to construct a conceptualisation of a basic social process (Charmaz, 2014; Morgan, 2020). Researchers who use traditional GT define the basic social process as the pervasive, unavoidable pattern that has distinct phases and is used universally by participants to navigate a central issue (Glaser & Holton, 2005). Constructivists and pragmatists, who embrace diversity, are less concerned with a fixed process used universally (Charmaz, 2014).

CGT analysis locates participants' meaning and action in the larger social contexts (such as faith, social conventions, culture) of which they may be unaware (Charmaz, 2014). It does this by first identifying the assumptions (e.g. abortion is amoral) upon which participants construct meaning and actions (e.g. limit time spent with women to reduce personal abjection). This analytical step arises from concept of Dewynian inquiry where people form beliefs about problems which inform the ways they go about resolving them (Dewey, 1933,1938 in Morgan, 2020). In addition, Charmaz (2014) asserts this process links the subjective to the social.

Following conventions of pragmatism, in GT, data collection (interviews) and analysis occur simultaneously. Coding is the analytic device used to break apart, examine, arrange and synthesise data collected during interviews (Charmaz, 2014; Glaser & Strauss, 1978). Coding categorises conceptual reoccurrences and similarities in the data (Birks & Mills, 2015) and facilitates the researcher moving from the empirical to the theoretical (Glaser & Strauss, 1978). Therefore, it escalates in theoretical complexity throughout the GT process (Birks & Mills, 2015; Charmaz, 2014; Glaser & Strauss, 1978). In line with the constructivist world view, which has emerged from pragmatism, CGT researchers accept that codes are constructed through their own perspective of the situation and the particular language they select to describe the codes (Charmaz, 2014). During the coding process I have reflexively examined my underlying assumptions and the language I use for codes.

For reasons of brevity, I did not discuss CGT coding in detail in the publications. Therefore, the following section describes the phases of coding I used to break open the empirical data and weave it back together theoretically to identify the basic social process.

Initial/open coding

In this phase of coding, I approached the interview transcripts line-by-line and created action (gerund/"-ing") codes. Charmaz advises gerund coding assists the researcher to stay close to (i.e. grounded in) the data (Charmaz, 2014). I found gerund coding also helped me to think about process rather than revert to "themes" which I was more familiar

with. I penetrated as many tentative analytic codes as possible, wrote reflexive memos and drew mind maps about the codes as well as any observations I made during the interviews. Table 2 displays a small example of my initial coding process.

Table 2: Line-by-line coding and memos

Memo (reflexivity *italicised)*	Transcript	Line-by-line coding
Primary care offers nurses more autonomy – I wonder if this was the motivation? In this section participant 2 begins to describe a backdoor approach to accessing working. She says it was the normal way of operating *and from my experience people did come into their jobs through relationships rather than interviews. I think this might be a structural issue here & structures are constructed through actions. People play routine roles to reinforce structures. In this situation there were probably the official rules of the organisation, but then there were the real, far more complex rules that the nurses followed.* HRE = human relationship education (sex ed). Ah – it's community education, not clinical education. Language is important – this is a euphemistic term used to described sexual reproductive education. *She's probably using it here as she is sounding me out* OR was it the standard term used at the time – later she reveals that she doesn't use euphemisms for abortion. This section builds on the previous memo on structures. Here the participant discusses involving outside organisations (airline company) in her nursing role. *From my own experience as a nurse who has worked in small communities, I know that using the community to provide access to health*	A: Okay then. Well, firstly, because I worked in primary healthcare, down in [State A], then we moved up here, I wanted to continue in that. And fortunately, in [regional town 1], I got a job with [sexual health organisation]. So it was a teaching job because I didn't like to work in clinical work. So from [regional town 1] we moved up here to [regional town 2]. And my husband was away working, but when he came home I used to go and help out at the clinic here. I really got a job through the back door, like we all did then. I started off in clinical work and then education became, sort of, far more important and I got – went into education. So I started with the HRE programme and all that sort of thing. Q: And where did your career lead you down – when did you get into the abortion care side of things? A: Well, it wasn't really – I think it was more on the side of, on part of sexual and reproductive health. That was big part of sexual reproductive health. And I guess we did some, sort of deals with airlines back then, to get people from [regional town 2] down to [Capital City] or somewhere so they could have abortions. Okay so what happened was, in the clinic – we had a really good clinic supervisor who I've worked closely with. We used to talk about these things, what we could do to help these young girls. Mainly were young ones that are not necessarily Indigenous but they were from more remote areas. And they weren't necessarily always young, they were older women too, that didn't want to proceed with their pregnancies. Because they	Wanting to continue working in PHC. Getting a sexual health job. Getting a teaching job. Preferring teaching to clinical work. Moving from town 1 to town 2. Helping out at the sexual health organisation. Getting the job through the back door. Starting in the clinic then moving to education. Educating more important. Starting with the HRE program. Doing deals with airlines. Getting people from A to B to have abortions. Having a really good clinical supervisor. Working closely with clinical supervisor. Talking about what we could do to help. Coming from remote areas. Young and older not wanting to proceed with pregnancies.

care is sometimes done when there are no other options. However, in my experience it is not a routine practice & only done in extreme, situations. In this situation the nurse has an established relationship with an airline worker who secures cheap tickets for the women to Capital for abortions. The "patient travel scheme" is negotiated over a game of tennis! So this was a role the airline worker was playing in this structure as well. What kind of structure allows such permeable membranes? Is it because the community was rather remote and they could just get away with it? This statement indicates that more than just the participant plays this clandestine role. *At this point, P2 gave a big grimace and rolled her chair back away from me. She was revealing something that she was not sure she should talk about.	couldn't afford it. We used to do a deal with a girl that we knew at [airline] which was an airline that we knew. So we was to get them down the back in the weekend. Arrange everything to the terminations done in [Capital City]*.	Unable to afford child. Doing a deal with a girl we knew at Airline. Getting them down and back in a weekend. Arranging everything to get terminations done.

Theoretical sampling

Theoretical sampling is a pragmatic inquiry device (Morgan, 2020). It occurs after the initial collection of data, as the researcher decides re-evaluates their original belief about the research topic and decides what data to collect next in order to drive theory construction (Charmaz, 2014). It involves making decisions about the key theoretical concepts identified through coding and identifying potential research participants who can provide rich data about those concepts to fill-out higher order codes and categories. Theoretical sampling uses abductive reasoning (Charmaz, 2014), which is the research process of going back and forth between data, analysis and conceptualisation and is a pragmatist device (Clarke et al., 2018; Morse et al., 2016). I had anticipated doing theoretical sampling after the fifth interview. However, participant 2 disclosed that, under the nose of her organisation, she had

helped smuggle people in DV situations to metropolitan areas where they could access abortions. This was an interesting and unforeseen direction which aligned with my sensitising concept of intersectionality (Collins, 2015) and hinted at hidden power (see Paper 2). Consistent with my third-wave feminist stance, I decided to pursue this line of inquiry and so asked the next participant how she navigated ethical, legal, or organisational boundaries; she had also transgressed. “Doing the wrong thing for the right reason” was the theoretical code that saturated most quickly and was the first elevated to a category. However, it took some time to unpack the nuances of “doing the wrong thing for the right reason”; this was assisted by constant comparative analysis, and then going back to the participants to seek clarification.

Constant comparative analysis

Throughout the process of coding, I simultaneously performed constant comparative analysis. Constant comparison, like coding, pushed me from the empirical towards the theoretical (Glaser & Strauss, 1967). It involved taking all of the analytical material (initial/open codes, focussed codes and categories) and comparing them with, and to, all other parts of the material (and raw data) to explore similarities, differences, variations and surprises (Hallberg, 2006, as cited in Charmaz, 2014). For example, I found that most participants transgressed. I identified all the codes and categories that I felt related to transgression and compared them with one another to see if there were any commonalities. I observed that transgressive actions seemed to be driven by a desire to provide person-centred care. I used this insight to inform theoretical sampling and asked subsequent participants what guided their actions when they were faced with difficult ethical decisions. I also compared the codes and categories for the few participants that had not transgressed and noticed that working in woman-centred *systems* was the commonality. I recorded these constant comparisons as memos which I used later in the study to construct the category “Committing to person-centred care”.

Focussed coding

Focussed coding drives the synthesis, analysis and conceptualisation of large segments of data to advance the theoretical direction of the research project (Charmaz, 2014). I analysed the initial/open coding (including observation memos codes and comparison codes) and tentatively decided which codes were the most significant and had the greatest analytical power (Charmaz, 2014). This was driven by my construction of the meaning of initial codes (Charmaz, 2014) and you can see how this is demonstrated in Table 2.

Constant comparative analysis also took place at this level to refine and construct new codes and tentative categories with "greater theoretical reach and centrality" (Charmaz, 2014, p. 146). For example, I grouped the following focussed codes together – "prolonging pregnancy", "increasing danger", "feeling unsupported" and "escalating frustration" – because when I compared my memos for each of these codes and returned to the data, I interpreted a sense of desperation occurring in the situation, almost as if clinicians were ready for fight or flight. I called this combined code "Being backed into a corner" and elevated it to a category.

During focussed coding, I selected and developed a single core category that encapsulated the emerging story implied or revealed by data (Birks & Mills, 2015; Charmaz, 2014). As outlined earlier, the purpose of CGT analysis is to construct a conceptualisation of the basic social process (Charmaz, 2014). This involves deciphering the main problem or issue in the substantive area and how participants resolve it. The resolution is known as the category (Hernandez, 2009). I interpreted that the main problem was "committing to person-centred care" which was resolved through "working with or against the system".

Theory construction and integration

A grounded theory is an explanation of the relationships between abstract concepts and categories as they relate to the basic social process (Birks & Mills, 2015; Charmaz, 2014). Aligned with the constructivist epistemology, grounded theories are abstract,

emergent, provisional, processual and are situated in the multiple perspectives of the participants (Birks & Mills, 2015; Charmaz, 2014). The core category (resolution to the core issue/problem), selected through focussed coding, is the foundation of the developing theory and its robustness relies on the theoretical saturation of categories throughout the research project (Birks & Mills, 2015).

I undertook theory construction, in line with the CGT process. First, I organised all of the analytical memos to be aligned with the major categories. Then I compared memos from the same category as well as between categories. I created new memos about ideas inspired by these comparisons (Charmaz, 2014). Finally, I constructed a diagram to demonstrate the logical schema of the memos and categories and how they relate to the core category. Theoretical sensitivity occurs when the researcher finds relationships between their categories that lead them to construct a theory that fits, works with, and is relevant to, their substantive area (Lapan, 2011). After 12 interviews, I located two clear pathways: one with motifs of transgression and underground networks, the other with integrated support structures and compliance. I was unable to discern any new information after 16 interviews but conducted two additional interviews to confirm saturation.

Within CGT the concept of “saturation” does not mean there is nothing further to add to the analysis (Nelson, 2016). Indeed, with its pragmatist underpinnings, CGT accepts that situations are constantly changing and evolving, therefore findings are always tentative (Clarke, 2018). However, as a metaphor, “saturation” is problematic (Dey, 1999) and has the potential to mislead and over-reach the research findings (Nelson, 2016). More appropriate terms to delineate the point at which the analyst has reach sufficient depth to construct a theory could be ‘theoretical sufficiency’ (Dey, 1999) or ‘conceptual depth’ (Nelson, 2016).

Theoretical coding

A theoretical code is a relational framework that connects all codes and categories to the core category (Hernandez, 2009). Theoretical coding is not used with all GT types

(e.g. Strauss and Corbin), and not all CGT studies generate theory. Indeed, Charmaz (2014) advises researchers to use theoretical coding only to the extent that it is useful. However, when applied, theoretical coding conceptualises analysis towards theory generation (Charmaz, 2014). Glaser (1978) has created coding families which can be used to undertake theoretical coding. Alternatively, researchers can use a theoretical framework arising out of the literature (Charmaz, 2014), which is what I did.

I undertook theoretical coding after I had both constructed my core category "working with or against the system" *and* completed the situational analysis; I used theoretical coding to unify both phases of the study. My rationale for this novel approach is discussed later in this chapter.

Phase B: Situational Analysis

This short section describes the SA methods used in Phase B of this thesis project. It includes a brief overview of SA, reiterating its usefulness in answering research question two and meeting the study aims. Next, it provides an explanation of what the situation is. I provide a thorough description of SA in the following chapter in Papers 4 and 5 and at the end of this chapter in Paper 2.

SA progresses CGT further around the interpretive turn by redirecting the analysis of the basic social process to an analysis of social environments. Thus, in SA, the root metaphor is ecological and not processual (Clarke et al., 2018, p. 15). In this doctoral study, it provided a mechanism to report the multilevel complexities that influence the process through which nurses and midwives provide abortion care to people victimised by GBV. The unit of analysis for SA is the broader situation of enquiry with the analysis centring on social domains which incorporate human and nonhuman elements (Clarke et al., 2018). These broader domains, fundamentally implicated in the way that nurses and midwives provide abortion care to people victimised by GBV, were not fully captured in the CGT analysis.

SA is underpinned by Straussian Grounded Theory (Clarke & Star, 2008; Strauss, 1978) and extends the analysis by using different tools to analyse the data (Clarke, 2012).

Like Straussian Grounded Theory, SA is a “theory/methods package” (Clarke et al., 2018, p. 24) underpinned by the epistemological and ontological assumptions and practices of American pragmatism philosophy and symbolic interactionism (Blumer, 1969; Dewey, 1938; Mead et al., 1938). Clarke et al. (2018, p. 25) assert that this combination pushes SA around the postmodern, post-structural and interpretive turns. First, it does so by using the Meadian approaches of “entering the perspectives of others” (Mead, 1932 in Clarke et al. 2018, p. 26) as well as the shared meaning of the material world. In doing so SA both accepts and emphasises the multiple and simultaneous interpretations of a situation and analysis is directed at understanding variation within a situation (Clarke, 2018). Along this same line, SA is oriented towards action and the analysis of processes and negotiations which aid the representation of variation, instability, and contingency (Clarke et al., 2018 p. 32). Like CGT, SA employs abductive reasoning, tacking backwards and forwards between the empirical data and conceptual analysis, so that theory generation is grounded in the realities of research participants (Clarke, 2018). Finally, SA is concerned with social ecologies or “worlds” (Clarke et al., 2018).

Social words theory is central to Straussian GT and contends that society is a layered mosaic of groups of varying sizes which generate lives of their own. Each social world has shared perspectives that contribute to identity construction and commitments to certain actions. Social worlds interact with and against each other and other social worlds in arenas (Strauss, 1978). SA extends social worlds theory by incorporating discourse analysis (Foucault, 1972) which analyses the role of power, self-restraint and the silencing of other perspectives through dialogue. SA also integrates actor-network theory (Haraway, 1991) which analyses the agency of non-human actants in a situation. Finally, SA extends social world theory by combining it with rhizomes and assemblages (Deleuze & Guattari, 1987) which relates to a map that is constructed between human and non-human elements, that can detach, reverse, modify and have multiple entry and exit points. These theoretical additions provide the utility in analysing the broader situational context of phenomena. Clarke et al. (2018) purport that SA manages complexity, unearths hidden or absent

positions, and pursues the analysis of power, a fundamental concept within abortion and GBV.

According to Clarke et al. (2018), the “situation” encompasses all the elements that are part of what is known in anthropology as “the field” or what we would colloquially call “the big picture”. This includes the human, nonhuman, and discursive elements, as well as collectives with shared commitments within and between collectives, and finally the positions taken, variations and differences and areas of controversy (Clarke, 2003; Clarke, 2016; Clarke et al., 2018). In this study, for example, this may relate to the positions taken around domestic violence, rape, and abortion.

SA was well-suited to answering the research question:

- How does the broader health care situation affect the way in which Australian nurses and midwives provide abortion care to people victimised by GBV?

Phase B addressed the following research aim:

- To explore how the elements of the broader situation affect the provision of abortion care to people victimised by DV or SXA.

Analysis

SA uses a cartographic approach to analysis (Clarke et al., 2016). Three maps (situational/relational, social worlds/arenas and positional) were charted throughout Phase B, not to form the final analysis per se, but to open the data up to new ways of thinking about it (Clarke, 2003). Examples of maps can be found in Chapter 4, as well as Papers 4 and 5.

Situational Analysis

The major elements in the situation (human, non-human, material, symbolic and discursive) identified in the scoping literature review and participant interview transcripts from Phase A, as well as my own knowledge (Clarke et al., 2018, p. 128) were jotted on a blank piece of paper (see Paper 4). This became the messy/working initial situational map. Also, the researcher (and supervisors) were plotted on the map so as to signify that the

researchers (and their socially constructed realities) became *part* of the research (Clarke et al., 2018). Memos were recorded on why each element was plotted, and elements that may be taken for granted in the situation (Clarke et al., 2018).

Relational analytics occurred after I constructed a basic messy situational map. Each element plotted on the messy map was systematically considered in relation to each other social process element on the map. I made analytical memos on the nature of the relationships between the elements (Clarke et al., 2018). The situational map, its categories and relational analytics were expanded through abductive reasoning, and theoretical sampling during interviews. This stage was complete once no new elements emerged in the interviews (Clarke, 2003).

Next, the messy maps were transformed into ordered abstract situational maps in which the data from the messy maps were categorised. This step is intended to force the researcher to think more systematically about the data and to examine the data more thoroughly (Clarke et al., 2018). Once again, I completed memos detailing new insights, and shifts in direction. Please refer to Paper 4 for the ordered situational map.

At this juncture, I pause to underscore the complexity of conducting simultaneous multiple method qualitative studies where both methods use abductive reasoning on the same data source (i.e. interviews). Morse and Niehaus' (2009) perspective on mixed and multiple method designs is that research methods should be conducted separately, in parallel until the point of interface so that questions, data and analysis do not merge. In conducting this study, I learnt that separate and parallel analysis is achievable when data collection precedes analysis, but not where collection and analysis are abductive. In retrospect I should have reconsidered the candidature examiner's advice to conduct the methods simultaneously. No doubt the examiner made this recommendation as Clarke et al. explicitly state that "these two methods (CGT and SA) may be used together as desired" (2018, p. 351). It was not until I was into the thick of situational mapping that I found the direction from Clarke et al. (2018) that "these (CGT and SA) are two different kinds of

analysis pursued separately. They are to be done one at a time, not blended together" (p. 109).

The truth is, I began conducting SA and CGT together but found it too cognitively demanding to separate them during relational mapping. Therefore, I completed the CGT phase before I moved on with the mapping analytics. In writing this methodology section, I have wondered if this period of data and analytical merger could have affected the direction of the findings. It is possible that plotting the elements of the situation (the first step of situational mapping) might have provoked new insights that I then could have pursued through interviews. However, the CGT act of theoretical sampling (i.e. following up on leads and dropping them when they lead to dead ends) probably prevented me from straying too far off course.

Social worlds/arenas analysis

Next, the major collectives, commitments, relations, and sites of action were charted on a new map. This map presented all the major groups, organisations, institutions, and other key collective actors and actants implicated in the abortion arena. The analytic focus of this phase was the relationships and ways in which key collective actors work together (Clarke et al., 2018, p. 150). This level of analysis assisted in situating the basic social process, analysed in Phase A, more broadly. Over many iterations, I reviewed interview transcripts, noted examples of collective action (i.e. possible evidence of social world activity) and plotted (and replotted) these as prospective social worlds and segments in the abortion arena. I gathered further data from participants and pre-produced sources to help chart each world's natural and contested borders and wrote memos about my decisions and findings. I used Clarke et al.'s (2018) social worlds/arenas theory conceptual toolbox and analytical questions to assist in analysing and writing focussed memos about the important worlds which presented themselves in the data (see Paper 5).

Then, quotes illustrating collective action for each social world or segment were added to a table and analysed using line-by-line and higher-order coding (Charmaz, 2014). I

wrote memos and drew analytic diagrams about the meaning of the codes, comparisons between codes, my analytical decisions, and my insights about the data. Finally, codes and diagrams were compared, using constant comparative analysis, focussed, then abstracted to categories.

Due to the post-structural positioning of Situational Analysis, the social worlds/arena map is complex; I identified 32 social worlds, and 12 segments (subparts of social worlds committed to different aspects of that world's work) which I rationalised into 10 zones of interaction, defined mainly by geographical location and politics (Figure 2).

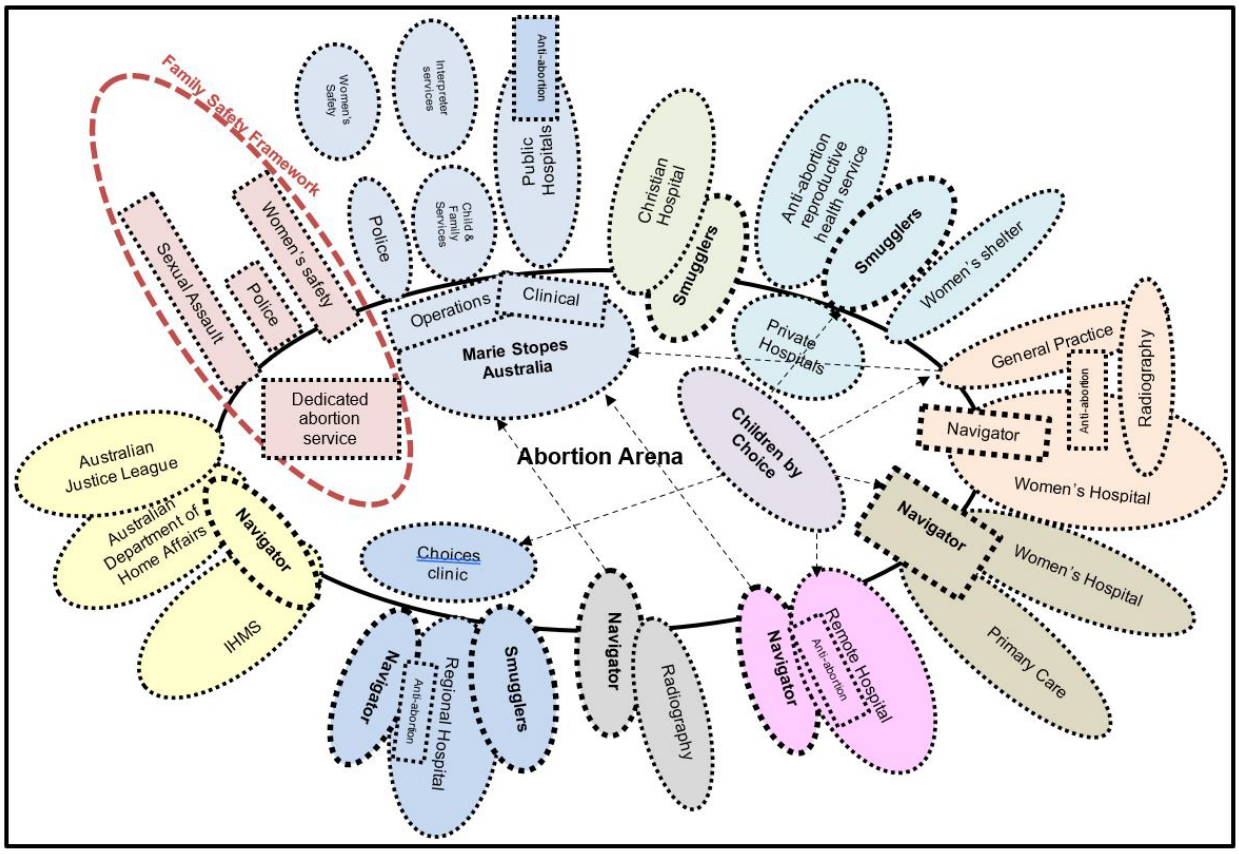


Figure 2: The Australian abortion arena

My aim was to situate the participants' basic social process, *working with or against the system*, within their broader worlds' actions and processes. Therefore, I used CGT coding to analyse collective actions (Clarke et al., 2018) within the 10 zones of interaction. The CGT process of constant comparison then assisted me to abstract four world "types" in which *working with or against the system* occurred. I named these "Smuggler", "Navigator",

"Marie Stopes Australia", and "Family Safety" worlds. Please refer to Paper 5 for the ordered situational map.

Positional analysis

The final analysis I conducted was positional mapping. Positional maps are a post-structural device which allow the researcher to see the heterogeneity of the situation and situated positions (Clarke et al., 2018). They allow the researcher to analyse the major positions taken on issues in the situation without associating them with a particular person or groups (because individuals can take multiple positions on a single topic). Positional mapping explicitly engages with the discursive elements in the situation. In this study, for example, it included positions taken regarding time, domestic violence and transgressing. From data gathered through interviews, I considered the basic issues in providing abortion care to people victimised by GBV. I then identified the core of the debate where there were different points of few. For each core debate, the two major axes of the argument were created into a graph (with an x and y axis). The positions taken (and not taken) in the debate were plotted on the graph.

Positional mapping remains close to the data with only positions, which are explicitly manifest in the data, being mapped. I produced analytic memos after each positional map was constructed about the positions explicitly articulated in the discourse, but also the positions that I suspected existed but that I could not locate. As positional maps only handle one core debate at a time, multiple positional maps were required. However, I did not intensively pursue positional analysis. While I include my positional maps in Appendix C, their analysis does not feature in this thesis. Claiming to use SA requires researchers to complete situational/relational, social worlds and positional mapping. However, as "arbitrators of what merits writing up" (Clarke et al., 2018, p. 430), I felt the analytical insights that positional mapping offered to the scope of this thesis study were already covered in Papers 4 and 5. During the write-up of this doctoral thesis, I had an insightful conversation with an industry expert about the abortion access versus abortion equity dilemma; the

prevailing social narrative seems to focus on access rather than equity. In the future I would like to use positional mapping to plot the participants' views on access and equity and compare it with the broader social narrative.

Point of interface between Phase A and Phase B

Phase A and Phase B are complete methods and can stand alone. However, together they depicted a process of nursing and midwifery agency within an oppressive health care ecology. I used theoretical coding to connect the theoretical categories of the greater thesis project to Essex's conceptualisation of *Resistance in Health and Healthcare* (2021). In doing so, I tell a unifying and cohesive story about the process of providing abortion care to people affected by GBV and elements of the broader Australian health care situation that affect it. This approach to theoretical coding is novel; Clarke et al. (2018) do not explicitly discuss its use in SA, and there is no direction on how to use theoretical coding in joint GCT and SA projects.

I justify the use of theoretical coding to unite the findings of this thesis study because SA (which used many CGT analytical devices) offered a deeper contextual understanding of the basic social process, *working with or against the system*; I felt it earnt its place into the relational framework (Hernandez, 2009). Thus, the theoretical coding process is detailed in Paper 6 in the Discussion Chapter.

Paper 2: Using intersectionality to increase the social justice reach of constructivist grounded theory: A worked example

Synopsis

Paper 2 reports on the methodological approach I used to explore Australian nurses and midwives' experiences when providing abortion care to people victimised by GBV. It emphasises an intersectional multi-level analysis that links the participants' experiences to the broader healthcare, religious and political structures to reveal how power relations are shaped and experienced. I describe how I used intersectionality as a sensitising concept which alerted me to processes of health care resistance within oppressive health systems.

Declaration of co-authorship and co-contribution

Using intersectionality to increase the social justice reach of constructivist grounded theory: A worked example

Mainey, L., O'Mullan, C., & Reid-Searl, K. (under review). Using intersectionality to increase the social justice reach of constructivist grounded theory: A worked example. *Australian Journal of Advanced Nursing*.

Nature of candidate's contribution, including percentage of total

In conducting the study, I was responsible for conceptualisation, methodology, analysis, writing and administration. This publication was written by me, and my contribution was 80%.

Nature of co-authors' contributions, including percentage of total

My co-author Catherine O'Mullan contributed to the paper by reviewing and supervising (10%). My co-author Kerry Reid-Searl contributed to the paper by reviewing and supervising (10%).

Using intersectionality to increase the social justice reach of constructivist grounded theory: A worked example

Abstract

Objective: Nursing and midwifery researchers who study issues that arise from inequity should not overlook the oppressive structures that marginalise and oppress patients and clinicians. However, this can present complexities that are difficult to address using conventional research methods.

Study Design and Methods: This paper evaluates our methodological design of joining constructivist grounded theory with situational analysis and intersectionality to study social justice topics. To demonstrate how we operationalised this novel research approach, we draw on examples from our study, which explored the experiences of Australian nurses and midwives who provide abortion care to people victimised by gender-based violence.

Results: Combining constructivist grounded theory, situational analysis, and intersectionality sensitised researchers to processes of health care resistance within oppressive systems. This methodological approach compelled us to apply reflexivity diligently, exposed the complexity of the research topic from multiple angles, and drew attention to health care injustice and a process of resistance within the broader healthcare situation.

Conclusion: Our methodological paper responds to the call to researchers who use social justice perspectives to use inquisitive approaches that draw out new discourses or analyse old discourses in new ways and examine peoples' experiences in the context of power structures and systems.

Keywords: intersectionality; social justice; constructivist grounded theory; situational analysis.

What is already known about the topic?

- Health inequities are unjust differences in health systems, rooted in discrimination, and commonly experienced by marginalised groups.

- Nursing and midwifery researchers routinely study clinical topics that arise from social and healthcare inequity. However, their research infrequently captures the influence and complexity of social or structural inequality on these topics.
- Social justice is a shared value at the centre of nursing and midwifery; however, it is not cultivated in education, research, or clinical practice.
- Joining intersectionality with constructivist grounded theory may present a novel yet congruent design to research inequality.

What this paper adds:

- Using intersectionality in nursing and midwifery research offers a dramatically different analysis of the power of marginalised social and professional groups.
- CGT researchers should use caution if imposing an intersectional "framework" upon emergent studies.
- Combining situational analysis with constructivist grounded theory and intersectional analytical tools is methodologically congruent and extends the analytical range of the research approach.
- Situational analysis extends the constructivist grounded theory/intersectionality approach, directly attending to social and structural power as well as the variability and diversity of participants' stances, attitudes, and positions.
- As a sensitising concept and heuristic device, intersectionality may assist CGT and SA researchers to theorise a process of resistance within systems and arenas of oppression.

Background

The social and cultural determinants of health are complex matrices that demonstrate how the conditions into which we are born, grow, live, socially and culturally connect, work, and age produce health and well-being disparities (Leonie Williamson et al., 2020; World Health Organization, 2008). Intersectionality offers a metaphor to develop a critical understanding of the social and cultural determinants. In its simplest terms, intersectionality is a heuristic device that can help examine how our multiple social identities (e.g. race, sexuality, migrant status, geography, religion) interact at the level of personal experience and within larger structures and systems of privilege and oppression (e.g. racism, sexism, nationalism, fundamentalism) (Bowleg, 2012; Hankivsky, 2014). Individuals and groups marginalised by intersectionality commonly experience the vicious cycle of health inequity, which is unjust and reductionist treatment perpetuated by health systems and rooted in discrimination (Damaskos et al., 2018; Hosseinzadegan et al., 2021). This cycle further amplifies oppression and poor health outcomes (Rai et al., 2020).

Social justice in healthcare is the attempt to rectify health inequities by distributing health resources fairly, irrespective of people's social identities; social justice focusses on partnership, protection, and participation of marginalised people (Robert Wood Johnson Foundation Initiative on the Future of Nursing, 2010, as cited in Hosseinzadegan et al., 2021; Mitchell et al., 2019). While nurses and midwives have an inglorious history of practising social justice, especially against First Nations people (Lovett & Brinckley, 2021; Walter, 2017), it is now an assumed central value of our professions (Walter, 2017). Nurses and midwives who provide direct patient care, or research health topics, often witness the catastrophic consequences that arise from health inequity (Small, 2019), such as inadequate primary care, removal from country and culture, and the deterioration of health and well-being (Conway et al., 2018). However, despite being compelled to practice social justice and perfectly positioned to be authorities on social justice, many clinicians and researchers seemingly fail to understand or address it (Hosseinzadegan et al., 2021; Walter, 2017). We

question the impact of oppression and marginalisation that nurses and midwives experience within the health system on their ability to promote social justice (Hosseinzadegan et al., 2021; Small, 2019).

In a summons to position nurses and midwives as champions of social justice, professional leaders have called on us to turn a critical eye towards structural power (Hosseinzadegan et al., 2021; Mitchell et al., 2019), seize the emotive power of patient stories to highlight health inequity (James et al., 2021), and incorporate social justice into the nursing curriculum (Hosseinzadegan et al., 2021). Likewise, researchers who study social justice health topics are encouraged to reconceptualise study designs to draw out new discourses, analyse old discourses in new ways, and examine peoples' experiences in the context of power structures and systems (Denzin & Lincoln, 2011; Hankivsky, 2014). Intersectionality provides researchers with such an analytic opportunity (Bowleg, 2012; Kassam et al., 2020; Lane, 2020; Rogers & Kelly, 2011).

To attend to the multifaceted complexities faced by marginalised people, some constructivist grounded theory (CGT) researchers, such as Kassam et al. (2020), Baird (2021) and Lindgren et al. (2017), have built on the methodology's feminist, postcolonial and anti-racism influences (Clarke, 2009) by combining it with intersectionality. As a point of difference to the published work of these authors, in this article we specifically address how to extend the social justice reach of CGT by combining it with situational analysis (SA), an extension of CGT, and intersectionality.

We have three aims for this article. First, to advance the nascent application of CGT with intersectionality by introducing new developments supporting CGT as a critical inquiry method for social justice research. Next, to present the philosophical and theoretical congruency of SA with intersectionality. Finally, to draw on examples from our recent study exploring the experiences of Australian nurses and midwives who provide abortion care to people victimised by gender-based violence (GBV) to demonstrate how we operationalised our research approach. Through our conceptualisation and demonstration, we highlight to

nursing and midwifery researchers and those from further afield, analytical devices to study the multifaceted complexities that drive health inequity.

Situating our research within broader social structures

The lead author (LM), an abortion nurse and doctoral student, set out to research abortion and GBV – taboo topics often veiled in secrecy, inherently related to power, and shaped through identity politics. Specifically, she sought to explain how nurses and midwives provide abortion care to people victimised by GBV and understand the broader situational factors that impact care. LM's positioning as a feminist, nurse and abortion care provider attuned her to power issues. From the outset of her research journey, she encountered narratives about abortion, nursing and midwifery that exposed the unchecked power within the academic community. Knowledge gatekeepers, such as librarians and GBV scholars, advised that abortion was not a significant issue. In reality, one in four Australian women will have an abortion in their lifetime (Scheil et al., 2016). These relatively high rates of abortion likely emerge from intersecting forms of oppression. For example, women in Australia who have elective abortions are three times more likely to be affected by GBV than those who do not end a pregnancy electively (Taft & Watson, 2007). In countries with more liberal reproductive health policies, easier abortion access and robust welfare systems, rates are half that of Australia's (Children by Choice, 2017).

In the academic literature on abortion and GBV, we found that the conceptualisation of “abortion care” was usually reduced to the abortion procedure itself, limiting the analysis to a thin slice of data. Therefore, we adopted a comprehensive definition of abortion care – delivered across a continuum from the diagnosis of pregnancy through to aftercare (Turner & Huber, 2013) – to reflect the diverse perspectives of nurses and midwives across the Australian healthcare sector. This provided an opportunity to inspect a broad arena of abortion care.

We also received advice that threatened to diminish nurses' and midwives' roles within the broader fields of GBV and abortion scholarship. Well-intentioned scholars

encouraged us to focus on GBV screening and referral within abortion care. We felt this reduced the highly contingent nature of nursing and midwifery work to a set of clinical tasks, threatened to suppress the agency and autonomy of nurses and midwives, and overshadowed the broader implications GBV could have for abortion care. Outsiders also conflated our work with the biomedical model, not understanding that nursing and midwifery practice is underpinned by different philosophies of care that emphasise person-centredness and social justice (International Confederation of Midwives, 2014; International Council of Nurses, 2012). These insights assisted LM to distill her axiological position – disrupting the prevailing narratives regarding abortion, nursing and midwifery care and legitimising and liberating nursing and midwifery knowledge. These objectives pointed her in an ideological direction towards third-wave feminism.

Third-wave feminism combines the second-wave postmodernism paradigm and the lens of intersectionality (Price, 2017). Together they oblige researchers to challenge hegemonic constructions of people and groups by bringing the “others” into the research process, empowering oppressed groups (Evans et al., 2014), taking a multi-axis approach towards identity and using methods that examine power structures and politics – including one's own power over the research process (Price, 2017). Within the smorgasbord of qualitative methodologies, we selected CGT to carry out our research project because it is well suited to questions of social justice (Charmaz, 2014, 2020) and is well used within nursing and midwifery (Higginbottom & Lauridsen, 2014).

While *intersectionality* is used as a metaphor to analyse the interaction of multiple social identities within larger structures and systems of privilege and oppression, the metaphor of *social processes* is used in CGT to explain connections between individuals and social structures, events and situations, and meanings and action (Charmaz, 2020). CGT is an emergent qualitative research design, meaning that it is inductive, indeterminate and open-ended and rejects notions of objectivity, reductionism, and predictability (Charmaz, 2008). CGT analyses are always located in time and the social context, fallible and provisional and subject to revision in the light of new data and analysis (Charmaz, 2017,

2020; Charmaz & Thornberg, 2021). Furthermore, CGT critically examines researcher positionality and accepts that they co-create data and analysis alongside participants (Charmaz, 2009, 2014; Higginbottom & Lauridsen, 2014; Nagel et al., 2015)

In SA, the root metaphor is *ecology* (Clarke et al., 2018, p. 15), and the unit of analysis is the broader situation of enquiry, centring on social domains that incorporate human and non-human elements (Clarke et al., 2018). Within our research project, SA provided a mechanism to analyse the social and structural complexities implicated in how nurses and midwives provide abortion care to people victimised by GBV. These complexities were not fully teased-out within the intersectional rendering of CGT alone.

We begin this paper by discussing CGT and SA's use in social justice research, exploring its use as critical inquiry methods. We then present intersectionality's genealogy, explore its congruence with CGT and argue for its considered application in nursing research. Finally, we review the limitations of combining intersectionality with emergent research methodologies to develop our approach further.

Grounded theory and social justice research

CGT is a second-generation, grounded theory (GT) methodology, influenced by feminism, postcolonial theory, anti-racism and other social formations (Clarke, 2009). In recent years Charmaz has claimed CGT as a critical inquiry method and offered it as an alternative approach to researching social justice issues (Charmaz, 2014, 2020). Unlike early positivist social justice research (Stage & Wells, 2014), critical inquiry takes a values stance towards issues such as fairness and equity and critiques social conditions such as poverty and privilege and systems of oppression (Charmaz, 2020). Critical inquiry requires that researchers deliberate on realities and ideals, comparing what is with what should be (https://www.springer.com/journal/11211). For example, in our research project, we took a reproductive justice stance towards abortion care and a gender equality stance towards GBV.

Generally speaking, the role of grounded theory is to explain a social process that unfolds over time, with clear beginnings, endings and points in-between (Charmaz, 2014; Morse et al., 2021). And explaining processes that arise from privilege and oppression can push critical inquiry and the research in new directions (Charmaz, 2017). This is because in CGT, to explain the process, researchers must connect external inputs from systems, groups or individuals with meanings and actions. These connections are often hidden from others, including the research participants (Charmaz, 2009, 2020). Figure 3 presents the basic social process that we constructed through our analysis. In this process, we connected external attitudes, practices, and complex pathways (inputs) with participants' feelings of being backed into a corner (meaning) and doing the wrong thing for the right reason (action). While nurses and midwives who read this article may recognise the process, almost nothing is written on it in the broader literature.

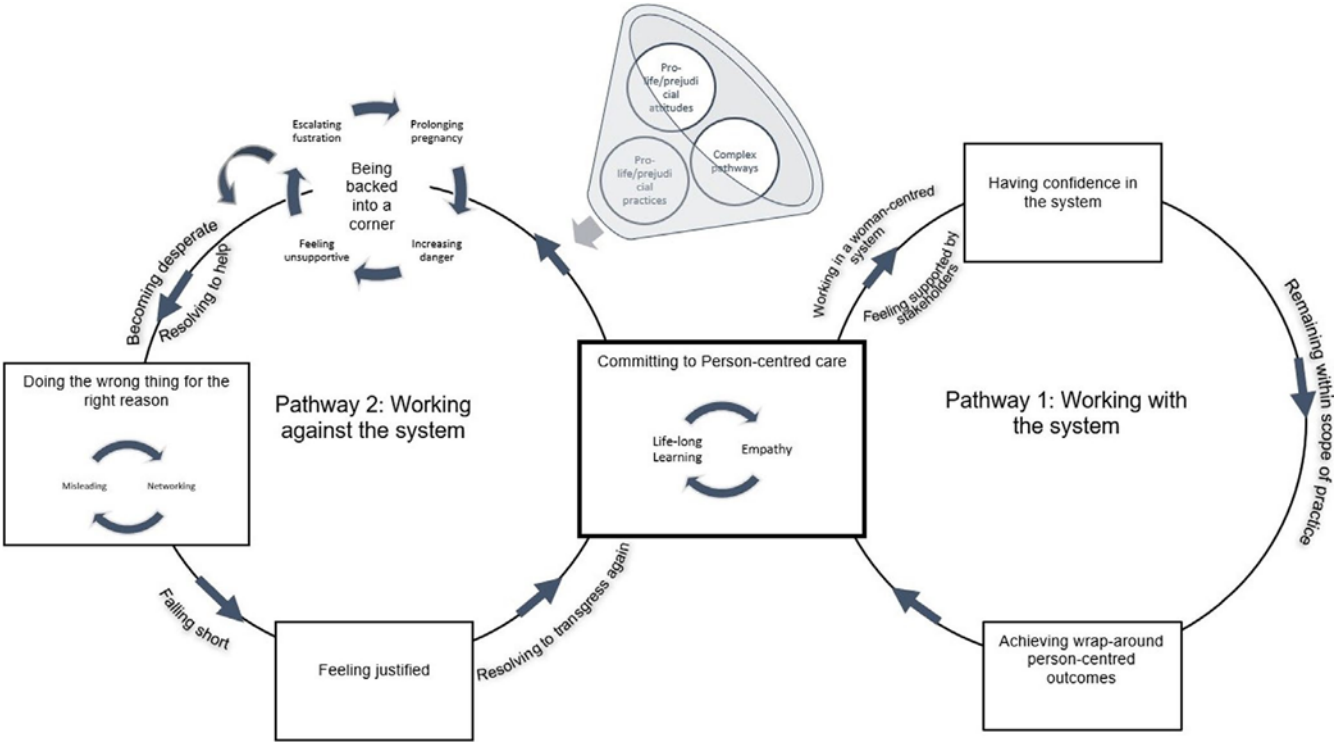


Figure 3: Working with or against the system

Unlike other forms of qualitative research, which are theory led, GT is data led. This means the data – people's perspectives – drive the selection of an appropriate theoretical framework at the end of the research project, not the other way around (Charmaz, 2020). In

other words, theory is *grounded* in the practical problems of the world. By avoiding the impost of a theoretical framework, researchers can understand what really matters to their research participants and change their research direction in the face of this information (Charmaz, 2014, 2020). For example, in the early stages of our research project, in response to the experiences of a participant we changed the direction of questioning to focus on transgressive actions of participants which led us to construct the core category "working with or against the system". Then we searched the healthcare literature for a framework that provided a theoretical explanation for the core category and found "resistance in health and healthcare" (Essex, 2021). The sequencing of theory construction is an important consideration for GT research when combining it with other theories or frameworks, such as intersectionality, and will be discussed in more detail later in this paper.

Strauss and Corbin (1990) paved the way for second-generation GT by moving away from its objectivist roots (Glaser et al., 1967) – criticised for focussing on narrow topics and treating them separately from their contexts (Charmaz, 2020) – and situating GT within American Pragmatism (Bryant, 2009; Charmaz, 2014), and later relativist pragmatism and constructivism (Rieger, 2019). This ongoing ontological shift opened GT analyses to the tenants of Dewey and Mead, who emphasised the importance of studying the empirical problems of everyday life (Morse et al., 2021) and accepted multiple and fluid views on reality, conditionality and reflexivity. This took classic GT's explanation of "what is happening" to address "why is it happening" and "what else could be happening" (Bryant, 2009; Charmaz, 2009). Pragmatism also moved GT's research findings (i.e., the truth or reality) away from being scientific and separate, to what works in the real world (Morse et al., 2021).

We can see Strauss and Corbin's uptake of pragmatism in many ways other ways. First, they embrace Dewey's concept of inquiry; a dual process of reflecting first on the nature of a problem (i.e., what are the inquirer's belief about the problem) and then on the consequences of a course of action to address the problem (Dewey, 1933,1938 in Morgan, 2020). This line of inquiry creates a cycle in which beliefs lead to actions, then

consequences then reviewed beliefs and so on. This cycle is seen within Straussian GT in the use of sensitising concepts (using prior beliefs as starting points to the research) and alternation between data collection and analysis (Morgan, 2020). Next, Straussian GT uses abduction which is a form of reasoning that involves tacking backwards and forwards between the data and analytical conceptualisation (and member checking). Using abduction, the researcher generates hypotheses from flashes of insight (which arise from their own belief system) that account for observations (Clarke, 2014; Morgan, 2020). In taking this pragmatic stance Straus and Corbin eschewed the idea of researcher objectivity and placed the researcher, and their prior beliefs, central to the research process (Morgan, 2020).

Strauss and Corbin also drew heavily upon Herbert Blumer's (1969) symbolic interactionism in their adaptation of GT, which carried over into CGT (Charmaz, 2014). Derived from pragmatism, symbolic interactionism assumes that reality is constructed through actions, socially interpreted through language and symbols and the lens of time (Charmaz, 2014; Schwalbe, 2020). Strauss and Corbin's approach located people, their actions and interactions in larger social structures, increased understanding of how structures work and invited alternative interpretations (Charmaz, 2020). Accordingly, it offered a theoretical explanation concerning social injustice and the conditions under which it develops, transforms or continues (Charmaz, 2014).

While Strauss and Corbin progressed slowly towards constructivism (Rieger, 2019), Charmaz unequivocally situated her rendering of GT within it (Birks & Mills, 2015; Clarke, 2005). In doing so she fully embraced a relativist and subjective epistemology and took the standpoint that conducting research was a non-neutral act (Charmaz, 2014). Consequently, people who use the CGT methodology undertake “strong reflexivity” and “methodological self-consciousness” to analyse how structural conditions and social positions affect their research work and practice, prompting them to scrutinise their moral commitments and responsibilities (Charmaz, 2009, 2017, 2020). LM used social identity mapping (Jacobson & Mustafa, 2019) to unpack the intertwined layers of her social identity, distinguish elements of her identity important to the research and determine the impact of these elements on the

research (Table 1). She also asked her supervisors (CO and KRS) to complete a reflective piece on their positionalities in relation to the research project, which she reflected on when tensions arose over terminology such as “abortion” versus “termination of pregnancy”.

Reflexivity is intentional self-awareness which encompasses ongoing analysis of subjective responses, dynamics between researchers and research participants, and the research process (Finlay, 2002). Unlike reflection, which is distant and takes place after an event, reflexivity is more immediate and action-oriented (Finlay, 2002). In other words, when researchers are reflexive, they consider how their lived experiences influence their current understandings, decisions, and actions and then decide what action to take next; it is an ongoing cycle throughout the whole research process. For example, LM received feedback from a journal article reviewer, who advised her to draw out the struggling process within the basic social process. As an abortion advocate, most recently part of a pro-choice coalition that worked on an abortion law reform campaign, LM was wary of words like “struggle”, which anti-abortion groups use to promote conscientious objection. Moreover, she did not feel “struggle” had earnt its way into the analysis as a code. Therefore, she declined the reviewer's suggestion on moral responsibility and analytical grounds.

Finally, LM wrote memos to keep an audit trail when her experiences offered unique analytical insight. For example, Charmaz (2014, p. 43) encourages novice researchers who use CGT to look for unusual or surprising actions in the data and consider what strikes as most noteworthy, interesting and telling. From LM's experiences, she chose to follow two significant surprises through theoretical sampling; some participants had clear GBV policies and procedures that they followed, other participants knowingly broke the rules. However, we are confident that someone with different experiences may have found other data more noteworthy and surprising.

Charmaz's suspicion of qualitative research, which centres on individualism without unearthing structural, power and ideological arrangements that underscored the analysis, led her to create CGT (Charmaz, 2017). SA moves GT analysis even further away from the individual, focussing entirely on the situation. According to Clarke et al. (2018), the “situation”

is all the elements that are part of what is known in anthropology as “the field” or what we would colloquially call “the big picture”. This includes the human, non-human, and discursive elements, shared commitments within and between collectives, and finally, positions, variations, differences, and areas of controversy (Clarke, 2003; Clarke, 2016; Clarke et al., 2018).

SA is also a critical inquiry method and uses different tools for the explicit analysis of power relations, offering concepts like “implicated actors and actants” as well as relational analytics and maps to wrestle with overt and covert sources of power (Clarke, 2021; Clarke et al., 2018). These broader domains were not fully realised in our CGT analysis. For example, SA provided a mechanism to report the multilevel complexities of abortion and GBV care and provisionally conclude that the health care system was mostly “unfit for purpose”. SA also allowed us to map the groups that work with and against each other in the abortion arena (Figure 4), and then focus on the groups complicit in “working with or against the system”.

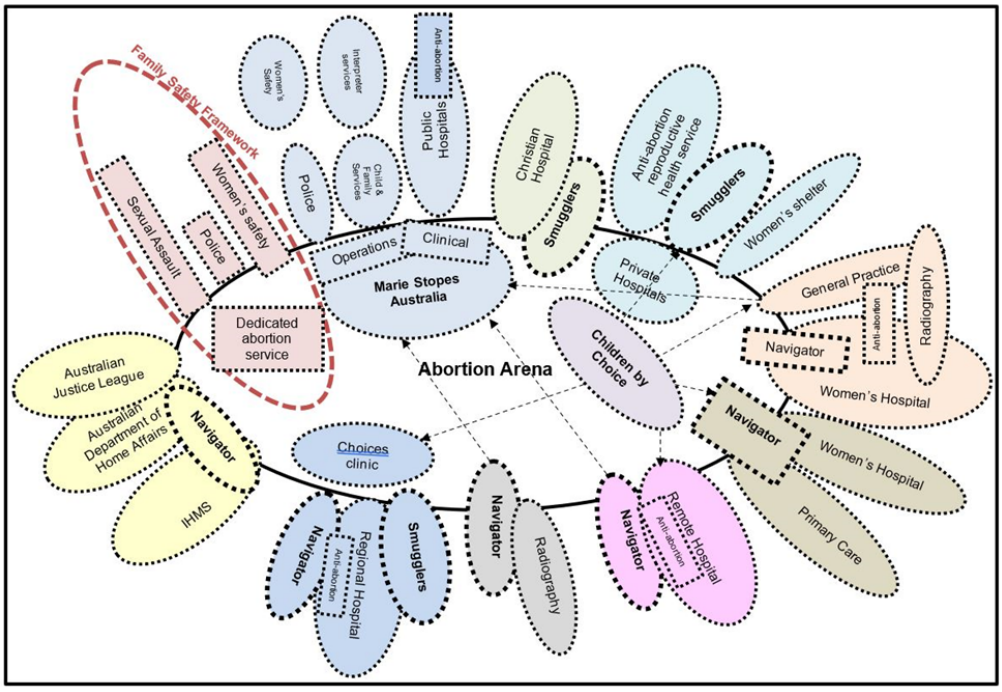


Figure 4: The Australian abortion arena

Like CGT, SA is underpinned by Strauss and Corbin's GT (Clarke & Star, 2008; Strauss, 1978), grounded in American Pragmatism and symbolic interactionism (Blumer,

1969; Dewey, 1938; Mead et al., 1938). However, SA also incorporates social words theory – also central to Strauss and Corbin's GT – which contends that society is a layered mosaic of groups of varying sizes that generate lives of their own. Each group (social world) has shared perspectives that contribute to identity construction and commitments to specific actions. Social worlds interact with and against each other and other social worlds in arenas (Strauss, 1978). In the case of our study, we identified the various social worlds that operated to various extents in the abortion arena (Figure 4).

SA extends social world theory by combining it with the metaphor of rhizomes and assemblages (Deleuze & Guattari, 1987), which relate to a map constructed between human and non-human elements that can detach and reverse modify and have multiple entry and exit points. It also integrates actor-network theory (Haraway, 1991) which analyses the agency of non-human actants in a situation. SA further extends social worlds theory by incorporating discourse analysis (Foucault, 1972) which analyses the role of power, self-restraint and the silencing of other perspectives through dialogue. These theoretical additions provide the utility in analysing the broader situational context of phenomena.

Intersectionality as social justice research

Intersectionality is a popular concept used by feminist scholars as a blanket metaphor to explain how women are simultaneously positioned within society (Phoenix & Pattynama, 2006). However, while intersectionality's take-up by feminism has provided it with international exposure, some of its renderings are accused of neutralising its critical edge (thus its potential for social-justice outcomes) and whitewashing its origins (Bilge, 2013) and consequently led to superficial application (Collins, 2019; Hankivsky & Jordan-Zachery, 2019). In this paper, we have drawn upon the work of Black feminist and social theorist Patricia Collins, her interpretation of intersectionality as critical social theory, and respond to her call to evolve intersectionality through the critical application with congruent methodologies (2019).

In simple terms, critical social theory combines critical inquiry and praxis (Collins & Bilge, 2020). It emerged from the Frankfurt School of social research and is conceptualised as both a tradition of thought (i.e. not a theory in the traditional sense) and an emancipatory process (Gannon & Davies, 2011). Critical social theory contends that systems, like health care, produce knowledge and narratives in ways that hide oppression. Therefore, oppressive outcomes such as health inequity manifest in complex ways as they distort and hide within contextually and culturally embedded practices of the system (Freeman & Vasconcelos, 2010). Critical social theory challenges knowledge that underpins everyday practice and reclaims knowledge and narratives of oppressed groups (Freeman & Vasconcelos, 2010; Gannon & Davies, 2011). Therefore, intersectionality as critical social theory provides CGT and SA with a political social justice edge.

In this paper we pay homage to and remain grounded in the Black and Indigenous roots of intersectionality, particularly racial formation theory (Collins, 2015). Racial formation theory (RFT) conceptualises race as situated within an ongoing relationship between separate yet interconnected social structures and cultural representations (Collins, 2015). Racial formations and racial projects are central concepts to RFT. Racial formations are accepted beliefs about racial groups based on power relations. An example from our study was the Australian Government's stance that people who travel to Australia by boat to seek asylum are criminals. Racial projects are actions taken toward or by racial groups. For example, the imprisonment of asylum seekers in offshore detention centres is a racial project performed by the Australian Government. Racial projects are championed and advanced by specific interpretive communities (e.g. governments and health communities), and those with greater power progress racial formations which advance particular racial projects (Collins, 2015). Thus, RFT shines a light on the epistemic power of elite communities (including the research community) over marginalised groups (Collins, 2019) and provides an intellectual and political space for marginalised groups to reveal collective knowledge and guide the *resistance* against racial inequality (Collins, 2015).

Intersectionality moves RFT beyond mono-categorical systems of racial inequality to multiple and complex systems inequality, organised and resisted through formations and projects (Collins, 2015). Figure 3 presents an example of intersectionality found within our research project.

Kassam et al. (2020) have previously demonstrated the theoretical congruence between intersectionality and CGT. Both share the tenants of reflexivity, complexity, variability and social justice (Kassam et al., 2020), which can be extended to SA. Like CGT and SA, intersectionality analyses power at the personal, group, and system levels. Congruence with intersectionality is particularly apparent with SA's social worlds/arenas analysis, where overlapping social worlds, like intersections, are spaces of contested power (Clarke et al., 2018; Collins, 2019).

Intersectionality offers exciting directions for nursing and GT scholars to reconceptualise power. First, intersectionality moves beyond CGT and SA's analysis of power by explicitly investigating how power and oppression at the personal, group and systems levels interlock. This complementary dimension draws out nuances of power, demonstrating how groups possess varying amounts of privilege and oppression within systems (Collins, 1990 in Thornton Dill & Kohlman, 2012). For example, nurses and midwives who conscientiously object to abortion may be oppressed by the gendered nature of their professions but privileged in health systems influenced by Christian values and narratives.

Second, as a critical social theory, intersectionality advances the emancipatory function (Leonardo, 2004) of CGT and SA and places it in the axes of critical analysis and social action (Kassam, 2021). Specifically, in our research project intersectionality enabled us to focus the analysis on hidden resistance against systems of oppression which in turn allowed us to criticise social inequality and injustice (Collins, 2019) – itself a form of social action. This approach offers a dramatically different analysis of health inequity, health care subordination, endurance and resistance. As evidenced in our study, intersectionality may assist CGT and SA researchers to theorise a process of resistance within systems and

arenas of oppression. This specific attention to resistance offers nursing and midwifery researchers and those who use CGT and SA a new lens through which to conceptualise nursing and midwifery work. Moreover, it provides resources for ongoing struggle for empowerment of our nursing and midwifery colleagues as well as people oppressed within health systems.

Finally, intersectionality as critical social theory is a theory-praxis package built from knowledge projects of oppressed people; it both analyses and becomes resistance (Collins, 2019). Conceptualising nurses and midwives as active agents in resistance disrupts the powerful epistemological frameworks that have shackled nurses and midwives to "oppressive versions of reality" (Gannon & Davies, 2011, p. 66) and perpetuated the narrative that they are apolitical and apathetic (Fackler et al., 2015; Rafferty, 2018). Nurses and midwives are regularly positioned at the crossroads of doing what is socially just, policy, and lawful; nursing and midwifery care are laden with resistance decisions and acts. Yet, these acts are largely unaccounted for in the literature (Essex, 2021). Intersectionality provides researchers with a way to undertake epistemological resistance and expose the various intersections in which nurses and midwives are positioned and the resistance projects they undertake.

Limitations

While intersectionality brings exciting emancipatory possibilities to CGT and SA, researchers must exercise methodological care when using them together. First and foremost, GT and SA are emergent research methods; GT specifically avoids influence from outside factors such as theories, frameworks and discourses (Birks & Mills, 2015; Charmaz, 2006). The use of intersectionality, even as a lens, let alone a framework, may inflame unresolved tensions about what constitutes as forcing data collection. The danger in employing theories or frameworks, like intersectionality, in GT and SA research is that everything – from data collection to writing up of findings – is advanced in a particular

direction. Accordingly, important issues to the research problem can be overlooked (Charmaz, 2020; Clarke et al., 2018).

We contend that the best way to use intersectionality with CGT and SA is as a sensitising concept. Sensitising concepts are broad ideas that provide initial, tentative thoughts about research topics (Blumer, 1969, as cited in Charmaz, 2014) and are used in GT as tentative tools for developing ideas about processes emerging from the data (Charmaz, 2014). Sensitising concepts must earn their way into the emergent analysis and be disregarded if they cannot. Thus, intersectionality can guide research, but it should not hijack it.

Researchers must also exercise caution when employing intersectionality with CGT and SA so as not to overextend the findings. Critical social theory does not subscribe to relativism (Gannon & Davies, 2011). In other words, intersectionality is committed to finding truth which is the impetus for resistance action. However, in CGT and SA, findings are always tentative and must be disregarded in the face of new information. Therefore, researchers must scrutinise their moral commitments to intersectionality and responsibilities to CGT and SA when communicating their findings and recommendations.

Conclusion

Approaching nursing and midwifery research using CGT, SA, and a lens of intersectionality offers opportunities to advance the study of multifaceted power relations that drive health inequity. Moreover, this approach drives social justice research forward, uncovering processes of resistance within oppressive systems, and providing an avenue to criticise health inequity and injustice. Those who would like to undertake studies with similar designs should do so cautiously to ensure CGT and SA remain emergent methods and are not commandeered by intersectionality.

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CHAPTER 4: FINDINGS

Paper 3: Working with or against the system: Nurses' and midwives' process of providing abortion care in the context of gender-based violence in Australia

- **AIM 1** To explain the process through which Australian nurses and midwives provide abortion care to people affected by GBV.

Synopsis

In Paper 3 I report on a CGT study which aimed to explain the process through which Australian nurses and midwives provide abortion care to people affected by gender-based violence. Paper 3 extends upon Paper 2, by providing a deeper description of the application of CGT in this study. I explain that participants underwent a process I named working with or against the system contingent on the degree to which the system (the interconnected networks through which a pregnant person, victimised by trauma, travels) was woman centred. When participants encountered barriers to person-centred abortion care, they bent or broke the law, local policy, and cultural norms to facilitate timely holistic care. Though many participants felt professionally compromised, their resolve to continue working against the system continued. I have used the term "woman centred", rather than "person-centred" to match participants' words.

Declaration of co-authorship and co-contribution

Working with or against the system: Nurses' and midwives' process of providing abortion care in the context of gender-based violence in Australia

Mainey, L., Reid-Searl, K., & O'Mullan, C. (2022). Working with or against the system: Nurses' and midwives' process of providing abortion care in the context of gender-based violence in Australia. *Journal of Advanced Nursing*. 1–13. https://doi.org/10.1111/jan.15226

Nature of candidate's contribution, including percentage of total

In conducting the study, I was responsible for conceptualisation, methodology, analysis, writing and administration. This publication was written by me, and my contribution was 75%.

Nature of co-authors' contributions, including percentage of total

My co-author Catherine O'Mullan contributed to the paper by reviewing and supervising (10%). My co-author Kerry Reid-Searl contributed to the paper by reviewing and supervising (15%).

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ORIGINAL RESEARCH: EMPIRICAL RESEARCH - QUALITATIVE

Working with or against the system: Nurses' and midwives' process of providing abortion care in the context of gender-based violence in Australia

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Abstract

Aims: The aim of this study was to explain the process through which Australian nurses and midwives provide abortion care to people affected by gender-based vio- lence (GBV).

Design: A constructivist grounded theory study.

Methods: This study took place between 2019 and 2021. The lead author conducted semi-structured interviews with 18 Australian nurses and midwives who provided abortion care. Participants were recruited through pro-abortion, nursing and midwifery networks using a snowballing technique. Data collection and analysis proceeded using purposive and theoretical sampling until we reached data saturation.

Findings: Participants revealed they underwent a process of *working with or against the system* contingent on the degree to which the system (the interconnected networks through which a pregnant person, victimized by trauma, travels) was woman centred. When participants encountered barriers to person-centred abortion care, they bent or broke the law, local policy and cultural norms to facilitate timely holistic care. Though many participants felt professionally compromised, their resolve to con- tinue working against the system continued.

Conclusion: Conservative abortion law, policies and clinical mores did not prevent participants from providing abortion care. The professional obligation to provide person-centred care was a higher priority than following the official or unofficial rules of the organizations.

Impact: This study addresses the clinical care of people accessing abortions in the context of GBV. Nurses and midwives may act out against the law, organizational policies and norms if prevented from providing person-centred care. This research is relevant for any location that restricts abortion through stigma, pro-life influences or politics.

KEYWORDS
abortion, gender-based violence, midwifery, nursing, patient-centred care

1 | INTRODUC TION

The provision of quality abortion care is a key component of comprehensive reproductive healthcare. Abortion is a relatively common procedure in Australia; one quarter of Australian women will have an abortion in their lifetimes (Scheil et al., 2016). Australian women who have elective abortions are three times more likely to be affected by gender-based violence (GBV) than those who do not end a pregnancy electively (Taft & Watson, 2007). Nurses and midwives are intrinsically involved in the care of people seeking abortions in the context of GBV and are potentially well position to provide meaning support. Beyond the tasks of screening and referral, which is just one component of caring for victims of GBV, little is known about how nurses and midwives provide care. To investigate their process of care, we gathered data from 18 nurses and midwives across Australia with at least 12 months experience of providing abortion care. In this article, we present a constructivist grounded theory study on the process through which Australian nurses and midwives provide abortion care to people affected by GBV. The following discussion outlines the significant issues that were identified in process of providing abortion care. We conclude the paper with recommendations to address some of the issues identified.

1.1 | Background

Pregnant people who have experienced GBV are almost three times more likely to have an abortion (adjusted odds ratio 2.68; 95% confidence interval [CI], 2.34–3.06) than people who are not victimized by GBV (Pallitto et al., 2013). The term *gender-based violence* is applied to sexual, reproductive, physical, psychological or financial abuse of people who are targeted because of their gender. The function of GBV is to diminish the power and social status of the victim (McCloskey, 2016). An extensive body of literature highlights the association between GBV and abortion. Common reasons for accessing abortion in the context of GBV include childhood sexual abuse, most commonly date rape (Bleil et al., 2011; Silverman et al., 2004), forced sex by intimate partners (Messing et al., 2014) and reproductive coercion which involves the control, and sabotage of birth control and pressure to have an abortion (Miller & Silverman, 2010). A cross-sectional study of 2465 women recruited from health services across Boston, USA, reports that a small number of people (around one in 100) seek abortion in the context of rape; however, cumulative experiences of GBV increases the odds of abortion with nearly all women who report four or more GBV events (overall odds 1.388 [CI = 1.13–1.69], p = .0012) having had an abortion (McCloskey, 2016).

The long-term outcomes for people victimized by GBV are poor. GBV can influence health directly (e.g. injury or self-harm), or indirectly such as limiting a person's earning capacity, social connections and access to healthcare (Ayre et al., 2016). GBV also increases exposure to other risk factors such as smoking and drug and alcohol use. It is associated with poor mental health and perinatal outcomes, chronic diseases and sexually transmitted infections (Ayre et al., 2016; World Health Organization, 2021). Despite the need for sensitive and high-quality care, people who have experienced GBV are at risk of experiencing abuse in healthcare (Barber, 2007; García-Moreno et al., 2015; Swahnberg et al., 2004). The general loss of power experienced by victims of GBV increases their vulnerability in the healthcare setting, leaving them susceptible to staffs' oppressive practices (Brüggemann & Swahnberg, 2013). People who seek abortions in this context may incur further abuse in healthcare related to structural or enacted abortion stigma, designed to shame and restrict access (Biggs et al., 2020) which is compounded by intersecting oppression along race (Wilson & Waqanaviti, 2021), gender expression (Moseson et al., 2020), class (Wolfinger, 2017), disability (Victorian Women with Disabilities Network, 2007) and geographic lines (Doran & Hornibrook, 2014).

A contemporary scoping review of the literature demonstrates that nurses and midwives perform a range of roles across the spectrum of abortion care––from the diagnosis of unplanned/untimed pregnancies, through to post-abortion care and are essential to abortion access and service delivery (Mainey et al., 2020). Consequently, nurses and midwives who provide abortion care are in a strong position to provide meaningful support to people victimized by GBV. However, the process of providing care for people who have experienced GBV is yet to be well defined or understood. Various sources suggest care could include physical assessment, clinical care of injuries and symptoms (Du Mont et al., 2014); documentation of the history of abuse, injuries or symptoms (Du Mont et al., 2014; Sutherland et al., 2014) or screening/enquiry and referral to support or legal services (Ben Natan et al., 2012; Colarossi et al., 2010; Perry et al., 2015). It may also include counselling and validating the person's experience (Spangaro et al., 2010), or conducting risk assessments (Snider et al., 2009). To date, the emerging body of knowledge on the phenomenon is predominantly from single-site mixed method, surveys or content analysis studies from North America with a focus mandatory screening (Colarossi et al., 2010; Perry et al., 2016; Sutherland et al., 2014; Wiebe & Janssen, 2001), targeted screening (O'Doherty et al., 2015) and routine enquiry (Perry et al., 2016). The findings of these studies highlight the tension in the wider domestic violence and sexual assault field around these types of assessments and the preparedness of clinicians to respond to disclosures.

As a point of difference, our research extends the current knowledge beyond the clinical tasks of screening and referral as this is not the only time a nurse or midwife may provide meaningful care to a person affected by violence. We have adopted Ipas's comprehensive definition of abortion care which is care delivered across a continuum from the diagnosis of pregnancy through to aftercare (Ipas, 2013) and therefore offer the perspectives of nurses and midwives from diverse clinical backgrounds across the Australian healthcare sector. In contrast to the descriptive and exploratory studies outlined above, constructivist grounded theory enables us to explain the process of providing abortion care in the context of GBV from the perspectives of the research participants (Birks & Mills, 2015). We have

approached the research from a social justice perspective using an intersectional feminist lens with a focus on care delivered to people who are at high risk of falling through the cracks.

Over the last decade, abortion law reform has swept across Australia; as of 2021, abortion is no longer a crime. This is a significant victory for reproductive justice and paves the way for abortion services to transition from private clinics, which provide the majority of abortions (Australian Institute of Health and Wellfare [AIHW] et al., 2005), to local public hospitals and primary care centres. Decriminalization of abortion also presents an exciting opportunity to increase abortion access and create services that are safe for vulnerable people. Reorientation of abortion delivery in Australia will be significantly informed by research that documents the processes of providing nursing and midwifery abortion care to people affected by GBV. Progressing our understanding of the process through which Australian nurses and midwives provide abortion care to people affected by GBV is therefore vital if improvements are to be made in the quality of abortion service delivery in Australia.

2 | THE STUDY

2.1 | Aims

The aim of this study was to explain the process through which Australian nurses and midwives provide abortion care to people affected by GBV.

2.2 | Design

This paper reports on Phase A, a constructivist grounded theory (Charmaz, 2014) study, which formed part of a simultaneous, two-phased qualitative multiple-methods doctoral project. The constructivist grounded theory analysed process of nurses and midwives at the individual level, while situational analysis (Clarke et al., 2016) was used in Phase B to investigate the broader situational elements of the Australian healthcare environment that affect abortion care for victims of GBV. The findings of Phase B are reported elsewhere.

Due to the stigmatized nature of abortion and domestic violence, and its interconnectedness with other forms of oppression, we approached the larger research project with an intersectional feminist lens. Intersectional feminism originates from the experiences of Black and Indigenous women whose identities are shaped by multi-level forces such as racism and imperialism which drive complexity and influence inequality (Crenshaw, 1990). More recently it has been used to analyse how hidden power relations shape the health experiences of people on the margins (Kassam et al., 2020). This standpoint guided our research design including the selection of methods, recruitment and analytical decisions.

We chose the constructivist grounded theory approach for Phase A, over classic or Straussian grounded theory because we wanted a method that positioned the lead author inside the research process, 'co-constructing experience and meaning with the research participants' (Birks et al., 2019, p. 3). The lead author comes to this research with expertise and experience in the abortion field. She understands the context of providing abortion care to people impacted by GBV but acknowledges the subjectivity she brings. Constructivist grounded theory provided her the tools to engage with her subjectivity reflexively (Charmaz, 2014) through a self-interviewing, theoretical journaling, discussion and debate with her supervisors and other experts in the field.

2.3 | Participants

Abortion care occurs across a continuum, from the detection of the unplanned/untimed pregnancy, the abortion procedure itself, to post-abortion care––including attention to other healthcare needs (Ipas, 2013). Consequently, nurses and midwives provide abortion care in a variety of practice areas, and except where they work in specialist abortion clinics, it is just one of their overall responsibilities (Mainey et al., 2020). In keeping with intersectional feminism, we wanted to capture the complexity of abortion care in our study. Also, using a diverse range of competing clinical perspectives provides unique and rich information and brings value to research projects (Lee-Jen Wu et al., 2014). The inclusion criteria for this research were any Australian nurse (registered or enrolled) or midwife who had provided abortion care for at least 12 months with first-hand experiencing of providing care to people victimized by GBV.

Due to the taboo nature, stigma and criminality associated with abortion and GBV, we anticipated that access to the field would be difficult (Liamputtong, 2007; Sadler et al., 2010). To overcome this potential problem, two adapted snowballing frameworks, outlined by Sadler et al. (2010), which are considered useful in identifying hard-to-reach and hidden populations, were used to recruit participants. First, the community organization, Children by Choice (CbyC), a Queensland-wide abortion referral agency, assisted in the initial recruitment of participants by contacting its Australia-wide membership base through email and social media inviting them to (1) take part in the research project and (2) disseminate the invitation to their associates. Marie Stopes Australia, the largest provider of abortion in the country, also assisted by advertising the research to its employees. The second recruitment strategy was to approach formal leaders and influencers, who work in the broad context of abortion, to recruit participants through social media. The lead author contacted reproductive justice influencers through twitter to disseminate the research invitation to their followers.

Twenty-three people registered for the study. During 2020 the research project paused as the authors dealt with COVID-19. When we recommenced the study in early 2021, we were unable to contact five participants. The sample size was 18 participants, including a recorded self-interview by the lead author, which was sufficient to reach theoretical saturation. The self-interview was conducted at the beginning of the project for reflexivity purposes and integrated into the analysis to fully claim our role as co-constructors

of experience and meaning (Birks et al., 2019). After 12 interviews, clear motifs of transgression and underground networks emerged from the data. We were unable to discern any new information after 16 interviews. The lead author conducted two additional interviews to confirm data saturation.

Table 1 sets out primary demographic data and the clinical background of the participants. Most participants were Anglo-Australian females and came from a broad range of rural, remote and metropolitan areas and practice settings.

2.4 | Data collection

We developed a three-question semi-structured interview guide which allowed us to address the research question and enabled participants to present new ideas. In line with a constructivist grounded theory approach, we created additional research questions (questions 4–8) in response to new information introduced by the participants (Table 2). The lead author asked all participants the same initial questions. She asked further questions of subsequent participants (Charmaz, 2014).

The lead author, trained and practised in in-depth interviewing techniques, conducted one-on-one semi-structured interviews, using multiple interview modalities for the convenience of the participants. These included face-to-face (n = 2), via telephone (n = 5) and zoom (n = 9) and over email for ongoing scheduling conflicts (n = 1). With the addition of the self-interview, there were 18 interviews in total. Interviews conducted via zoom were recorded through zoom technology, all other interviews (excluding the email) were recorded by an audio recording device. The interviews lasted between 35 and 100 min and participants were not remunerated for their time. We obtained electronic or verbal consent from all participants and permission to be audio recorded. A transcription service transcribed the recordings ver- batim for analyses.

2.5 | Ethical considerations

CQUniversity Human Research Ethics Committee approved this project (HREC0000021264). Multiple ethical considerations are attached to this study. Abortion was a criminal offence in some Australia States during the interview phase, though it was always legal in the context of GBV. Nonetheless, not all clinicians understood this and felt discomfort disclosing their involvement in abortion care. Some participants were traumatized by their clinical

TABLE 1 Primary demographic data

Participant primary demographic data				
	Gender	Cultural background	Area of clinical practice	Practice setting
1	Female	Anglo Australian	Major Urban	Abortion Services
2	Female	Australian	Other Urban	Multipurpose Health Centre
3	Female	Australian	Major Urban/ Rural	Perioperative environment/ General Practice
4	Female	Australian	Rural	Multipurpose Health Centre
5	Female	Anglican	Other Urban	Perioperative Environment
6	Female	Not stated	Other Urban	Family Planning
7	Female	Not stated	Other Urban	Obstetrics/Gynaecology
8	Female	English/ Australian	Remote	Community Midwife
9	Female	Australian	Major Urban	Perioperative Environment
10	Female	Not stated	Multiple sites	Abortion Services
11	Female	British	Major Urban	Abortion Services
12	Female	Australian	Other Urban	Abortion Services
13	Female	Australian	Other Urban	Family Planning/Sexual Health
14	Female	Australian	Remote	Multipurpose Health Centre
15	Female	Caucasian/ Scottish	Major Urban	General Practice
16	Female	Scottish	Remote	Community midwife
17	Female	Not Stated	Major Urban	Obstetrics/Gynaecology
18	Female	Not Stated	Major Urban	Abortion Centre

experiences. While they were upset when they recounted their stories, they hoped their contribution could make a difference. They were provided with resources for psychological support, followed up by the lead author, and kept abreast of the project's progress. Some participants disclosed transgressive practices, including illegal activities. Their identities will remain confidential.

At different times, the research team supervisors have felt the burden of the clinicians' stories. We have debriefed after emotional interviews and have supported each other as we have read through transcripts and contemplated the gravity of the findings.

TABLE 2 Interview questions

Interview questions
1. Can you tell me about your experiences when you provide abortion care to people affected by domestic violence or sexual assault?
2. What promotes your ability to provide effective care in this context?
3. What interferes with your ability to provide effective care in this context?
4. How do you navigate ethical, legal and organizational boundaries associated with abortion, domestic violence or sexual assault?
5. How do you decide who to refer a pregnant person to?
6. What are the most stressful elements of this work for you, and what supports do you use?
7. When you are in a difficult ethical situation, what guides your actions?
8. Have you ever felt that your safety was in danger? If so, what did you do?

2.6 | Data analysis

The analytic team included a doctoral student (interviewer and lead author) and her two supervisors. The lead author reviewed the participant's transcripts closely, constructing initial, line-by-line and action-by-action codes. At the same time, she wrote memos and drew diagrams about the meaning of the codes, the constant comparative process comparing codes, actions and categories, her following decisions, and her insights about the data. We created additional interview questions based on the important and common codes (focussed codes) constructed from the analysis. We continued this process until we reached data saturation.

2.7 | Rigour

We used various strategies to ensure trustworthiness and cred- ibility; a self-interview to assist with reflexivity and methodologi- cal memos to record when we might be working off assumptions (Charmaz, 2014). The lead author checked transcripts against the original recording. The second and third authors independently reviewed the open coding of transcripts. Finally, we conducted member checking to ensure the theory reflected participants' experiences. The lead author presented all participants with the findings of the research either by email, zoom or phone. She asked if the findings accurately reflected their experience and if she had missed or misunderstood anything. Five participants responded, one person corrected a minor misunderstanding about her practice, all believed

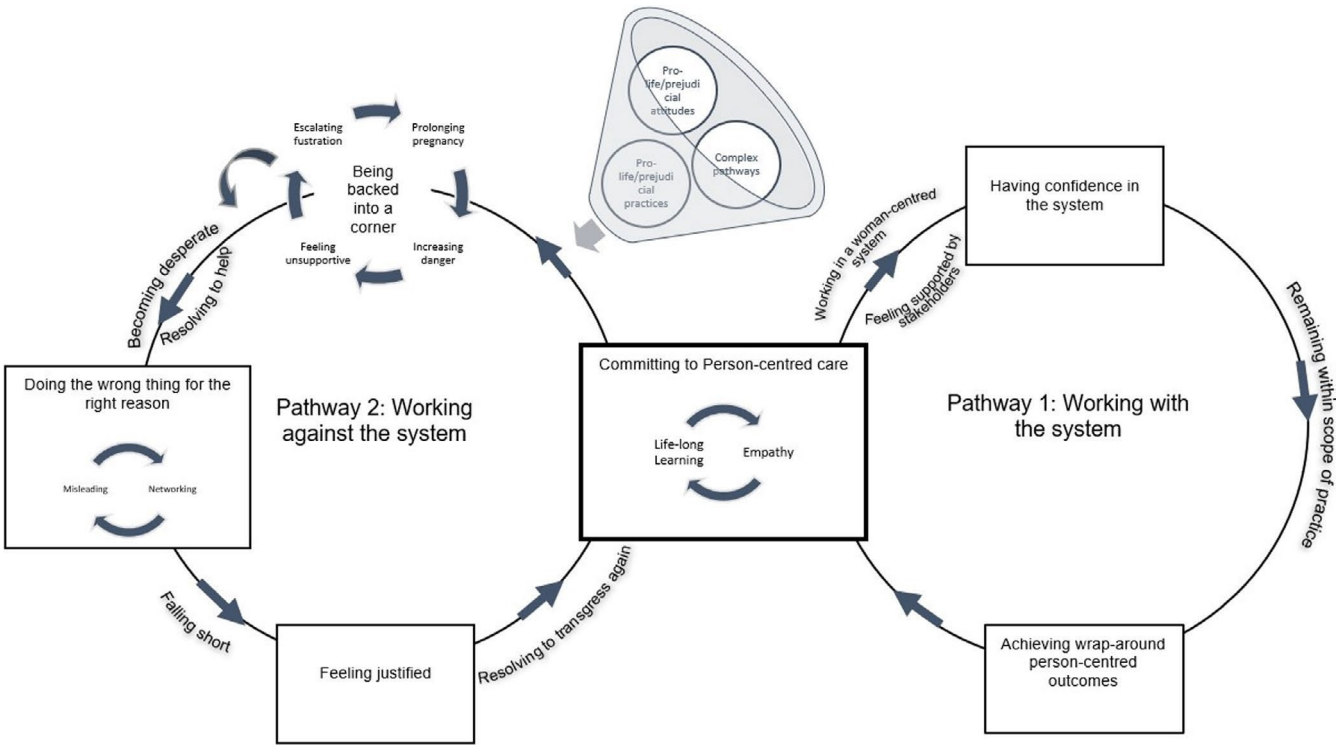

FIGURE 1 Australian nurses' and midwives' process of providing abortion care in the context of gender-based violence

the findings captured the process they used to provide abortion care to people affected by GBV.

3 | FINDINGS

The grounded theory developed from this research reveals the process through which Australian nurses and midwives provide abortion care to people affected by GBV. The main concern for the participants was *committing to person-centred care*. As indicated in Figure 1, the process took two cyclical pathways contingent on the work environment. On pathway 1, *working with a (woman-centred) system* led to *achieving person-centred outcomes*. On pathway 2, a period of *being backed into a corner* due to increasing gestation as well as health and safety risk led to *doing the wrong thing for the right reason* and *feeling justified*. Using the technique of storyline, a grounded theory device advocated by grounded theorists Birks and Mills (2015), we will present and explain these findings in further detail. The major codes that we constructed during the analysis are italicized in the narrative that follows.

3.1 | Core category: Committing to person-centred care

Participants committed themselves to person-centred care. They felt it was the central aspect of their clinical practice. They wanted pregnant people to feel empowered throughout the abortion process and treated with dignity by the healthcare system.

> [We are] woman centred and it's about individualising care, and very much taking the approach that all women are different, and their approach to their pregnancy will be different, and so therefore because there's an opportunity to have a one-on-one established relationship, we quite often, well what we find is the outcomes are much better. P15

Clinicians arrived at this standpoint through *empathizing* and *lifelong learning*. *Empathizing* explains how participants were provoked to think about the needs of the pregnant person in relation to their professional responsibility, the capability of the clinical environment and their own moral or political stance on abortion or GBV. For some participants, empathy was amplified through *personal insight* of GBV.

> I grew up around a lot of domestic violence. So, I think, I'm very aware that it does happen to anyone, whereas, I think, a lot of people around me they thought that trauma didn't impact people. P7

Empathizing led to doubling down on their commitment to safe, timely and stigma-free care and putting aside conflicting personal values.

> I grew up Catholic…I'm not comfortable (with abortion) after 12 weeks… one woman in particular… Her partner was quite controlling, and she wasn't telling him that she was pregnant…she got an RU486 off of an online site from India… she couldn't get access to anything here, and she was in a real state…by the time she realized that this RU486 wasn't working, she was 14.5 weeks pregnant, and had a noticeable tummy to her. I found that very challenging, but at the same time, I did everything we could… I could see how destroyed she was, and I know that it's not my place to judge… my compassion side overruled that personal value, and I knew that this woman was going to do whatever she could do to have this termination, so she needed to have it safely. P6

Participants felt that they needed to be knowledgeable to provide person-centred care. *Life-long learning* was a common, even when content did not fall into line with the workplace culture or practice. A relatively small number of workplaces provided training opportunities and most participants were dissatisfied with the level of preregistration education they received. It was common for participants to seek out the training themselves:

> I attended a university that's Catholic based, so in our midwifery curriculum we weren't actually taught about abortion…which of course you go out in your grad year and puts you on a back foot immediately. I obviously had to self-educate around the area. P8

From the main concern of providing person-centred care, participants embarked on two distinct pathways. Those *working with the (women-centred) system* had little trouble achieving their goal. On the other hand, participants working in less supportive organizations found themselves *working against the system*.

3.2 | Pathway 1: Working with the (woman-centred) system

The process of providing nursing and midwifery abortion care to people affected by GBV was straightforward and viewed as both empowering and supportive for pregnant people and most clinicians *working in a woman-centred system*. In this context the term 'system' refers to the interconnected network of organizations which provide care from the diagnosis of the unplanned/untimed pregnancy, the abortion procedure itself and attention to other issues, such as GBV.

3.2.1 | Having confidence in the system

Having confidence in the system meant participants reported (1) feeling *supported by stakeholders* and consequently, (2) *remaining within*

the organizational scope of practice. In women-centred systems participants reported feeling confident in providing person-centred care to people victimized by GBV. This is because robust wrap-around support mechanisms were built into the system ensuring that screening for domestic violence and sexual assault was routine, and support services were integrated, leaving participants *feeling supported by stakeholders* and therefore provided care *having confidence in the system*:

> I think it's probably the thing that we do the best at our centre is that its really holistic, integrated kind of approach… There's a sexual assault service…They'll work closely with us… (and) work in with [police] and there's other domestic violence services and things that we refer to…because of that multiagency family safety framework…(which) draws in information from all the different services that that woman might have interacted with. I think they get a really good, overall picture of what the risks look like for that woman or for that family. P1

Participants who trusted that the healthcare system provided adequate support for people victimized by GBV found themselves *remaining within their organizational scope of practice*:

> The nurse's role is to focus on the clinical side of things. But it was a social worker's role to identify [domestic violence] and respond to that. P4

3.2.2 | Achieving wrap-around person-centred outcomes

Ultimately participants were positive in their view of how providing care in women-centred systems impacted on their ability to achieve wrap-around person-centred outcomes:

> I am working within a role which provides direct care co-ordination to women requesting ToP (termination of pregnancy). This service assists women in accessing ToP in the public health system and assists in referrals to wrap around services such as social supports etc to provide more holistic care. P17

Across space and time, participants came back to the commitment to person-centred abortion care. In other words, if they changed employer or if some condition in the organization changed, they flipped to Pathway 2: working against the system.

3.3 | Pathway 2: Working against the system

Working in systems that blocked person-centred abortion care was a source of frustration for nurses and midwives and resulted in a process of *working against the system* that involved *being backed into a corner*, *doing the wrong thing for the right reason*, and resulted in *feeling justified*.

3.3.1 | Being backed into a corner

Being backed into a corner reveals how participants reported they struggled when they felt that pregnant people were trapped by various interactive and compounding clinical and non-clinical barriers to person-centred care. It includes (1) *prolonging the pregnancy* (2) *increasing danger* (3) *feeling unsupportive* (4) *escalating frustration* and finally, (5) *becoming desperate*. Pregnant people were backed into a corner by prejudicial or pro-life attitudes and practices of staff members as well as overly complex and costly care pathways.

> I wanted to deliver excellent healthcare to refugees…I get a bit emotional talking about [facility]. It wasn't patient-centred care. it's a farce of a health system, it was people pushing bits of paper around, nothing happening for the patient. It was the appearance of something happening, but patient-centred care was not the focus. P14

This had the effect of *prolonging the pregnancy*. Pregnancies were significantly prolonged in hospitals or small communities where key personnel were conscientious objectors and where people waited weeks for ultrasound dating scans. This, in turn, reduced the person's suitability for medical abortion––the cheaper option––leaving many people to travel long distances for costly surgical care. Being backed into a corner also exposed pregnant people to *increasing danger* from the perpetrator, as well as pejorative or negligent clinical staff or from self-harm:

> She'd been evicted from their house because of her partner's domestic violence issues he was really violent, choking, really aggressive behaviour, threatening to kill her on multiple occasion…She already had five children…[She] proceeded to tell me that she'd been suicidal for quite a number of weeks [and] was trying to think of ways that she could get rid of the baby herself…I spoke to the obstetrician; because of his faith he didn't believe in performing [abortions]…So eventually this woman, was referred to a town that was about an hour-and-a-half drive. The public transport into town was really terrible, obviously she had multiple kids that she had to look after, her car was also on the fritz.. So getting her to travel to a referral centre to then go through counselling regarding her termination was pretty much impossible for her. P8

Escalating frustration developed among participants in response the distress and growing danger to pregnant people. Frustrations escalated when abortion access was denied due to practitioners' moral

beliefs, causing participants to feel that person-centred care was *being blocked*:

> Oh, I get pissed off. It's hard. It's frustrating in that regardless of what your personal beliefs are; I believe that everyone has the right to have access to [abortion]. P3

Frustration also arose when organizations took a narrow view of person-centredness leaving participants to *feeling unsupportive*:

> (T)here's been the understanding that, well, we are a day surgery, we're not here to support. We can't support women outside the realm of their day procedure. So that's been eternally frustrating. P9

Significant frustrations arose as the health of the pregnant person deteriorated. In these situations, participants contended with *becoming desperate*:

> Meanwhile, she's self-harming, she's taking tablets, she has plans for suicide. As I said, she's a very intelligent, capable, resourceful young woman and she's in a desperate situation… It was really stressful. I thought she might die. P14

3.3.2 | Doing the wrong thing for the right reason

Doing the wrong thing for the right reasons meant that participants reported (1) *resolving to help*, (2) *networking* and, (3) *misleading the system*. As frustrations rose, participants' commitment to assist the pregnant person solidified. *Resolving to help* required *networking* with like-minded people, both in the community and clinical practice, committed to undoing the barriers, streamlining abortion access and increasing support:

> So I played tennis with a girl who worked for [Airline] and we arranged things… we had a really good clinic supervisor…we used to talk about these things, what we could do to help these young girls.

> I had seen so much violence come through that I thought, well there's a way that we and [women's shelter] could work together. P2

Having established a network, participants commenced transgressing. Due to the time pressures of abortion, the focus of most clinician's transgressive practice was *misleading the system* to get the person to the abortion:

> Most of the places that I work at were church hospitals, so therefore it wasn't seen to be appropriate for [abortion].... So, they they'd be booked in for a D&C and then it would have the word suction next to it, which indicated to us in theatre what was happening. But it wasn't indicated to senior management exactly what they were doing. P6

Some participants also described additional assistance related to other matters such as contraception and psychosocial support:

> There was this one time that a lady couldn't pay for an Implanon…it was me, the doctors and the RN, and we were like, 'This is ridiculous. She's had three kids… [Organization] surely can afford contraception. Let's just put it in and not tell anyone,'… I got asked, weeks later, about it and then I couldn't lie and then I got in trouble. I still think we did the wrong thing for the right reason. P10

3.3.3 | Feeling justified

In feeling justified, participants reported (1) falling short but (2) resolving to transgress again. Because person-centred care relies on a system-wide approach, and participants were working in small underground networks, they were unable to fully realize the outcomes they desired. This left some feeling they were *falling short* of person-centred care:

> I just don't want women to be inconvenienced by having to travel away from home [for surgical abortions]. But, we're not there yet. P15

Participants subsequently expressed concern for patients who, despite the clinicians' transgressive practices, were left to navigate through the complex healthcare system, bear the expense of a costly private procedure or return home to a potentially unsafe environment:

> We had a patient, and she was just covered in bruises and she was going back to that situation. That terrified me…She's like, 'Oh, I have nowhere else to go. I have no money.' What do you do? It's terrifying sending someone back and then never following up again. P10

Despite not meeting person-centred outcomes, the convergence of their deep commitment to person-centred care, frustration over the injustice of restrictive abortion policies and practices, and concern for patients left participants *feeling justified* by their actions. This occurred even when participants were worried by the risks they had exposed themselves to:

> So I really didn't know what the consequences for me would be. I was scared, wasn't sleeping, hardly eating, started smoking… but what sustained me

> was that I knew I was doing the right thing and if I walked away from this and did nothing, then that would be a lot worse. I couldn't do that. I could not walk away from this and I knew I was doing the right thing. P14

Feelings of justification occurred unanimously among participants, irrespective of getting away with the transgressive practice or getting caught. No one reported feeling guilt or remorse for their transgressive practice. Even the clinicians who were reprimanded for their behaviour felt they were on the right side of history.

> I actually sleep very well at night knowing that women have support people when they need them. P15.

The primacy of providing person-centred abortion care––even by breaking the rules––meant *resolving to transgress again* which they carried through when required. Thus, this was a cyclical process with the commitment to person-centred care driving all action. Once again, if the conditions changed, participants flipped to Pathway 1.

4 | DISCUSSION

This constructivist grounded theory study provides a rich explanation of the process through which participants provide abortion care to people affected by GBV. In doing so it expands the body of knowledge in the substantive area. Further it uncovers the dynamic processes related to power and access in the healthcare environment which impact on person-centred abortion care.

Person-centred care is central to the Nursing and Midwifery Board of Australia's expectations of clinicians (Nursing and Midwifery Board of Australia, 2016), so it was unremarkable that it was the main concern for participants. However, it was unanticipated that it was the catalyst for two unique cyclical care processes. Participants who *worked with the system*, perceived that patients received person-centred care through holistic and wrap- around services. Consequently, their process of care was one of the compliance with their scope of practice and the policies of the workplace. While readers could speculate that participants who followed this process held excessively optimistic views or practiced wilful blindness towards their health service, the cyclical nature of their care process highlights that clinicians continuously assessing for person-centred care and would manage their work environment accordingly.

We discovered that person-centred care put many participants in conflict with Board's requirement to 'compl(y) with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions' (Nursing and Midwifery Board of Australia, 2016). Clinicians working in systems that were not woman-centred felt many laws and policies that they came up against were paternalistic and unnecessary. The extent to which clinicians felt their ability to provide person-centred care was stymied was an important revelation of this research and helped to contextualize their reasons for working against the system, undermining the law, local policy and institutional culture. Moreover, they felt justified and prepared to carry on transgressing if required. Because abortion care is just one of the tasks carried out by nurses and midwives 'working against the system' probably has broader reach than abortion care, and these findings ought to catch the attention of health administration, and legislators. We suggest that policy and legislation, antithetical to health practitioners' codes of conduct (backed by documents such as the Universal Declaration of Human Rights), will not be adhered to. While there is very little documented about these types of healthcare transgressions it is plausible that it goes on unrecognized to protect patients and healthcare providers (Essex, 2021). Further research is required in this area.

Clinicians, especially midwives, are cognisant of the imposition of medical domination, over-cautious care and policy and guidelines which revoke autonomy and choice for pregnant people (Cooper, 2019). Moore et al. (2017) study on the barriers and facilitators of person-centred care in different healthcare settings in Sweden and England supports found that the heavy machinery of the healthcare system, built around the biomedical paradigm, were inflexible to patient needs. We suggest that healthcare environments require a cultural shift to embrace a paradigm to cater for diversity and offer flexibility of care, power sharing and abortion options. A study which reviewed Indian policy to address person-centred care in abortion found that the Indian government under its 'maternal and newborn health, family planning, and abortion strategy', provided national comprehensive abortion care guide- lines. Their intent was that every healthcare service should be able to provide comprehensive abortion care (Srivastava et al., 2017). We recommend the development of similar guidelines based on the evidence including the World Health Organization's technical and policy guidance for safe abortion (World Health Organization, 2012) and the Woman-centred, comprehensive abortion care reference manual (Ipas, 2013).

Secondary findings from this research reflect that some participants sought out their own education because they did not feel adequately prepared by their undergraduate studies. This might pierce at the heart of the problem: the healthcare workforce is unqualified to provide care to people seeking abortion, especially in the context of GBV, and may explain why many participants witnessed the retraumatization of patients by the health system. Knowledge about how and if nursing and midwifery students are taught abortion care is limited, though it would seem to correspond with the participants experiences. Two international studies (Cappiello et al., 2017; Mizuno, 2014) found that abortion-related curriculum is most often taught in ethics, rather than evidence-based practice. Contemporary Australian and international litera- ture about domestic violence education, finds it is not widespread with corresponding lack of student confidence in providing care related to domestic violence (Collins et al., 2020; Hutchinson et al., 2020).

The hit-and-miss nature of abortion and GBV education is disappointing. First, the role of midwives (and nurses who work in relevant contexts) is not solely to care for people with planned and wanted pregnancies. Providing care to people with unintended or mistimed pregnancies, including abortion care, is a core competency for basic entry-level midwifery practice (International Confederation of Midwives, 2018). On the face of it, universities that omit abortion care from their curriculum, on religious grounds or not, are doing both their students and the public a disservice. Second, evidence-based education leads to more positive views towards abortion and GBV care which could, hypothetically, lead to more person-centred services. A cross-sectional multicentre survey conducted on in Poland (Michalik et al., 2019) compared the attitudes of first and final year midwifery students towards abortion care. Significant intergroup differences in willingness to participate in abortion care, in the context of health, rape and severe foetal defect, were noted between the groups with third year students' willingness being significantly higher. A mixed-methods study by Colarossi et al. (2010) found that abortion care clinicians who had undergone training around domestic violence and sexual assault had more positive attitudes towards screening for domestic violence and sexual assault and felt more prepared to discuss current and historical violence compared with those without training.

Repeatedly participants felt that the lack of appropriately skilled pro-abortion providers was a major barrier to person-centred abortion care. In Australia, where limited access to abortion care is compounded by a tyranny of distance, nurses and midwives have a relatively conservative scope of practice. A scoping review conducted by the authors (Mainey et al., 2020) found that nurses and midwives are underutilized in their role and, if trained appropriately, are as safe in performing medical and surgical abortions as medical personnel. A nurse or midwife-led approach to medical abortion, particularly in primary care, may address the provider shortfall (Dawson et al., 2016; de Moel-Mandel & Graham, 2019).

This study highlights the multifaceted social and environmental complexities that drive the process through which nurses and midwives provide abortion care to people victimized by GBV. Further research is necessary to specifically examine the situational and political factors that compel nurses and midwives to work with or against the system.

4.1 | Limitations

While not strictly a limitation, this is a study, drawn from a sample of 18 Australian clinicians. The grounded theory explains their experiences and should not be assumed to explain the experiences of all clinicians working in all abortion care contexts; further research is required in this area. By the same token, as it is qualitative research, the findings are explanatory and should not be used to predict future actions. The participants were female and largely monocultural; a more diverse sample could have led to more nuanced findings.

5 | CONCLUSION

Nurses and midwives involved in this study worked with or against the system when providing abortion care to people affected by GBV. Person-centred care was their priority, however if it was jeopardized by laws, policies or the healthcare culture, they would transgress. While they tried, they were unable to provide care to the same levels as clinicians supported by woman-centred healthcare services. None of them felt any remorse for their actions, however some found it difficult to cope with the situations they were put in. This mid-range theory may serve as a framework for commissions of enquiry to understand the transgressive practices of healthcare providers. Our findings stressed the importance of a health-sector wide cultural shift to facilitate person-centred abortion care as well as support for people victimized by GBV.

CONFLICT OF INTEREST

The lead author has previously worked at Marie Stopes Australia who assisted with participant recruitment.

AUTHOR CONTRIBUTIONS

This paper is a part of Lydia Mainey's doctoral project. Lydia Mainey worked with her supervisors Catherine O'Mullan and Kerry Reid-Searl to create the research design. Catherine O'Mullan and Kerry Reid-Searl provided oversight during the data collection and analysis phase. Lydia Mainey wrote and revised this paper, her supervisors provided feedback and advice.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions

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Paper 4: Unfit for purpose: A situational analysis of abortion care and gender-based violence

- **Aim 2** To map the elements of the broader health care situation that affect the provision of abortion care to people affected by GBV.

Synopsis

Paper 4 is a SA study which aimed to investigate the broader situational elements of the Australian healthcare environment that affect abortion care for victims of GBV. Paper 4 builds on Paper 2, by describing the SA method (situational mapping in particular) in greater detail. It also builds on Paper 3, by shifting the analysis from the individual level to the organisational, thereby allowing me to theorise[8] the organisational factors that compelled clinicians to undertake a process of working with or against the system. Participants in this study believed patients were mostly uncatered for. They described a workforce unprepared to provide abortion care, generally, and GBV interventions more specifically. Participants found that their anti-abortion colleagues centred themselves rather than patients, with many revealing that the workplace environments placed clinicians' and patients' safety at risk.

In September 2021, I presented Paper 4 at the Joint Australasian HIV&AIDS and Sexual Health Conferences and won the Early Career Award: Social, Political and Cultural Aspects of HIV and Sexual & Reproductive Health in the Australasian Region. After disseminating my research findings, I was contacted by Desert Blue Connect, a women- and family-centred holistic service in Western Australia, who advised they will be using the findings and recommendations of this study to advocate for swipe card security access (Appendix B).

[8] Unlike Constructivist Grounded Theory, the role of Situational Analysis is to theorise, not to generate theory. Through theorising, we have gained a working understanding of how the broader situation (the healthcare environment), affects the provision of abortion care for victims of domestic violence or sexual assault. Clarke, A., Friese, C., & Washburn, R. (2016). *Situational analysis in practice: Mapping research with grounded theory*. Routledge Ltd - M.U.A.

Declaration of co-authorship and co-contribution

Unfit for purpose: A situational analysis of abortion care and gender-based violence

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Nature of candidate's contribution, including percentage of total

In conducting the study, I was responsible for conceptualisation, methodology, analysis, writing and administration. This publication was written by me, and my contribution was 75%.

Nature of co-authors' contributions, including percentage of total

My co-author Catherine O'Mullan contributed to the paper by reviewing and supervising (15%). My co-author Kerry Reid-Searl contributed to the paper by reviewing and supervising (10%).

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Original article

Unfit for purpose: A situational analysis of abortion care and gender-based violence

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abstract

Problem: Timely access to comprehensive abortion care is fundamental to reproductive autonomy; however, factors such as geographical location, politics, and religious influences create obstacles to this goal and may have distressing consequences for people seeking abortions in the context of gender-based vio- lence.
Aim: To investigate the broader situational elements of the Australian healthcare environment that affect abortion care for victims of gender-based violence.
Methodology: Situational Analysis was used to conduct this study. The lead author interviewed 18 clinicians about their experiences of providing abortion care in the context of gender-based violence. Transcripts were analysed using situational maps, identifying the human and non-human elements affecting clinical care.
Findings: Participants believed that patients were "*mostly uncatered for*." They described a workforce unprepared to provide abortion care, generally, and gender-based violence interventions more specifically. Clinicians found that their pro-life colleagues centred their own needs, and many revealed that the workplace environments placed clinicians' and patients' safety at risk.
Discussion: While abortion is a safe and straightforward procedure, the interconnectedness of time sensitivity, stigma, shifting legal landscapes, and high rates of gender-based violence mean that it is probably more complex than the current work models plan for. A trauma-informed integrated approach that pro- tects the safety and wellbeing of patients and staff is needed.
Conclusion: Healthcare services should implement streamlined evidence-based and trauma-informed abortion pathways that take full advantage of nurses' and midwives' skills, knowledge, and potential. As a priority, healthcare services should also introduce security measures and protocols to keep staff and patients safe.

Summary of relevance

Problem

Understanding of the obstacles faced by abortion-seeking peo- ple, victimised by gender-based violence, is still emerging.

What is already known

Legal restriction, overly complicated referral pathways, high financial costs, and health care stigma add unnecessary barriers to abortion care.

What this paper adds

Evidence that inadequate skill-mix, convoluted abortion referral pathways and unsafe workplaces compounded the distress of peo- ple victimised by gender-based violence as well as the nurses and midwives who provided their care.

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1. Introduction

The 1994 International Conference on Population and Devel- opment (ICPD) reclassified women's reproductive capacity from a mechanism for population control to an issue of female autonomy and empowerment (Shalev, 1998, p. 1). The ICPD acknowledged that reproductive health is determined by access to health care as well as social status and pervasive gender discrimination. Thus, they recommend that all reproductive health programs be based on women's right to reproductive autonomy and gender equality (Shalev, 1998). Access to comprehensive abortion care is a com- ponent of reproductive health, providing options for women to choose the timing, spacing and number of children (World Health Oraganization, 2021).

The comprehensive abortion care model is a person-centred ap- proach aimed at reducing unplanned pregnancies, unsafe abortions and maternal mortality by tailoring abortion care to each person's social circumstances and individual need (Ipas, 2013). The dimen- sions of comprehensive abortion care include integrated services, safe and legal access to abortion, treatment of complications, coun- selling, contraception services, decentralisation, affordability and attention to other issues (Ipas, 2013). Despite Ipas (2013) – a global organisation that works to expand safe abortion access and con- traception – and the World Health Organisation (WHO) setting out technical and policy guidance for planning and managing compre- hensive abortion care within health systems (World Health Ora- ganization, 2012), barriers to equitable access continue to plague many high-income countries (Lindo, Myers, Schlosser, & Cunning- ham, 2020; Norman et al., 2019).

Political intrusion in the Australian abortion arena has been a mainstay since the early 20th century when many politicians took the view that it directly threatened (white) nation building (Baird, 2006). As a consequence, abortion or the procurement of an abortion drug, has been a serious crime (de Costa, Douglas, Ham- blin, Ramsay, & Shircore, 2015; Sifris & Belton, 2017) until very re- cently. While a series of separate law reforms throughout the last decade has seen abortion decriminalised in most of the country, they have resulted in inconsistent development of abortion laws (de Costa et al., 2015; Sifris & Belton, 2017). Commonwealth inter- ference with abortion care played out, in 1996 when the Howard Government, in exchange for his vote on the privatisation of Tele- com, agreed to Pro-life Senator, Brian Harradine's, demand to re- classify the abortifacient drug RU486 as "restricted goods." This reclassification mandated ministerial approval for importation of RU486, consequently restricting women's access to medical abor- tion (Sawer, 2012). Minister for Health, Tony Abbott, attempted to reduce access further by proposing legislation to restricting Medi- care funding for abortion (Sawer, 2012). However, a cross-party in- tervention by four female senators sponsored a bill to lift the min- isterial veto on RU486 (Sawer, 2012) and won by an overwhelm- ing majority (Baird, 2013). Despite this win, RU486 remains over- regulated and costly to import (Baird, 2015).

On top of the legal restriction, studies in Australia and around the world have found evidence of overly complicated referral path- ways, high financial costs, and stigmatisation within the health- care system (LaRoche, Wynn, & Foster, 2020; Lindo et al., 2020; Norman et al., 2019) adding unnecessary barriers to abortion care. These barriers can delay care, reduce abortion options, increase the need to travel for more complex care and increase the cost of the procedure (Upadhyay, 2017; World Health Oraganization, 2012). Furthermore, barriers disproportionately affect marginalised peo- ple (Upadhyay, 2017) such as those affected by gender-based vi- olence (GBV) who are more likely to seek out abortions, request multiple abortions or present for late-term abortions (Aston & Be- wley, 2009; Gee, Mitra, Wan, Chavkin, & Long, 2009; Hall, Chappell, Parnell, Seed, & Bewley, 2014; Taft & Watson, 2007). In Australia, one-in-four women will have an abortion in their lifetime and are up to three times more likely to have experienced GBV, specifically domestic violence, than women who continue with their pregnan- cies (Taft & Watson, 2007). Domestic violence is a strong risk factor for morbidity and mortality for Australian women aged between 0 and 44 years (Ayre, Lum On, Webster, Gourley, & Moon, 2016), and the time around pregnancy is when it can first present or escalate. Where abortion is concerned, the provision of comprehensive abortion care may put nurses and midwives in direct opposition to the legislation, local policy, or pro-life health care culture. More- over, these barriers may affect the quality of care (Darney et al., 2018), which is noteworthy because quality care is a human right (World Health Oraganization, 2017).

Our understanding of the obstacles people face when exercising their reproductive autonomy is still emerging, as is our knowledge of the policies and programmes that ensure peoples' sexual and reproductive health and rights (Bearak et al., 2020). We recently conducted a Constructivist Grounded Theory study and found that Australian nurses and midwives practise "working with or against the system" (breaking laws and policy and undermining clinical mores), navigating around barriers to deliver person-centred abor- tion care. The purpose of this paper is to explore how the broader situation affects the way nurses and midwives provide abortion care for victims of domestic violence or sexual assault.

2. Participants

We recruited Australian nurses and midwives who had at least 12 months experience of working in an abortion care context (from the diagnosis of the unintended/untimed pregnancy to post- abortion care). The clinicians were recruited, using snowball sam- pling, as part of a larger doctoral thesis project through the pro- choice organisations Children-by-Choice, Marie Stopes, and an on- line social media campaign.

Our final recruitment number was 18, which was led by data saturation (Charmaz, 2014; Guest, Bunce, & Johnson, 2006). We have outlined basic descriptors such as practice setting and ge- ographical classification (Table 1). One clinician worked in an offshore facility which will remain undisclosed to protect her anonymity.

3. Methods

This study is part of a simultaneous multiple methods construc- tivist grounded theory doctoral project exploring the experiences of nurses and midwives who provide care to people seeking abor- tions in the context of domestic violence and sexual assault. Phase A analysed the meanings, actions, and practices of the participants. This paper reports on Phase B1, which used Situational Analysis to move the analysis, to the organisational level, uncovering structural elements that may be hidden (Clarke Friese, & Washburn, 2018)

The unit of analysis for Situational Analysis is the broader situa- tion of enquiry, with the analysis centring on social domains which incorporate human and nonhuman elements (Clarke et al., 2018). Situational Analysis uses a mapping approach to analysis. Three maps (situational, social worlds/arenas and positional) were char- tered strategically throughout Phase B with the intent of exposing the data and providing the researcher with different ways of think- ing about the data (Clarke et al., 2018). This paper reports on the analysis drawn from the situational mapping.

3.1. Data collection

We developed a three-question semi-structured interview guide to address the research questions and allow participants to present new ideas. We added further research questions (questions 4 –

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Table 1
Sample characteristics

	Gender	Cultural background	Rural/remote/metropolitan area	Practice setting
1	Female	Anglo Australian	Major Urban	Abortion Services
2	Female	Australian	Other Urban	Multi-Purpose Health Centre
3	Female	Australian	Major Urban/Rural	Peri-operative environment/General Practice
4	Female	Australian	Rural	Multi-Purpose Health Centre
5	Female	Anglican	Other Urban	Perioperative Environment
6	Female	Not stated	Other Urban	Family Planning
7	Female	Not stated	Other Urban	Obstetrics/Gynaecology
8	Female	English/Australian	Remote	Community Midwife
9	Female	Australian	Major Urban	Perioperative Environment
10	Female	Not stated	Multiple sites	Abortion Services
11	Female	British	Major Urban	Abortion Services
12	Female	Australian	Other Urban	Abortion Services
13	Female	Australian	Other Urban	Family Planning/Sexual Health
14	Female	Australian	Remote	Multi-Purpose Health Centre
15	Female	Caucasian/Scottish	Major Urban	General Practice
16	Female	Scottish	Remote	Community midwife
17	Female	Not Stated	Major Urban	Obstetrics/Gynaecology
18	Female	Not Stated	Major Urban	Abortion Centre

Table 2
Interview questions

1. Can you tell me about your experiences when you provide abortion care to people affected by domestic violence or sexual assault?
2. What promotes your ability to provide effective care in this context?
3. What interferes with your ability to provide effective care in this context?
4. How do you navigate ethical, legal, and organisational boundaries associated with abortion, domestic violence or sexual assault?
5. How do you decide who to refer a pregnant person to?
6. What are the most stressful elements of this work for you, and what supports do you use?
7. When you are in a difficult ethical situation, what guides your actions?
8. Have you ever felt that your safety was in danger? If so, what did you do?

8) in response to new information introduced by the participants (Table 2). The purpose of the interview was to understand clin- icians' experiences providing abortion care to people affected by domestic violence or sexual assault and the barriers and enablers they encountered. We added further questions about their trans- gressive practices, particularly those related to circumventing legal, organisational, or ward-specific barriers associated with abortion, domestic violence, or sexual assault, and how their underlying be- liefs guide their actions. Additionally, we asked about stressful ele- ments of their work as well as their supports. We asked all partic- ipants the same initial questions, but further questions were asked of subsequent participants (Charmaz, 2014).

The lead author, who is trained and experienced in in-depth in- terviewing techniques and previously worked as an abortion nurse, conducted the one-on-one interviews face-to-face, via telephone, and zoom, and over email. We used face-to-face interviews for two participants to reduce difficulty navigating technology. Depending on their preferences, we used telephone or zoom interviews for the remaining participants because they lived in different areas of Australia. We used an email interview for one clinician because of ongoing scheduling conflicts. We obtained electronic or verbal con- sent from all participants and permission to be audio-recorded. A transcription service transcribed the recordings for analyses.

3.2. Analysis

The Phase A analysis used Constructivist Grounded Theory to conceptualise the basic social process (Charmaz, 2014) nurses and midwives use when providing abortion care to victims of domes- tic violence or sexual assault. The basic social process is the per- vasive, unavoidable pattern that has distinct phases and is used universally by participants to navigate a central issue (Glaser & Holton, 2005). Our Constructivist Grounded Theory was "*working with or against the system*."

In this study (Phase B), we used Situational Analysis, an ex- tension of Constructivist Grounded Theory, to analyse thick situ- ational complexities (Clarke et al., 2018) of providing abortion care to domestic violence and sexual assault victims as they appeared in the same clinicians' transcripts. Situational Analysis uses a range of mapping activities to analyse the data at different levels (situa- tional, relational, social worlds/arenas and positional). In this pa- per, we focus and report on the situational level.

The lead author jotted down all human and nonhuman ele- ments in the clinicians' stories (messy situational mapping) and created analytical memos about what she found (Fig. A). Then she ordered the messy map into a structured table of themes, creating memos as new insights emerged (Table 4).

The analytic team included a doctoral student (interviewer and lead author) and the second author, a research academic and women's sexual health expert. The last author, a nursing profes- sor, provided analytic oversight. The lead author reviewed the in- terview transcripts, catalogued the elements (humans, nonhumans, organisations, discourses) and summarised her thoughts in a series of memos. Throughout the process, the lead and third author met regularly to review and revise the interview guide. The lead and second authors met periodically to reflect on the situational analy- sis process. The memos generated from these mapping exercises were coded and then abstracted to higher-order codes until an overarching theme *"mostly uncatered for"* and three subthemes "*in- adequate skill mix*," "*convoluted care pathways"* and "*physical safety concerns"* emerged. Table 3 demonstrates how theoretical memos were promoted to higher order codes and subthemes.

We used various strategies to ensure trustworthiness and cred- ibility. First the lead author conducted a self-interview to assist with reflexivity and kept methodological memos to record when she might be working off assumptions (Charmaz, 2014). The lead author checked transcripts against the original recording. The sec- ond and third authors independently reviewed the open coding of transcripts. Finally, we conducted member checking to ensure

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Table 3
Construction of subthemes

Subtheme	Higher-order code	Initial codes	Memo
Inadequate skill-mix Displaced workload Overextending practice practice	Brain-drain	Perpetual brain-drain Displaced workload Violating Scope of	Most participants in casualised workforces described a high turnover rate, representing a perpetual brain drain and associated higher responsibility and workload placed on more constant staff. They often found themselves working outside of their scope.
Contextual brain-drain.			By removing themselves from care, conscientious objectors reduced skills and knowledge available to patients and more junior staff members.
		Displaced workload Unsafe work practice	Staff felt they had to do the work of 2 or 3 people.
Inefficiencies related to knowledge-gap		Unfilled knowledge gap	It's normal for participants to report a general lack of knowledge around DV and SXA and describe general ignorance in the workplace. Doesn't seem to be too much training or discussions over it.
		Extended consultation times	Clinician spending hours with DV patients, possibly in part because they lack confidence in their clinical decision-making in this area. Midwives are more tuned in because of their education and screening tools.

Table 4
Ordered situational analysis map

Individual/Human Elements/Actors (***unorganised*** people in the situation)	Non-human elements
Pregnant people Perpetrators Family members	Abortion Environment security Domestic violence/reproductive coercion training Domestic violence Screening Patient assessments Abortion education Ultra-sound scans Blood tests Abortion procedure Mind-altering medication (anaesthetic/analgesia) Abortifacient medications (Misoprostol/Mifepristone) Nursing/medical documentation Illegal abortions Roster/Shift work Patient Load Casualisation of workforce Patient-travel schemes Telehealth Lived experience of trauma Models/Frameworks of care (Feminist, Continuity of Care, Person/woman-centred) Spirituality
Collective Human Elements/Actors	Implicated/Silent Actors/Actants
<u>Macro</u> Marie Stopes Australia Children by Choice Pro-choice groups Integrated women's health centres Integrated Family Safety Networks Police Religious universities DV Connect <u>Meso</u> Perioperative suites Gynaecology wards Maternity services Specialised abortion services Primary Care Services Sexual and Reproductive Health services Nurse navigators <u>Micro</u> Clinician-allied health networks Clinician-Community networks Clinician-GP networks Surgeon-Operating Room staff networks Clinician- Pro-choice networks Pregnant person's support networks Discursive constructions of individual and/or collective human actors	Religious-political networks Anti-choice networks Human right to reproductive autonomy Marginalised people Discursive Constructions of Nonhuman Actants

(*continued on next page*)

Table 4 (*continued*)

Individual/Human Elements/Actors (***unorganised*** people in the situation)	Non-human elements
Seekers of abortion for DV/SXA reasons Stigmatised – often overlapping stigma (abortion, gender-based violence, culture, refugee status) Traumatised by the process Vulnerable Abortion-focussed (Sometimes) Reticent to DV assistance Falling through the cracks Perpetrator Intimidating Difficult to identify <u>Macro</u> Integrated services – streamlined, supportive towards pregnant people, clinically safe. Police – inconsistent responses to people reporting DV; workplace security officers. Abortion clinics – conveyor belt, profit-driven Public Hospitals – cattle cars Reproductive Health Services – politically timid Pro-choice groups – informative and brave Religious universities – incomplete educators <u>Meso</u> Anti-choice staff – bullies, stigmatisers, obstructive, controlling people's futures. Abortion centres/Operating theatres – unsafe skill mix/flying by the seat of our pants. <u>Micro</u> Clinician-community networks - Flying by the seat of our pants, Pioneering, Brave, Doing the right thing. Clinician-GP networks – viable workaround Operating theatre networks – working under the radar, doing the wrong thing for the right reason, flying by the seat of our pants.	Abortion – life-changing, life-saving, best option Clinical practice in regional Australia – from the dark ages. Clinical education – inconsistent Care planning - based on assessment Care planning - based on intuition Abortion pathway – often unnecessarily protracted Ultra-sound scan – expensive, unnecessary, traumatic. Illegal abortions – rare, but still occurring, understandable Healthcare service as a place of safety for the pregnant person. Home as an unsafe place post-abortion. Rostering – ensuring workload goes to a pro-choice clinician Shift work – little to be done for DV/SXA on a night shift. Patient Load – abortion patients often seen as "simple", more time given to other types of patients due to time pressures. Casualisation of workforce – inconsistencies of skill mix, inappropriate clinical decision making Patient-travel scheme – restrictive, non-compassionate Telehealth – potentially increases patient danger, impedes assessment and informed consent. Lived experience of trauma – assists in understanding and providing care to people experiencing gender-based violence. Models/Frameworks of care (Feminist, Continuity of Care, Person/woman-centred, Trauma-informed care) – underpinning decision-making. More important than legislation, local policy or hospital culture. Spirituality (pro-choice nurses) – something to be aware of and negotiated on a case-by-case basis. Often outweighed by the needs of the patient.
Political/Economic Elements Accreditation of nursing and midwifery courses Clinician Scope of Practice Abortion politics Religious freedom Conscientious objections Privatisation of Health Care	Sociocultural/Symbolic Elements Catholic values Vulnerability of people from Culturally and Linguistically Diverse backgrounds. Culturally and Linguistically Diverse Clinicians perceptions of DV. Increasing awareness of DV Abortion codes (i.e., D&C (suction); "options")
Temporal Elements Abortion Law Reforms DV & SXA awareness Timely access to abortion – referral/scans etc increases gestation and the complexity for the woman.	Spatial Elements Southern States (more progressive) Northern States (less progressive) Stand-alone clinics Access – Rural and remote, cost. Abortion centres in major centres Surgeons' private offices Fly-in-fly-out doctors
Major Issues/Debates (usually contested) Pro-choice/Anti-choice Doing the wrong thing for the right reason Role of the clinician vs the role of a business Priority of care – Safety/Timely Abortion. Suitability of abortion-care/gender-based violence education	Related Discourses Intersectionality Feminism Implicit bias Human Rights of Refugees Secularism Reproductive autonomy

the theory reflected participants' experiences. The lead author presented all participants with the findings of the research either by email, zoom or phone. She asked if the findings accurately re- flected their experience and if she had missed or misunderstood anything. Five participants responded, one person corrected a mi- nor misunderstanding about her practice, all believed the findings captured the abortion care situation.

4. Findings

We framed the research question, "How does the broader sit- uation affect how nurses and midwives provide abortion care for victims of domestic violence or sexual assault?." The overarching theme we constructed from the Situational Analysis was "*Mostly uncatered for,"* referring to the fact that the healthcare environ- ment rarely takes abortion seriously - particularly in the picture of gender-based violence. Three critical elements of the healthcare system affect abortion care for victims of gender-based violence. These are reported under *"Inadequate skill mix," "Convoluted care pathways,"* and *"Physical safety concerns."*

4.1. Overarching theme: Mostly uncatered for

Our first study determined that the primary concern for clini- cians was that pregnant people received person-centred abortion care. Clinicians described this as timely, stigma-free, clinically safe,

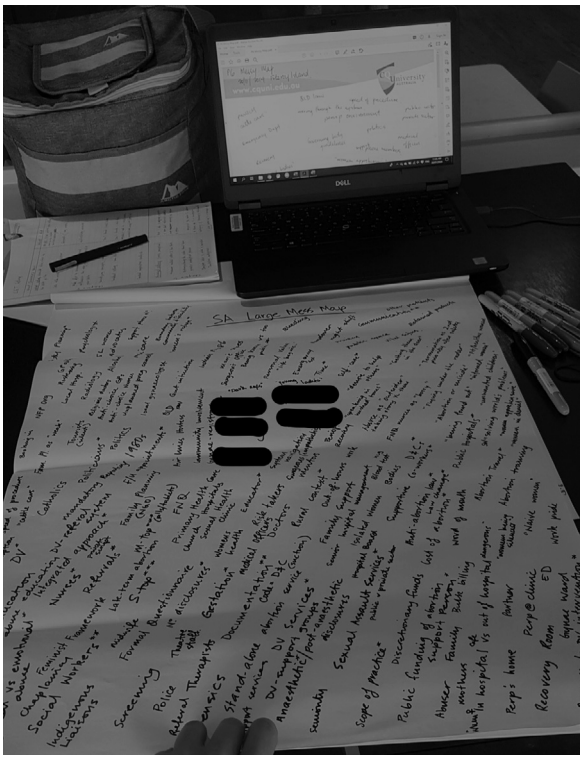

Fig. A. Messy Mapping.

and physically safe. If the work environment prevented them from meeting this core objective, they found their alternative avenues to person-centredness by rule-bending and breaking (Mainey, Reid-Searl, & O'Mullan).

In this study, we drilled deeper through using Situational Anal- ysis to determine what it was about the healthcare environ- ment that created obstacles to person-centred abortion care. With very few exceptions, clinicians described a healthcare environment where abortion – particularly in the context of gender-based vi- olence - was not taken seriously. Therefore, pregnant people and perpetrators were mostly uncatered for.

Please refer to Table 4 where we have catalogued the salient elements from the participants' interviews.

4.1.1. Subtheme one: Inadequate skill mix

At a foundational level, many clinicians felt that abortion care was impacted by inadequate skill mixes leading them to have mixed feelings about their workplace's readiness to provide clin- ical care to people seeking abortions. In the context of gender- based violence, more specifically, most clinicians felt that clinical personnel were inadequately prepared to recognise and respond appropriately. The exception to this finding was Participant 1 who worked in a publicly funded abortion centre. She felt competent and well informed through training on screening for domestic vi- olence and responding to disclosures. Moreover, reflective practice was encouraged through ongoing feedback from social worker col- leagues. As Participant 1 explained:

"*They'll give us some feedback after the referral's been made. So, if we pinpointed that we thought there might've been serious safety concerns…they'll quite often give us a bit of feedback and say, 'Yep, we identified these risk factors, and these were the referrals that we made as a result.*'"

This was not the experience of most participants who felt their workplace was underprepared to provide care for people seeking abortions in the context of gender-based violence. Participant 10, who worked in a stand-alone abortion clinic with a high turn-over of casual staff, described:

"*Quite often they would come to me and ask me what to do. (I) was like, 'Oh, geez, like, I've never done this before and neither have you. So let's work it out together,.* "

Staff also explained that disclosures of gender-based violence disrupted workflow,

"*There's a pressure for nursing staff to keep their interview short, as part of patient flow. I know that (a disclosure is) a varia- tion…There could be nurses that have experienced domestic vio- lence themselves that may pick up on cues that wouldn't neces- sarily be there for another nurse…what happens when you open those questions up and you discover that there's a real need there, that you're in a setting, in a day surgery setting where there's lim- ited time. That's the frustrating part,*"

Participant 9.

Clinicians who worked in larger hospital environments reported that rostering around conscientious objectors was an ongoing is- sue. In the perioperative setting, conscientious objectors rostered in emergency theatres disrupted patient flow. Participant 7, a peri-operative nurse, explained the impact of conscientious objectors in the context of the emergency theatre:

"*people would be like, it's an emergency and do their job…And some people wouldn't – and then that would be hard in an emer- gency setting to rejig theatres. So, it impacted the patient at the end of the day, as well."*

Some clinicians did not believe that they were working to their full scope of practice and felt that they could relieve the burden on other health professionals, ensuring patients received timely, ap- propriate care. Enrolled nurses were particularly concerned about the restrictions put on their practice when they often had more knowledge and experience than their registered nurse colleagues. Participant 11 described her annoyance,

"*So I can't give any kind of IV in, you know, like, the Buscopan or the Ondansetron or anything, put that canula in recovery. If I was on a ward, I'd be doing that… we're not allowed to read the results…We have to refer it to an RN. Oh look, I know in our clinic because I've been there the longest, I'm the one that reads the bhcg results and the ultrasound results. You know, like, I can read them, and I can hold an abdo ultrasound on while we're doing a late case, you know, I can find a foetus. So those are skills that I gained with working with (here), but it just feels…that they go, no, you're crap, you're an EN."*

Registered nurses and midwives also felt they were under- utilised, as Participant 5 explained:

"*I came back to a tertiary hospital, and honestly, the scope of prac- tice of nurses in a big tertiary hospital that's got a great reputa- tion, it was often about handing a history to a doctor. And having worked autonomously as a community nurse and midwife I was just completely blown away. And so, as part of my project, I'm trying to get a competency framework for nurses, because I figure that that will be helpful here within the unit, but also be helpful for nurses who are thinking about taking on medical abortion, and expanding their scope of practice in that regard*".

4.1.2. Subtheme two: Convoluted care pathways

The second key element of the healthcare environment relates to care pathways. When asked how their care was impeded or en- abled, most clinicians described a situation where overly complex pathways disrupted access to abortion care. Overall, they did not feel that abortions were triaged appropriately in the system. They

felt follow-up appointments with counselling services and waiting times for ultra-sound scans were unnecessary if they prolonged the pregnancy. Moreover, they felt that abortion, complicated by gender-based violence, should be an even higher priority. They explained that long waiting periods led to emotional deterioration and increased financial cost to pregnant people. As Participant 13, a dual nurse practitioner and extended practice midwife described:

"*I had to do a referral for girl…living with an ex-partner who has become an ice addict, and he's giving her a lot of drama…she's also got a baby that's very sickly, and she herself mentally was just melting down. And she ended up going and taking a loan out because they were taking too long*".

Pregnant people in rural and remote locations faced further bar- riers - reduced access to referring practitioners, lack of surgical abortion options and lack of timely access to domestic violence support services leading to heavy financial burdens, the continu- ation of pregnancy to birth, and in one case, illegal abortion. Par- ticipants 15, a remote community midwife, described a scenario where she tried to access funds for a woman to travel for a surgi- cal abortion:

"*She wasn't in a position to continue with the pregnancy, her part- ner was in prison for domestic violence, she was actually pregnant to [someone else]. And so, the fear of what would happen to her and her children when he was released from prison, it just had to happen, there was no choice, she could not continue with this pregnancy. And her medical officers decided that she didn't meet criteria, and so she was denied travel…she actually sold her car [to pay for the abortion]".*

4.1.3. Subtheme: Physical safety concerns

The final key element of the healthcare environment relates to physical safety concerns. Many clinicians revealed how the work- place did not cater for the staff or patient physical safety. While not an everyday occurrence, clinicians recalled situations where they felt unsafe, or threatened by domestic violence perpetrators or scared for patients. Nurse managers, untrained in de-escalation, were left to confront angry partners and decide when and if to call the police. Participant 12, a nurse-manager of an abortion clinic, described:

"*I remember him saying to me, "You are a murderer." I don't think I reacted particularly professionally in that situation. I remember getting very angry…I was so conflicted that she was going home to a violent house, and that she was in danger herself…I made the call in the end, I called the police to come and talk to him and to talk to her, and they did…I don't know if I made things better for her or a lot worse.*"

Some clinicians discussed their concerns about the safety of telehealth patients. Participant 10 described a situation that left her feeling shaken and helpless:

"*I could hear a man yelling in the background, and I just said to her… 'Answer yes or no…Is that your partner in the background?' She's like, 'Yes.' I said, 'Does he know that you're doing this?' 'No.' I said, 'Are you safe?' And she said, 'No', …I could hear him yelling*
…and I tried to start the consult…the next thing I heard was, like, a big bang and then the call disconnected."

Clinicians who worked in smaller centres, such as stand-alone abortion clinics and remote area hospitals, revealed aspects of their physical space that increased their risk of harm. Participant 11 de- scribed a scenario where an abusive partner tried to break into the clinic:

"*We had another lady who had sneaked in with a friend, and then her husband must have had the phone tracker on…he was banging on the front door and trying to get in, and we had to get the police, and he was escorted from the building but then he came back in…in the end she (manager) said, 'Oh, let him in, let him in.'"*

The absence of security (guards, locking doors, policy and procedures) meant that staff would improvise when a risk to physical safety presented itself. Participant 9 described how staff would intervene:

"*we would hold them for longer, and in those cases…we would intervene with say, the police or domestic violence workers, we would hold the patient there in our secure location. So what I mean by secure is…an area where only staff are allowed…So we would then make sure that we could…basically walk people out the back door into the care of DV workers."*

Most clinicians did not recognise the risk of violence to them- selves; their primary concern was to protect the pregnant person. Participant 15, a manager, recalled a situation where one of her colleagues used a personal vehicle to pick up a woman who feared her violent partner:

"*She was driving past the end of the woman's street, and she said, 'I'll be there in 30 seconds, come outside, get in my car.' And then when she was telling me about it the next day, I was just say- ing, 'What are you thinking? That's nuts.' And she said, 'What is? What's nuts?' and I said, 'You just put yourself in an unbelievably vulnerable situation.'"*

5. Discussion

With few exceptions, clinicians painted a concerning picture of how ill-prepared the healthcare environment is to provide compre- hensive abortion care. In a highly developed country like Australia, which purports to have one of the best healthcare systems glob- ally (Australian Department of Health, 2019), the healthcare en- vironment lets down vulnerable people. Participants' transgressive actions – working against the system –may not be condoned, but they can begin to be understood when taking in all the situational elements. A multipronged and coordinated approach is required to upskill and reorient the healthcare sector, streamline abortion care, and improve patient and staff safety.

Abortion is a very safe and straightforward procedure. However, our study found that the interconnectedness of time sensitivity, stigma, shifting legal landscapes, and high rates of gender-based violence mean that it is probably more complex than the Aus- tralian health sector credits. We recommend that health services perform a ground-level Work Complexity Assessment (WCA) to re- evaluate work processes, delegation relationships (Weydt, 2009) and educational needs in their contexts. In our study, it was evident that conscientious objectors and people who held un- favourable views towards people seeking abortions reduced the skill mix available to patients receiving abortion care and added to the workloads of pro-choice nurses and midwives. We recom- mend that healthcare services providing abortion care have pro- choice hiring policies. If this is not feasible, we recommend further research to quantify the number of conscientious objectors work- ing in areas that provide abortion care to inform WCA and work- load allocation models. This is a new research direction, and no doubt will be challenging in the current context of high staff turn- over. Moreover, is unlikely to decrease a culture of abortion stigma within work units.

Skill mix must also be supported by workload allocation models that allow clinicians to help victims - domestic violence disclosures should not be a clinical variance. Many clinicians discussed the disruption that occurred to their work areas because of disclosures. In their study of universal screening at a free-standing abortion clinic

in North America, Wiebe and Janssen (2001) identified that while screening was part of organisational policy and screening proto- cols were in place, approximately half of the women presenting for abortions were not screened. This was due to a perceived lack of time, lack of interpreting services or protocols regarding partner presence in the interview room. A screening algorithm with an as- sociated care pathway may reduce the time clinicians spend with patients and reassure them that they have provided appropriate support.

Care pathways are also one way to streamline abortion care. A cross-institution integrated care pathway would assist preg- nant people's progress through the health system in an ap- propriate timeframe, reducing their risk of being "bouncing around" or falling through the cracks. Such pathways should be evidence-based and trauma-informed and embed the WHO, IPAS and national healthcare guidelines. Graham, Jayadeva, and Guthrie (2010) investigated the use of an integrated abortion care pathway across two hospitals in the UK. They found that the pathway was useful for high-quality record keeping and maintaining high-quality care. They proposed the addition of a postabortion care component to the pathway to enhance care further. Many countries have successfully streamlined abortion care (and improved access) by extending the scope of practice of nurses and midwives to provide medical and surgical abortions (Mainey, O'Mullan, Reid-Searl, Taylor, & Baird, 2020).

Evidence from multiple international feasibility studies has con- cluded that nurses and midwives, who have received appropriate training, are at least as safe in providing medical and surgical abor- tions as medical personnel (Mainey et al., 2020). Task-sharing and task-shifting efforts can include removing arbitrary constraints on clinician's scopes of practice and the training of clinicians to offer all aspects of abortion care (Ipas, 2013). de Moel-Mandel, Graham, and Taket, (2019) used a Delphi process to develop a nurse-led model of care for the Australian primary care setting. They also recommends shared care models with telemedicine providers in areas where there are barriers to pharmacy access. Action such as competency-based training (de Moel-Mandel et al., 2019) is needed to get models such as these off the ground and rolled out on a national level. Much of this could be done at a policy level by incorporating the WHO's technical and policy guidelines for abor- tion care (World Health Organization, 2012) and Ipas' guidance on comprehensive abortion care (Ipas, 2013). Such changes, however, would require amendments to regulatory structures, funding mod- els and relaxation of prescribing and abortion procurement restric- tions.

Many participants discussed the traumatising affect the health- care system had upon patients. Trauma-informed domestic vio- lence and sexual assault screening, which respects patient au- tonomy, should be a key component of the integrated care pathway and link with action-oriented outcomes such as safety planning, lethality assessment, and referrals. Evidence suggests that clinicians require direction and support in this regard (Sutherland, Fontenot, & Fantasia, 2014) and also with docu- menting associated mental and physical injuries and symptoms (Colarossi, Breitbart, & Betancourt, 2010). Perry, Murphy, Rankin, Cowett, and Harwood (2016) found that most healthcare profes- sionals learnt about sexual assault through the voluntary disclo- sures of patients. If used at all, screening tools were variable in how they were applied. Further, most participants were unaware of protocols in use to screen and refer participants. We, therefore, recommend that the design of such pathways compel the clinician to follow such protocols.

Finally, the physical safety of abortion care services, (includ- ing telehealth), requires immediate review. Participants described troubling situations where colleagues put themselves in risky sit- uations with aggressive perpetrators. As Ford (Ford, 2010) notes, it is unsafe to isolate clinicians and aggressive partners or patients together, inside or outside the clinical environment. To improve physical safety, all staff should receive regular training regarding managing aggression in the workplace; healthcare environments also need to recognise and develop protocols to address aggres- sion in this unique context. Security enhancements, such as swipe access security doors, could also enhance safety without impos- ing on the pleasantness of the physical environment (Ford, 2010). With respect to telehealth clinicians, a recent synthesis and adap- tion of evidence-based domestic violence guidelines for telehealth reiterated that bearing witness to gender-based violence, even over the phone or the internet, may cause vicarious trauma (Jack et al., 2021). Organisations should provide proactive and reactive care to mitigate vicarious trauma, such as integrating trauma-informed policies that acknowledge historical trauma experienced by staff, clinical supervision, caseload management and regular screening for vicarious trauma (Jack et al., 2021). Jack et al. (2021) suggest developing a plan when a consultation is suddenly disconnected, including ringing a support person or the police and having a unique code that patients can use if they are in danger.

5.1. Limitations

The abortion and women's safety landscapes are constantly changing; therefore, in line with Situational Analysis our find- ings are tentative (Clarke, Friese, & Washburn, 2016). During this project, abortion law changed in two Australian States. Unlike Con- structivist Grounded Theory, the role of Situational Analysis is to theorise, not to generate theory (Clarke et al., 2016). Through theorising, we have gained a working understanding of how the broader situation (the healthcare environment), affects the provi- sion of abortion care for victims of domestic violence or sexual assault. The major limitation to Situational Analysis is that it cap- tures a moment in time. The abortion landscape continues to shift and as such our findings need to be regularly revised, updated or discarded in the face of change (Clarke, n.d.).

6. Conclusion

Healthcare environments should be primed to provide person- centred abortion care to pregnant people, particularly after the re- cent decriminalisation of abortion across most of Australia. Stream- lined local abortion pathways that take full advantage of nurses' and midwives' skills, knowledge, and potential should be evidence- based and trauma-informed. Abortion care pathways should also be integrated with women's safety organisations and have cultural safety mechanisms such as staff education, translation services and cultural liaisons. Organisations should also review the physical and psychological safety of their policies and practices to reduce the risk of injury or vicarious trauma to staff and patients.

Author contribution

Lydia Mainey: Conceptualisation, Methodology, Validation, For- mal analysis, Investigation, Data Curation, Writing - Original Draft, Visualisation. **Catherine O'Mullan:** Supervision, Writing - Review & Editing. **Kerry Reid-Searl:** Supervision, Writing - Review & Editing.

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Ethical statement

This study is part of the lead author's PhD project, and it in- volves human research. It is a qualitative scientific research project.

It received ethical approval from CQUniversity Australia human re- search ethics committee (HREC0000021264) on the 4th of Decem- ber 2018.

Conflict of interest

The lead author has previously worked for Marie Stopes Aus- tralia, who recruited some of the participants for this project.

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Paper 5: Reproductive power and justice: An Australian social worlds/arenas analysis of abortion and gender-based violence care

- **Aim 2** To map the elements of the broader health care situation that affect the provision of abortion care to people affected by GBV.

Synopsis

Paper 5 reports on a SA study that aimed to map the groups that operate at the nexus of abortion and gender-based violence in Australia and explain their collective actions. Specifically, the study uses a constructivist grounded theory approach to social worlds/arenas mapping, another analytical tool from the Situational Analysis "theory/methods package", to move the analysis to the collective social action level. This process enabled me to locate the social worlds that operate inside the abortion arena and understand how they exercise their power and what effect this has on providing abortion care to victims of GBV. Paper 5 builds on Paper 2 and 3 by describing the SA method (social worlds/arenas mapping in particular) in greater detail and by shifting the analysis from the individual level and organisational level. This process allowed me to theorise the collective social factors that compelled clinicians to undertake a process of working with or against the system.

I uncovered many worlds that collaborate, collide, and exert power over access to abortion and women's safety which I grouped into 10 zones of interaction. The findings demonstrate that the Australian abortion arena is a complex network of competing or allied worlds that increase or reduce the marginalisation of victims of GBV. I then focussed the analysis on the actions of four important worlds – Smuggler, Navigator, Marie Stopes Australia, and the Family Safety Framework; each world attempts to incorporate gender-based violence responses into their work to increase abortion access. The findings call attention to pro- and anti-abortion worlds that continue to influence abortion

care in Australia and emphasise the importance of streamlined, safe and confidential pathways for people who disclose gender-based violence.

Declaration of co-authorship and co-contribution

Reproductive power and justice: An Australian social worlds/arenas analysis of abortion and gender-based violence care

Mainey, L., O'Mullan, C., & Reid-Searl, K. (under review). Reproductive power and justice: An Australian social worlds/arenas analysis of abortion and gender-based violence care. *Nursing Inquiry***.**

Nature of candidate's contribution, including percentage of total

In conducting the study, I was responsible for conceptualisation, methodology, analysis, writing and administration. This publication was written by me, and my contribution was 75%.

Nature of co-authors' contributions, including percentage of total

My co-author Catherine O'Mullan contributed to the paper by reviewing and supervising (15%). My co-author Kerry Reid-Searl contributed to the paper by reviewing and supervising (10%).

Reproductive power and justice: An Australian social worlds/arenas analysis of abortion and gender-based violence care

Abstract

Clinicians' ability to provide reproductive justice for people who access abortion care is shaped by intersecting layers of power and oppression. This study used an intersectional situational analysis approach explore and theorise how reproductive justice is operationalised for people affected by gender-based violence within the Australian abortion arena at a systems level. We analysed 18 nursing and midwifery interviews and pre-produced artefacts and located major groups that wield power over abortion access and pregnant people's safety. We located and discussed in detail four groups – Smugglers, Navigators, Marie Stopes Australia, and the Family Safety Framework that undertake sanctioned and non-sanctioned activities to provide a safety net for people seeking abortions in the context of gender-based violence. We call attention to pro and anti-abortion groups that continue to influence abortion care in Australia and emphasise the importance of high-quality abortion care for people who disclose gender-based violence.

Introduction

Abortion care inequity is a form of structural violence against pregnant people, disproportionately disadvantaging those impacted by intersectional issues such as gender-based violence (GBV), poverty, race, disability, and geographic location (Baird & Millar, 2020a). Nurses' and midwives' abilities to offer meaningful reproductive choices and comprehensive abortion care are likewise shaped by these intersecting layers of oppression (Mainey et al., 2022a, 2022b).

Reproductive justice is a social justice movement, that takes an intersectional activist approach towards reproductive health (Burger et al., 2022; Ross & Solinger, 2017). The movement highlights and resists systemic oppression by drawing on the human right to a safe and dignified context in which to manage fertility, reproduce and

become parents (Ross & Solinger, 2017). While equitable access to abortion care is an important component of reproductive justice, on its own, abortion does not constitute reproductive justice (Ross & Solinger, 2017). In other words, providing abortion without attending to the underlying factors which caused the unplanned/mistimed pregnancy or led to decision to have the abortion in the first place prevents pregnancy-capable people from having real reproductive choices (Ross & Solinger, 2017).

Emerging literature reveals small reproductive justice initiatives, such as the University of Florida Mobile Outreach Clinic (Nall et al., 2021), Chicago Health Connect One doula home visiting service for teenage parents (Glink, 1998 Hans & White, 2019) and the Florida State University Young Parents Project home visiting program for court-involved teenagers (Hans & White, 2019). These outreach programs, which operate to increase reproductive autonomy bring integrated, culturally safe services to end-users (Hans & White, 2019; Nall et al., 2021). However, there is little evidence of the wider health system, and professional groups within these systems, incorporating reproductive justice into their policies and procedures.

Despite the nursing and midwifery communities' reticence to adopt reproductive justice as a framework for practice (Burger et al., 2022; Hawke, 2021), Australian research is revealing how individuals within these professional groups undertake subversive acts to provide the safety net for pregnant people who are failed by social and health systems. For example, in her recent discussion paper on subversive acts in everyday midwifery, Hawke (2021), reveals that Australian midwives undermine health establishments as part of routine care to provide woman-centred outcomes. Likewise, our recent study of how Australian nurses and midwives provide abortion care to people victimised by GBV, reports that participants would purposely work against systems to provide person-centred outcomes (Mainey et al., 2022b).

While there is a call for the nursing and midwifery profession to incorporate a reproductive justice framework for practice (Burger et al., 2022; Escobar, 2019; Nelson, 2021), by virtue of being an intersectional approach, reproductive justice does not work

without a systems-wide commitment. For this reason, the broader health community calls for a reimaging of health systems and services to centre reproductive justice (Britt et al., 2021; Nall et al., 2021; Shankar et al., 2021).

Over past 15 years, Australia has decriminalised abortion care in every State and Territory except Western Australia (Children by Choice, 2021). It is now a priority for mainstream health services to take responsibility for abortion care, which until now has been the remit of private providers (Australian Institute of Health and Wellfare et al., 2005). At this juncture, it is timely for health services to reconsider how they will provide abortion care, particularly for people marginalised by intersectionality.

This paper explores and theorises how reproductive justice is operationalised within the Australian abortion arena at a systems-level level. We begin by situating our paper within the broader abortion and intersectionality literature to highlight its significance before focussing on GBV. We then present our research design and findings; a map of the Australian abortion arena and an explanation of the collective processes of four group types that work to increase reproductive justice within broader health systems.

Abortion, intersectionality, and gender-based violence.

Estimates suggest one in four Australian women will have an abortion in their lifetime (Scheil et al., 2016). However, these relatively high rates of abortion are not necessarily evidence of reproductive autonomy but likely emerge from intersecting forms of oppression. In countries with more liberal reproductive health policies, easier abortion access and robust welfare systems, rates are half that of Australia's (Children by Choice, 2017). Australia's high take-up of abortion is likely because the alternative choice, parenthood, is unfeasible for many people (Baird & Millar, 2020b).

The underpinning neoliberal ideology of the Australia welfare state places individual's – including those who care for children - primary responsibility to the economy (Wolfinger, 2014). Images of immorality, poverty and the *welfare queen* are

used in Australia and abroad (Thakkilapati, 2019; Wolfinger, 2014) to denigrate single parents (particularly mothers) and promote the perception that they cheat the system. These stereotypes have persisted over time; from the forced adoptions of illegitimate children in the 1940s to 1970s (Community Affairs Reference Committee, 2012), to more recent discourses such as a 2017 article published in a major Australian newspaper beginning, “Single mothers have been crying poor, but are raking in tens of thousands of dollars in welfare” (in Wolfinger, 2017).These stereotypes correlate with punitive welfare policy leading to Australian pregnancy-capable people’s migration out of the home and into the workforce, downgrading parenting to just one activity that they perform (Wolfinger, 2014).

Ableism is a system of simultaneous bias and exclusion of people with disabilities and inclusion and affirmation of able-bodied people (Zimmer, 2021) that intersects with neoliberalism and is associated with reproductive inequality. Individual economic self-sufficiency and independence are aspirations within neoliberal society, and raising children to become autonomous adults is an ingrained cultural assumption, particularly for mothers (Tabatabai, 2020). Early state-sponsored attempts to weed-out the “burdens” on society, such as the sterilisation of the “feeble-minded” and “criminals”, have given way to reproductive technologies that offer choices “that maximize a child’s capacity to flourish in and contribute to society while minimizing their chance of being a so-called societal ‘burden’” (Valentine, 2021, p. 2). In other words, within neoliberalist societies such as Australia, pressure to electively abort foetuses with a disability is part of the culture.

Ableist attitudes negate the agency and sexuality of people with disabilities. This leads to disbelief regarding the person’s pregnancy, and stereotyped attitudes towards their ability to consent to an abortion (Victorian Women with Disabilities Network, 2007). Furthermore, within neoliberalist society, parenting is seen as successful when done independently (Tabatabai, 2020). Consequently, many people living with a disability who find themselves pregnant face abortion coercion from family

members, health providers and paid carers and guardians (Lee, 2019; Victorian Women with Disabilities Network, 2007).

Of course, reproductive inequality is not limited to those with disabilities. Much is known about the practices aimed at Indigenous women and women of colour globally such as the forced sterilisation programs in Canadian and US (Pereira, 2015; Ryan et al., 2021). In Australia, from 1910-1970 Aboriginal children were kidnapped, exploited and neglected under the guise of various government assimilation policies (Wilson & Waqanaviti, 2021). Discriminatory and punitive policies targeting Aboriginal and Torres Strait Islander mothers continue today. For example, the Parents Next program forces fulltime Aboriginal mothers to complete mandatory tasks in exchange for welfare assistance. Many find it impossible complete these tasks and provide care for their extended families. Thus, single parents are pushed further into poverty, perpetuating the stereotype of the neglectful Aboriginal parent (Human Rights Law Centre, 2019). Furthermore, Aboriginal and Torres Strait Islander people have higher odds of presenting for a later-term abortion (>9weeks) which suggests they face ongoing barriers to early care (Shankar et al., 2017).

GBV is an umbrella term for any unwanted harm perpetrated against a person that arises from unequal power relationships based on socially constructed gender-roles and gender-identities (Wirtz et al., 2020). GBV and abortion overlap when reproduction is controlled by the state, an institution, the law, medical establishment, patriarchy (Chadwick et al., 2021) or at the interpersonal level. Common forms of interpersonal GBV (domestic violence (DV) and sexual assault (SXA)), unintended/untimed pregnancy, and abortion (Gee et al., 2009; McCloskey, 2016; Oberg et al., 2014; Taft & Watson, 2007; Tinglöf et al., 2015). Reasons for accessing abortion in the context of GBV include childhood sexual abuse, date rape (Bleil et al., 2011; Silverman et al., 2004), forced sex by intimate partners (Messing et al., 2014), and reproductive coercion (Miller & Silverman, 2010).

A cross-sectional study of 2465 women recruited from health services across Boston, USA, reports that a cumulative experience of GBV increases the odds of abortion with nearly all women who report four or more GBV events having had an abortion (McCloskey, 2016). The most recent Australian study on the issue, found that women who access abortions are three times more likely to be affected by DV and SXA than those who do not terminate a pregnancy (Taft & Watson, 2007). Women who present for multiple abortions or later-term abortions have even higher rates of DV or SXA (Aston & Bewley, 2009; Gee et al., 2009; Hall et al., 2014). Transgender people experience GBV at rates much higher than the general population and are less likely to recognise, report, or receive support (O'Halloran, 2015). Moreover, they are often reluctant to seek reproductive health care (Abern et al., 2018) and are more likely to face healthcare discrimination which likely obstructs their access to abortion care (Moseson et al., 2020).

The long-term outcomes for people victimised by GBV are poor. For example, GBV can directly influence health (e.g., injury or self-harm), or indirectly, limiting a person’s earning capacity, social connections, and access to health care (Ayre et al., 2016). GBV also increases exposure to other risk factors such as smoking and drug and alcohol use. It is associated with poor mental health and perinatal outcomes, chronic diseases, and sexually transmitted infections (Ayre et al., 2016; World Health Organization, 2021).

These contradictory constraints on abortion and parenthood, highlight the intersection of race, class, gender, ability, and power and cannot be separated from the health care experience.

Methodology

This paper reports on the final phase of an intersectional extended constructivist grounded theory (CGT) doctoral project, exploring Australian nurses' and midwives' experiences of providing abortion care to people victimised by GBV. CGT is

a second-generation grounded theory methodology, influenced by feminism, postcolonial theory, anti-racism and other social formations (Clarke, 2009). It is claimed as a critical inquiry method and offered as an approach to researching social justice issues (Charmaz, 2014, 2020).

In the first phase of this study, we identified a process of resistance in which participants engaged to provide person-centred care (Mainey et al., 2022b). In this next phase we use Situational Analysis (SA), an extension of CGT, to move the analysis away from the individual nurses and midwives, to focussing entirely on the situation (Clarke et al., 2018). In particular we used social worlds/arenas mapping, a heuristic device used in SA (Clarke et al., 2018, p. 7), to study collective social action. In doing so, we located the main groups that operate inside the Australian abortion arena, identified four group types that endeavour to achieve reproductive justice and theorised about the processes these groups undertake.

Participants

We used the same dataset from the first phase of this study – interview transcripts of 18 Australian nurses and midwives who had at least 12 months of experience providing comprehensive abortion care, which is care delivered across a continuum from the diagnosis of pregnancy through to aftercare (Turner & Huber, 2013). Most participants were Anglo-Australian females and came from a broad range of rural, remote, and metropolitan areas and practice settings. Please refer to Mainey et al. (2022b) for detailed information on the recruitment process, participant demographics.

Data Collection

LM, previously a nurse unit manager at Marie Stopes Australia who is trained and experienced in in-depth interviewing techniques, conducted the one-on-one interviews face-to-face (n=2), via telephone (n=5) and zoom (n=9) and over email

(n=1). Please refer to (Mainey et al., 2022b) for detailed information on the interview guide and questions.

We used social worlds/arenas analytic tools to analyse the interviews and found we required more information. Therefore, we returned to participants to ask follow-up questions and retrieved data from pre-produced sources (organisational websites).

Ethical considerations

This study received ethical approval from the CQUniversity Australia human research ethics committee (HREC0000021264); several ethical considerations were relevant. During the research project abortion was a criminal offence in some Australian States - though it was legal in the context of gender-based violence. However, not all clinicians understood this and felt a level of discomfort disclosing their involvement in abortion care. Some participants became upset, recounting how they were traumatised by their clinical experiences. We offered to stop the interview, but participants felt their contributions were essential and hoped to make a difference. The interviewer provided them with resources for psychological support, followed up, and kept them abreast of the project's progress. Many participants disclosed transgressive practices, including illegal activities. For this reason, their identities will remain confidential, and the dataset will not be shared.

At different times, the research team have felt the burden of the clinicians' stories. We have debriefed after emotional interviews and have supported each other as we have read through transcripts and contemplated the gravity of the findings.

Analysis

We used the Situational Analysis application of social worlds/arenas mapping to chart the groups (social worlds) in the Australian abortion arena and analyse collective structures (i.e. power) and actions in the situation (Clarke et al., 2018). First, over many iterations, LM reviewed interview transcripts, noted examples of collective action (i.e.,

possible evidence of social world activity) and plotted these as prospective social worlds and sub-worlds in the abortion arena. She gathered further data from participants and pre-produced sources to help chart each world's natural and contested borders and wrote memos about her decisions and findings. We also used Clarke et al.'s (2018) social worlds/arenas theory conceptual toolbox and analytical questions to assist in analysing and writing focussed memos about the important worlds which presented themselves in the data (Table 3).

Next, quotes illustrating collective action for each group were added to a table and analysed using line-by-line and higher-order coding (Charmaz, 2014). LM wrote memos and drew analytic diagrams about the meaning of the codes, comparisons between codes, her analytical decisions, and her insights about the data. Finally, codes and diagrams were compared, using constant comparative analysis, focused, then abstracted to categories and checked by the co-authors.

Table 3: Example of coding and memoing using Clarke's conceptual toolbox and analytical questions

Participant 2			
Toolbox item	Code	Analytical Questions	Memo
Universe of Discourse	Smuggling people Networking Religious impact on abortion access	What is the work of this world?	To identify and refer people to abortion. To arrange for them to get to City A or over the border to Town B and back again. To refer people to the domestic violence service.
Situations	Connecting with the community	What are the commitments of this world?	To help women who do not want to continue with their pregnancies.
Identities	Being Bossy Being risqué	How do its participants believe they should go about fulfilling them?	Initially, they felt that the employer should challenge the law- but the organisation didn't do this. So, the participants used their positions in the organisation and an airline company to access women who require abortions and cheap airline tickets.
Commitments	Not wanting to be in that situation	How does this world describe itself/present itself in its discourse?	Bossy, risqué, risk takers, flying by the seat of their pants.
Shared ideologies	Anger at the lack of access	How does it describe other worlds in the arena?	Employer – weak for not challenging abortion law. Other abortion worlds in a public hospital – vaguely aware of them but not in their zone of influence.

Primary activities	Arranging everything Assisting with people who wanted termination Getting cheaper airfares Arranging to go down and back for an abortion. Finding out if she had DV Being the conduit Staying under the radar	What actions have been taken by this social world in the past? What actions are anticipated in the future?	The SW has successfully moved women between rural and remote communities to a Capital City and across the border to access abortion care. The SW will not act in the future as the critical link – airline worker – moved to a new job.
Particular Sites	Playing tennis Coming to us because they heard we could help. Seeing them in motel rooms and out of hours	How is the work furthering this world's agenda organised?	The SW relies on its reputation within communities. The nurse manager provides support and encouragement. The educator has access to the field and identifies the women who want abortions and who are in DV situations. The medical officers provide referrals to abortion clinics. The educator provides names to the airline worker during a tennis match and refers DV victims to women's shelter. The airline worker provides cheap tickets to the women.
Technologies	Getting cheaper airfares	What technologies are used and implicated?	Obtaining airline tickets was the major technology. Everything else seemed quite low-tech.
Specialised knowledges	Dealing with a girl at airline Being good communicators Knowing where to go for abortion	Are there other interesting non-human actants linked to this world? If so, why and how?	Paperwork – there is a very limited paper trail on purpose.

More formal organisations	Employer Abortion centre A & B.	Are there particular sites where the action is organised? What are they like?	Family planning – low supervision from upper management as the clinic was remote—low input from medical staff as they were not consistent. Tennis – social/community event.
Going concerns	Being found out Taking her own life Accounting for time.	What are the major topics of discourse and debate in this world?	Helping women get access to abortion. The legal apathy of employer.
Entrepreneurs	Seeing a way to work together	What other worlds seem to matter most to this world?	Employers – because they need to stay employed to do their work, so they can't be found out. Political-Religious world – set the agenda for women's reproductive autonomy.
Mavericks	Flying by the seat of our pants.	What else seems important to this world?	Ongoing abortion reform.
Segments/subworlds	Nil – world too small.		
Reform movements	Nil		
Bandwagons	Nil		
Intersections	Seeing so much violence coming through		
Segmentations	Nil		
Implicated actors/actants	Women "not knowing about themselves" Knowing about D&C cases at the public hospital.		
Boundary Objects	Feeling cross with the organisation		

Work objects	Not documenting things		
Discourses	Abortion coming under sexual and reproductive health		
Temporality	Airline worker moving away.		

We used various strategies to ensure trustworthiness and credibility; a self-interview to assist with reflexivity and methodological memos to record when we might have been working off assumptions (Charmaz, 2014). CO and KRS independently reviewed the open coding of transcripts. Finally, LM presented all participants with the research findings either by email, zoom or phone. Five participants responded, one person corrected a minor misunderstanding about her practice, all believed the findings captured the process they used to provide abortion care to people affected by GBV.

Findings

The findings of this research trace some of the major groups which operate in the Australian abortion arena and reveal the processes through which four group types attempt to operationalise reproductive justice.

Abortion arena map

Figure 5 is a map depicting some of the main groups that operate within the Australian abortion arena. Colour-coded clusters indicate groups that interact with each other, and arrowed lines indicate cooperation between groups. Areas of overlap between groups are analytically important and signify contested borders which are sites of power and resistance.

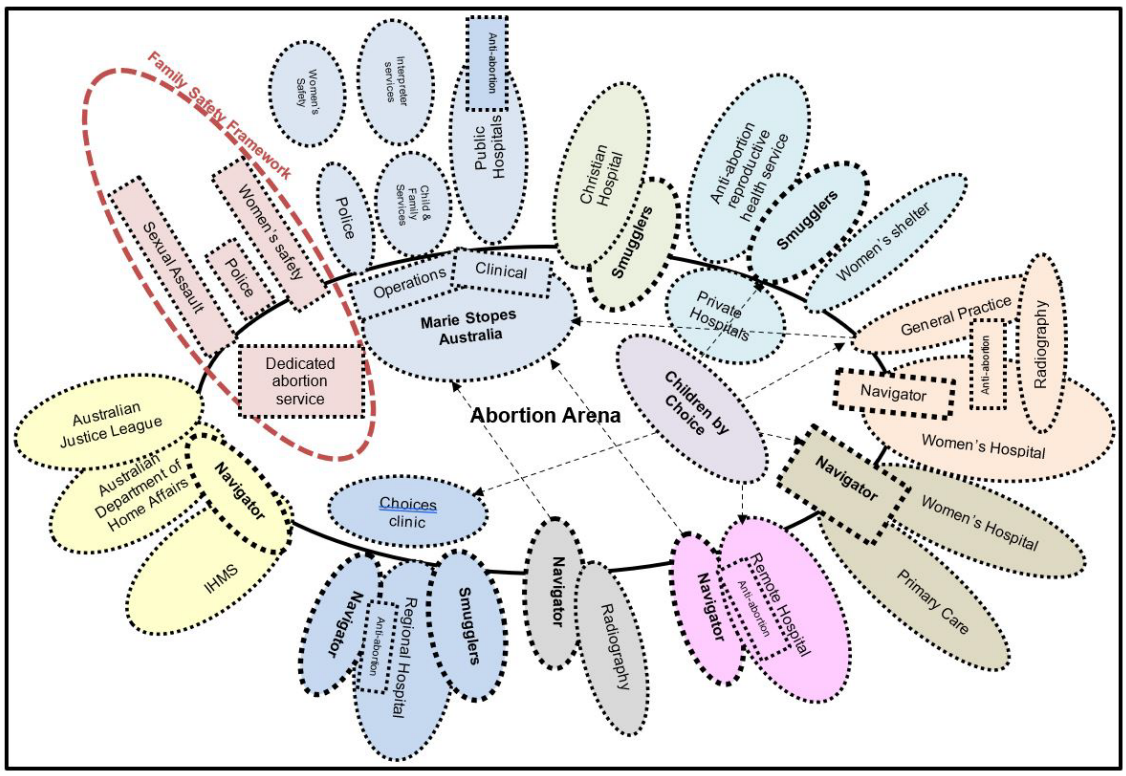

Figure 5: The Australian abortion arena

We charted 10 cluster groups; some were small, located in one geographic location and contained within one workplace (e.g., light-green Christian Hospital/Smuggler cluster). Other clusters were expansive, worked across Australia and incorporated multiple agencies (e.g., light blue Marie Stopes Australia cluster). In addition, multiple groups within the clusters held collaborative relationships with the pro-choice organisation Marie Stopes Australia, which accepted referrals particularly for late-term abortions and Children by Choice, which assisted with funding for travel to abortion care and the abortion procedure.

This map demonstrates multiple sites of contested action and resistance (i.e., overlapping group boundaries). State and Federal politics (not just abortion-related politics) were common sources of contestation within most clusters. For example, Australian immigration law drove disputes related to abortion access within the Refugee Health cluster (yellow) and contributed to an episode of escalating GBV. Anti-abortion groups operated widely, but more subtly, within the arena both in Christian-affiliated organisation, public hospitals, and primary care. In the public sector, anti-

abortion groups were unofficial yet wielded significant power which infiltrated up to the executive level of health services. These groups hostaged workflow and workloads through conscientious objection and prevented or limited abortion care within whole health services. Another point of contestation was between health services and radiography departments which operated on different timelines than people requiring abortions.

In the next section we focus our analysis on four groups/group types – Smugglers, Navigators, Marie Stopes Australia (MSA), Family Safety Framework (FSF). Each of these groups attempted to achieve reproductive justice outcomes for people who seek abortion in the context of GBV.

Group processes

Table 4 presents an overview of the core processes of Smuggler, Navigator, MSA, and FSF groups, the underlying steps and drivers of the processes and illustrative quotes from participant transcripts.

Table 4: The work of abortion access groups

Group/world	Core Process	Action	Sub-steps and drivers	Illustrative quotes
Smuggler	Smuggling to abortion care	1. Working opportunistically	Assisting abortion access + Valuing women above politics	We had good support from some of the doctors who did the referrals for the clients…We used to deal with a girl that we knew at (airline). She used to get them down and back (to the abortion clinic) in a weekend. P2
			Creating a conduit	I was the conduit between that person out in the field (and the clinic) …So, if I was out in the field they talk to me. I said, well, this is what you can do…If I was out in the sticks doing some educational trip, I would go and see (people wanting abortions) in their motel rooms. Or they'd come to me out of hours. P2

		2. Operating under noses	Hiding Patients	So, they'd be booked in for a D&C and then it would have the word suction next to it, which indicated to us in theatre what was happening. But it wasn't indicated to senior management exactly what we were doing. P6
			Carefully connecting to supportive worlds	I could go and talk to the Chaplaincy, but I had to be very generic about what I said… because they were the Chaplaincy, and we were in breach of what they really expected of us. P6
			Keeping others in the dark	Well, I guess the big challenge is if we were found out…That was a challenge, not letting other people know. It's a big challenge for the girl at (airline), of course. And I think that the challenge for our own position, what had happened if we were found out – we had to think of the legal aspect. P2

		3. Dissolving	Departure of key personnel	Because of the change of staff and also that the girl from (airline) left, we didn't have anyone to go through. P2
Navigator	Navigating through complex systems	1. Becoming Desperate	Creating straightforward pathways	I'm working as a project manager on the sexual and reproductive health clinical champion project. And the rationale behind the project is to support, particularly the primary care providers to increase their scope of practice to offer medical abortion to the women who seek abortion. P4 (We are) a cohort of midwives who want women to have access to any service that they require… I think that we have a very woman-centred service. All the midwives that work there are on the same page…Having a safe place where women feel respected and valued and that the woman is always at the centre of care and decision making. P15

		2. Acting in opposition 3.	Quietly breaking minor rules	I had been told by my boss that if you were offering women abortion, it was illegal, and I wasn't to say the word at all… I think (the patient) was wanting me to tell her how to get rid of the baby at home …I said, "If you decide that you want an abortion I can give you the contacts, I can give you the contacts so it can be done legally." P8
			Openly challenging	We do what is right, not what is expected…We have strength and determination to challenge, initiate, educate and prevent. (Extract from the mission statement of P3's social world). And so, I wrote an open letter to politicians saying, “This is what’s happening (at refugee detention centre). Can someone please help because, people will die because of this (de facto anti-abortion) policy,”. I gave that letter to (journalist), and he wrote some articles about it. P14

			Connecting to supportive worlds	I am working within a role which provides direct care co-ordination to women requesting (abortion). This service assists women in accessing (abortion) in the public health system and assists in referrals to wrap around services such as social supports etc, to provide more holistic care…Support from all stakeholders within the health service has given us the ability to provide appropriate care to these women. We are setting up processes to streamline access for women as well as improve services as we assess current demand. P17
		4. Dissolving	Disappearing barriers OR Departure of key personnel	Another doctor is happy to be the first (abortion) referrer now, so there is no longer any need for us to (write an abortion referral). P3

Marie Stopes	Propping up public health systems	1. Servicing the country	Providing abortion care for complex patients	She was only (a teenager), she'd already had three kids, she was in a DV relationship, she was (at our gestation) cut off. She was also an IV drug user, so she had no veins. She had to have miso - she spat it out... She ran away from the clinic three times, and she got a phone and threw it against the wall. We had to send (her) away. (She) could in no way deal with the pregnancy. P10

		2. Supporting	Offering pre- and post-abortion counselling + Establishing safety partnerships + Ad hoc safety supports	So there's a process; when they are booked in through the Support Centre for their appointment, they can ask to be referred on to counselling. Counselling will call them for an intake, and then try and reach them before their appointment (and) scale them on a level (of) importance… And then that's available to them as a service afterwards as well. So they've always got free access to post-abortion counselling as well. P16 There's been a lot of work around partnerships and working with consumers and looking at local need and local community need. So all of our clinics have a list of who their local DV services are. We've done quite a lot of work around that. So that in any case there would be the knowledge that we can pass on that referral, whether it's by handing out a brochure or a card or having direct conversation with those services. We've got a pretty good understanding of our local community needs. P9

				We did have one lady, she had a suitcase with her and she's like, "I can't go anywhere. I don't know what to do." I sat with her for a good half an hour and then I was like, "Okay, I'm just going to go and speak to my boss and see if we can get you any help." So then, yeah, I just went to the NUM's office and, basically, explained what the patient explained to me. I said, "She's not safe. Is there anything that we are able to do?". And that's when the NUM said, "Oh, I'm not sure, but we can call up head office and see if we can get her put up in a motel,". P10

		3. Conflicting priorities	Being fast paced + Pressuring nursing staff to keep their care episodes short	If we weren't so time poor and driven by patient flow because of a business model where we have staff there for a certain period of time…P9 If you've got someone distraught it does make it hard if your NUM [Nurse Unit Manager] or whoever is telling you to hurry up…(If) they're like, "Come on, come on, there's bed lock. We need to get three from theatre." It's like, "Ah, just stop theatre for a second." It's frustrating, but you're like, "Okay, I'll just do the best I can." P10
			Treating DV as a clinical variance + Handing over care	Our NUM she's really good and she'll often take over. If the DV victim really needs more help and we can give that, just even to chat, our NUM will often take over and do that bit. So that's quite good actually. P11

		4. Scaling Back	Closing clinics + Focussing on sustainable models of care	It is with our deepest regret that we need to announce the closure of our clinics in Southport, Townsville and Rockhampton in Queensland, and Newcastle in New South Wales…As an organisation, we must now turn our attention to building more sustainable models of care and the unique benefit we provide the communities which we can sustainably service. Organisation's website.
Integrated	Driving Integrated Service Response	1. Assessing Risk	Formal Screening	We do formal screening for domestic violence at every consultation…We ask, "has your partner, a member of your family, or somebody that you live with or someone else close to you, has anyone made you feel afraid? Have they hurt you physically or thrown things at you? Have they made you feel humiliated and put you down?". P1

		2. Getting a better picture	Sharing information + Holding forensic evidence	The (Integrated network) seeks to ensure that services to families most at risk of violence are provided in a more structured and systematic way, through agencies sharing information about high-risk families and taking responsibility for supporting these families to navigate the system of services to help them. Integrated network webpage. (B)ecause of that multiagency family safety framework thing, I think that's really good, because it draws in information from all the different services that that woman might have interacted with. So, I think they get a really good, overall picture of what the risks look like for that woman or for that family. P1

		3. Taking positive action	Alerting supervisor +/- Referring to Police	People can elect to have the forensic evidence collected and stored for 12 months. So, even if they haven't decided yet, whether or not they wanted to contact the police about it, we can facilitate that for them, so they can keep their options open. P1 We've got the domestic violence referral system, through to SAPOL, where it's a multiagency approach. So, if somebody's got very, very high-risk factors through this questionnaire, it can be referred to SAPOL without their consent, basically. P1

Smuggler groups are small ephemeral collectives of sexual health nurses and doctors, theatre nurses, obstetricians and midwives employed by or contracted to public health services with influential anti-abortion sub-groups or by anti-abortion reproductive health services. Smugglers operate exclusively at the level of contestation boundaries, resisting anti-abortion influences such as law, and health care policy. Members of smuggler groups come together opportunistically to work when the right conditions present themselves. Their core process is smuggling people to abortion care by gaining access to the field or technologies, such as operating theatres. Usually, these groups have at least one member who works independently from the health service to connect with pregnant people seeking abortions and technologies unavailable through the service. Smuggler groups leverage the health service's resources and processes, creating a conduit between the service and pregnant people.

Hiding patients is a crucial strategy of smuggler worlds. This strategy is accomplished by using false diagnoses, deceptive (or no) documentation, and rostering pro-life staff away to other areas while the abortion takes place. At the confluence of abortion and GBV, smuggler groups intersect with women's safety and counselling worlds. Therefore*,* carefully connecting patients to supportive groups is a secondary role of these worlds. Smuggler groups are constantly threatened by being discovered and thus focus on keeping others in the dark. The longevity of smuggler groups is tenuous, and dissolution often occurs due to the departure of key personnel.

Navigator groups, which operate officially and unofficially within the abortion arena, include membership of nurses, nurse navigators, nurse practitioners, midwives, medical personnel, counsellors, Indigenous liaisons, journalists, and lawyers. Official navigator groups seem relatively new in the arena, arising from abortion law reform and funded as time-limited projects. Unofficial navigator groups arise for brief and specific situations, often for social justice or human rights issues such as refugee health and reproductive justice. The major contested boundaries for navigator groups are

bureaucracy and fragmented care and their fundamental process is navigating people through complex systems.

Official navigator groups gain support from health service stakeholders to streamline services and navigate people through complex systems. Unofficial navigator groups streamline abortion care by quietly breaking the rules, frequently by doctoring paperwork or providing abortion access advice. They often work with Children by Choice to help fund private abortions at MSA. Navigator groups clash with the anti-abortion groups and group members, such as medical colleagues, pro-life clinicians, radiography groups, larger health services, and government departments that limit access to abortion. However, they collaborate with women's safety groups and legal groups. Once again, when GBV was a concern, connecting people to support services was primarily important. Official navigator groups appear to be incorporated into health systems while unofficial groups disband once barriers to care disappear.

MSA is a not-for-profit, non-governmental organisation and the largest provider of abortion in Australia. In the abortion arena, this group's fundamental purpose is propping up public health systems by providing abortion care either in-clinic or via telehealth. MSA has several stand-alone abortion clinics that employ nurses, midwives, specialised general practitioners, obstetricians, gynaecologists, counsellors, and others. Working with State/Territory Governments is a crucial task and has been instrumental in propping up public health systems, and consequently, providing care to people with complex medical and social histories.

MSA provides supports such as pre and post appointment counselling and has established safety partnerships within local communities and ad hoc safety supports. However, this supportive outlook is prone to breaking down in many clinics because of conflicting priorities between the business and clinical sub-groups. Being fast-paced was a universal issue blamed on MSA's business model, fly-in fly-out medical staff or medical staff who have set finish times. This pressured nursing and midwifery staff to keep their care episodes short. Consequently, GBV was treated as a clinical variance

and patients who experienced GBV were commonly handed over to more experienced colleagues.

The FSF is a large and established group of integrated segments including (but not limited to) a publicly funded stand-alone abortion service, sexual assault service, a range of women's safety and support services and the police. FSF was formed under the South Australian Government's women's safety strategy. In the abortion arena, its core process is driving integrated service responses to violence against pregnant people. Within the stand-alone abortion service, assessing for risk is carried out by nursing staff through formal screening and working closely with women's safety services. Getting a better picture of safety risks is a key strategy of the FSF, which is done by sharing information and storing forensics within the abortion centre. Taking positive action occurs when a nurse identifies a person at risk of imminent danger and involves alerting social workers and contacting the police.

Discussion

This study provides an important overview of some of the groups which operate within the Australian abortion arena, specifically at the nexus of GBV. The study also theorises the processes four groups use to provide reproductive justice outcomes and draws attention to the struggles inherent in achieving this.

Reproductive justice is predicated on the human right to access to high-quality health care (Ross & Solinger, 2017). With a few exceptions, clinicians revealed that high-quality abortion care remains inaccessible for many marginalised people in Australian. Our social worlds/arenas map may illuminate one of the main barriers to high-quality care - anti-abortion action. Anti-abortion activity was charted across much of the abortion arena; this activity corroborates with international studies. Several studies highlight how the anti-abortion stance of conscientious objection impedes and actively sabotages legal abortion access, disproportionately impacting people who live

in rural areas or experience economic disadvantage (Cohen & Joffe, 2020; Davis et al., 2022).

Despite abortion law reform, which occurred neither quietly nor quickly, many public health services had failed to upskill and upscale to provide abortion services at the time of our study. In light of our findings, one must seriously consider the influence of high-level anti-abortion action within health services on this outcome. Such actions would wade into the realm of *reproductive violence*, an overarching term for a range of coercive and violent experiences across a pregnancy that extends beyond domestic violence and sexual assault (Chiweshe et al, 2021 in Chadwick et al., 2021). Systems of power, such as health services, are especially invested in perpetrating reproductive violence against groups impacted by intersectionality (Chadwick et al., 2021). As an initial step, we recommend both National and State government directives to all public health services -and private organisations contracted to government agencies (such as correctional and detention centres) - to provide abortion care. This must be supported by employment of suitable staff and comprehensive upskilling of current staff. We also recommend State and Territory governments revise the terms of reference of hospital board membership in publicly funded health services to ensure minimum numbers of pro-abortion membership.

Reproductive justice is also based on the access to housing, education, a living wage, a healthy environment, and a safety net for when these resources fail (Ross & Solinger, 2017). GBV is a pernicious social issue, accelerated by failing social systems (Maury et al., 2022), and, as well as unplanned pregnancy, it can exacerbate social issues such as homelessness and financial insecurity, and lead to poor health (Australian Institute of Health and Welfare, 2021; Maki, 2017). Health services, therefore, are logically situated as an entry point to the safety net for people victimised by GBV. We found evidence of how this was operationalised within Smuggler, Navigator, MSA and the FSF groups. FSF and some Navigator groups appear to invest resources to drive proactive integrated responses to people victimised by GBV and

other intersectional issues. While Smuggler, MSA and many Navigator groups provide links to social supports they seem to prioritise abortion access. This appears due to the time-critical nature of abortion, secrecy under which groups must work or the organisational business model.

However, the Australian social safety net remains complex, difficult to navigate and prone to failures which are more likely to affect pregnancy-capable people (Maury et al., 2022). While this study highlights some of the struggles inherent in achieving reproductive justice at the nexus of abortion and gender-based violence, further research is necessary to move beyond individual clinician stories to specifically examine systems in more depth.

Limitations

This paper offers an analysis of the social worlds central to abortion care and GBV in Australia as found in the discourses of 18 nurses and midwives and some pre-produced material. We do not aim to provide an exhaustive overview of all existing viewpoints on the topic.

The role of Situational Analysis is to *theorise* and not to construct theory (Clarke et al., 2018), meaning that the findings are always provisional. The abortion and women's safety landscapes are constantly changing; during this project, abortion law changed in three States and is now almost decriminalised across Australia. Through theorising, we have understood how the broader situation (the socio-political environment) affects the provision of abortion care for people victimised by GBV. Our findings need to be regularly revised, updated or discarded in the face of change (Clarke, n.d.).

This is a study drawn from a sample of 18 Australian clinicians and pre-produced artefacts. Therefore, the basic processes of the four social worlds cannot be taken to explain the experiences of all worlds in all abortion arenas. By the same token, the findings are explanatory and have limited use in predicting future actions. The

participants were largely monocultural, and a more diverse sample could have led to more nuanced findings.

Conclusion

The Australian abortion arena is a complex domain of groups with competing and allied interests. Some actions of these worlds increase or reduce oppression faced by marginalised people, such as people victimised by GBV. Of concern, these actions can prevent or limit abortion care within whole health services. In this study, four worlds/world-types work to expand abortion access to victims of GBV. These are Smuggler, Navigator, Marie Stopes Australia and Family Safety Framework. These worlds attempt to incorporate GBV responses into their work with varying levels of success. Exposing the processes of these groups and revealing their strugggles is an importnat step foreward in understanding reproductive justice. However, if we are to move forward and achive reproductive justice, it is important to move beyond the stories of individual clinician and small groups and focus analyse the health systems.

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CHAPTER 5: DISCUSSION

Paper 6: Resistance in the abortion arena: Applying Essex conceptualisation to a multi-phased study on the experiences of Australian nurses and midwives who provide abortion care to people victimised by gender-based violence.

- To explain the process through which Australian nurses and midwives provide abortion care to people victimised by gender-based violence (GBV).
- To explore how the elements of the broader situation affect the provision of abortion care to people victimised by GBV.

Synopsis

In the preceding chapter I explained a process that participants undertook when providing abortion care to people victimised by GBV working with or against the system (Paper 3). Next, I demonstrated that participants felt the organisational environment left abortion care mostly uncatered for, especially in the context of GBV (Paper 4). Finally, I charted the Australian abortion arena and uncovered a complex network of words and segments with competing interests and mixed responses to abortion care in the context of GBV. The focus was directed towards four worlds that attempted to incorporate GBV responses into their work to increase abortion access – Smuggler, Navigator, Marie Stopes Australia, and Family Safety Framework (Paper 5). These findings are timely and significant for the Australian health sector. At present, the sector is reconfiguring in the face of abortion decriminalisation and adapting to the scaling back of surgical abortion provision by the private sector. Grounded theory methodology uses theoretical coding to move the analysis in a theoretical direction to tell a unifying story about the focussed codes and categories. In the context of this thesis, theoretical coding allows me to tell a unifying and cohesive story about the three findings papers. In Chapter 6 I introduce Essex's

conceptualisation of "resistance in health and healthcare" and apply it as a theoretical code to the findings of the thesis.

Declaration of co-authorship and co-contribution

Resistance in health and healthcare: Applying Essex conceptualisation to a multi-phased study on the experiences of Australian nurses and midwives who provide abortion care to people victimised by gender-based violence.

Mainey, L., O'Mullan, C., & Reid-Searl, K. (under review). Resistance in health and healthcare: Applying Essex conceptualisation to a multi-phased study on the experiences of Australian nurses and midwives who provide abortion care to people victimised by gender-based violence. *Bioethics*.

Nature of candidate's contribution, including percentage of total

In conducting the study, I was responsible for conceptualisation, methodology, analysis, writing and administration. This publication was written by me, and my contribution was 80%.

Nature of co-authors' contributions, including percentage of total

My co-author Catherine O'Mullan contributed to the paper by reviewing and supervising (10%). My co-author Kerry Reid-Searl contributed to the paper by reviewing and supervising (10%).

Resistance in health and healthcare: Applying Essex conceptualisation to a multi-phased study on the experiences of Australian nurses and midwives who provide abortion care to people victimised by gender-based violence.

Abstract

In this article, we explore the act of resistance by nurses and midwives at the nexus of abortion care and gender-based violence. We commence with a brief overview of a multi-phased extended grounded doctoral project which analysed the individual, situational and socio-political experiences of Australian nurses and midwives who provide abortion care to people victimised by gender-based violence. We then turn to Essex's conceptualisation of resistance in health and healthcare and draw upon these concepts to tell a unifying and cohesive story about how nurses and midwives exercise their politics. Vignettes taken from the three study phases are provided for demonstrative purposes. Finally, we discuss the potential of resistance in health and healthcare as a postmodern feminist research tool to analyse acts by nurses and midwives which could be categorised as political.

Keywords: Resistance, Abortion, Gender-based violence, Nursing, Midwifery

Introduction

The Bible recounts the story of two midwives, Shiphrah and Puah, who defied an edict from the Pharoah to kill all Hebrew males during their birth. When called before the Pharaoh to explain their defiance, the midwives delivered a formulated explanation: due to their strength, knowledge of childbirth and short labours, Hebrew women had delivered their babies long before they arrived to assist (Carter, 2010). This is purported to be the first recorded case of resistance in healthcare; there have been many more.

In more recent times, as part of a doctoral thesis, we conducted a multiple methods study examining Australian nurses' and midwives' experience of providing abortion care to people victimised by gender-based violence (CQUniversity Australia Human Research Ethics Committee approval: HREC0000021264). We interviewed 18 Australian nurses and midwives who had at least 12 months experience working in any context that provided

abortion care. Then we analysed the interview transcripts at the levels of individual action (constructivist grounded theory), the organisation (situational analysis) and group action (social worlds/arenas analysis). We will provide a brief outline of the major findings below.

In phase one, a study that analysed individual action and processes, participants revealed they underwent a process that we named *working with or against the system.* This process was contingent on the degree to which the system (the interconnected networks through which a pregnant person, victimised by trauma, travels) was woman centred. When participants encountered barriers to woman-centred abortion care, they described actions that suggested they bent or broke the law, local policy, and cultural norms to facilitate timely holistic care (Figure 4). Though many participants felt professionally compromised, their resolve to continue working against the system continued. We concluded that conservative abortion laws, policies and clinical culture did not prevent participants from providing abortion care. The professional obligation to provide person-centred care was a higher priority than following the official or unofficial rules of the organisations (Mainey et al., 2022b).

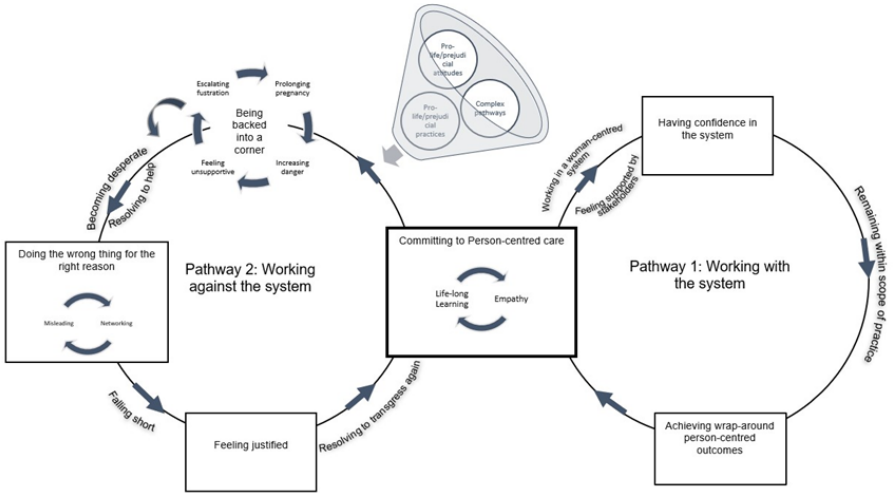

Figure 6 Working with or against the system

The second phase study turned the focus from individual action to the organisational environment. We found that participants believed that patients are *mostly uncatered for.* They described a workforce unprepared to provide abortion care, generally, and gender-

based violence interventions more specifically. Clinicians found that their pro-life colleagues centred their own needs, and many revealed that the workplace environments placed clinicians' and patients' safety at risk. We concluded that while abortion is a safe and straightforward procedure, the interconnectedness of time sensitivity, stigma, shifting legal landscapes, and high rates of gender-based violence mean that it is probably more complex than the current work models plan for (Mainey et al., 2022a).

In the third-phase study, we mapped the major groups (worlds) of influence in the Australian abortion arena and focussed our analysis on four worlds that increased abortion access. We discovered hidden worlds that undertake a process we termed *smuggling people to abortion care*, and worlds whose fundamental task is *navigating pregnant people through complex systems and bureaucracies*. Two other worlds of interest were Marie Stopes Australia whose main concern is *providing abortion care* and the Family Safety Framework whose core process is *driving integrated service responses*. We concluded that abortion and GBV intersect, and therefore should not be separated in the health system response. To create effective abortion services for pregnant people impacted by GBV, health services need to ensure GBV is addressed as an integral part of abortion services delivery (Mainey et al., under review).

Together these three studies depict a healthcare ecology that oppresses some people who seek and provide abortion care. Furthermore, the results from the studies unearthed underground action by pro- and anti-abortion individuals and groups which undermined practice guidelines, policy, and the law and highlighted risks to professionals who involved themselves in these transgressive actions. These widespread acts of defiance sit in juxtaposition to the numerous articles that have been written on the low uptake of political action by frontline nurses and midwives (Benton et al., 2017; Ditlopo et al., 2014; Woodward et al., 2016).

In 2021, Essex published the article "Resistance in Health and Healthcare" in which he conceptualised how clinicians act in response to power, most often against contentious, harmful or unjust rules, practices, polices or structures (Essex, 2021). Essex's

conceptualisation brings together different definitions and typologies of resistance. These range from civil resistance, which is associated with public nonviolent actions (Chenoweth & Cunningham, 2013), class resistance, involving any act by a subordinate class to mitigate oppression by super-ordinate class (Scott, 1985), to any dissident acts that express opposition to a dominant system (Delmas, 2018).

In his article, Essex identifies the characteristics of the process of *Resistance in Health and Healthcare* (RHH) which we have abstracted and present in Table 1 and the discussion that follows.

Table 5: Resistance in health and healthcare

Characteristics of resistance in health and healthcare	
Positionality	Carried out by anyone acting as or identifying as a healthcare professional. Bringing legitimacy due to the level of trust held with the community and difficulty discrediting actions. Well positioned to observe and act on healthcare injustice.
Active oppositionality	Any actions or omissions in opposition to something, usually power. Actions can from people with lower or greater structural power. Actions do not have to be altruistic.
Varying recognisability	Action does not need to be recognised by the opposition.
Emergent intentionality	Does not have to be done with intent.

Positionality

Positionality is a unique feature of RHH and sets it apart from other types of resistance. In the conceptualisation of RHH, positionality refers specifically to who is doing the resisting and the perceived legitimacy they bring to their actions. Essex underscores the importance of resistance performed by healthcare workers because they are held in high regard and trusted by the public. Therefore others (e.g. the media) have difficulty in discrediting their actions.

The nursing and midwifery professions take a unique position that centres healthcare on personhood and health equity (International Council of Nurses, 1998). Operationally this means we address people's health concerns and consider aspects of the person's life that might be relevant to their condition (e.g. socio-economic, relational or environmental) (Kim,

2015; Thorne, 2018). This social justice stance contributes towards the high-level public trust placed in nurses (Fowler, 2016). Accordingly, in our first study we found that individual participants positioned themselves as providers of person-centred care. This was the central aspect of their clinical practice; they wanted people to feel empowered throughout the abortion process and treated with dignity by the healthcare system (Mainey et al., 2022b).

When analysing the action of groups in the abortion arena (Study 3) we found the usefulness of positionality extended beyond *legitimacy*. Positionality as “employees of a health service”, allowed access to hidden communities (people seeking abortion) and technologies (such as operating theatres) which allowed them to undertake RHH activities (Mainey et al., under review).

While positionality is especially important for performative acts of RHH such as whistleblowing or protest marching in uniform (Essex, 2021), we found few examples of this in our study. Instead, we found an abundance of examples relating to what Essex refers to as resistance through delivering routine care (Essex, 2021). As he notes, providing healthcare and protecting health and well-being can of themselves be acts of resistance. Vignette 1 illustrates resistance through delivering routine care that we observed in our research project.

Vignette 1: An operating theatre clinical nurse who worked for a Christian hospital described how an obstetrician-gynaecologist admitted people for surgery under a fabricated diagnosis. The nurses ensured (i) anti-abortion staff were rostered away from theatre and (ii) assisted with the abortion procedure (Mainey et al., under review).

Essex also contends that healthcare professionals are uniquely positioned to call out harmful policies and advocate for protective alternatives (Essex, 2021). In our second study participants found a range of policies that left people victimised by GBV and seeking abortions *mostly uncatered for*. We will discuss these in more detail in the next section.

Active oppositionality

In RHH, active oppositionality refers to a broad range of activities – improvised or planned, legal or illegal – performed in opposition to something, usually power. These could range from performative acts such as protest marches, to acts of civil disobedience and everyday resistance such as stealing from an employer or working slowly (Essex, 2021). Issues that create the impetus for RHH, lean towards “contentious, harmful or unjust rules, practices, policies or structures” (Essex, 2021). In our research these ranged from national issues like immigration policy to more localised problems such as care pathways and inadequate skill mix (Mainey et al., 2022a). Vignette 2 illustrates resistance performed in opposition to new legislation introduced by the Australian Government restricting travel to Australia for medical care.

Vignette 2: A clinical nurse-midwife, working in an Australian offshore refugee detention centre in a global south, highly Christian country, contravened the terms of her employment to leak a letter to the national media. She exposed a new piece of legislation, quietly introduced by the Australian Government, preventing pregnant people from travelling to Australia for abortions and thus acting as a de facto abortion ban.

The most common types of RHH we observed were acts of everyday resistance in opposition to the harmful policies that individuals perceived backed pregnant people and clinicians into a corner (Mainey et al., 2022b). Issues that created the impetus for RHH were factors that resulted in increased gestation, financial burden and health and safety risks. Participants were concerned by inadequate skills mix caused by lack of training, workflow pressures, arbitrary restrictions on scope of practice and impact of conscientious objectors on patient safety. They also felt that abortion care pathways were overly complex, protracted, and expensive. Furthermore, many felt the workplace didn’t cater for patient and staff safety (Mainey et al., 2022a). In response, participants took part in what we termed “doing the wrong thing for the right reason” which involved networking with like-minded people, misleading the system and assisting the person to access safe and timely abortion

care (Mainey, et al., 2022b). Vignette 3 is an example of everyday resistance in opposition to the cost of contraception.

Vignette 3: A group of clinicians (nurses and doctors) stole an intra-uterine device from their organisation for a person in a domestic violence situation who could not afford long-acting contraception following an abortion (Mainey et al., 2022b).

While many definitions of resistance are conceptualised as being performed by the oppressed in reaction to something unjust; Essex argues for a broader description (Essex, 2021). He claims that while RHH generally comes from below, it can also come from people who are structurally more powerful; moreover, RHH does not have to be motivated by altruism. This typology of RHH was commonly reported by participants. It often involved anti-abortion nurses, midwives and doctors conscientiously objecting to, or being derogatory towards, people seeking abortion though also occurred between high-level nursing and medical staff towards lower-level nurses and midwives (Mainey et al., 2022b). Vignette 4 illustrates RHH performed by the structurally powerful.

Vignette 4: A senior obstetrician in a public regional hospital actively cautioned a junior midwife who was part of a pro-choice community group. Despite abortion being legal for the health and safety of the pregnant person, senior staff forbade staff from discussing abortion with clients. Midwives felt their contracts would not be renewed if they offered clients choice (Mainey et al., 2022b).

Varying recognisability

Political resistance has been framed by some as communicative action, meaning that its purpose is to draw the public's attention to issues "to touch the majority's sense of morality" (Atilgan, 2019, p. 171). Moore argues that acts of resistance are those which are perceived by the resisted to be working against their own interests (Moore, 2000). Again, Essex's conceptualisation brings the broader lens of everyday resistance (Scott, 1985) to the debate. As indicated above, providing healthcare, and protecting health and well-being can of themselves be acts of resistance and such acts can be subtle and go unnoticed (Essex,

2021). We observed that everyday acts of RHH were extremely common practice and, in many cases, *relied* on nurses and midwives “quietly breaking minor rules” and “keeping others in the dark” (Mainey et al., under review). In other words, it was intentional that the RHH was overlooked. Vignette 5 provides an example of RHH that relied on going undetected.

Vignette 5: In a state where abortion requires two medical practitioners to make independent referrals, a nurse and practice manager in a rural town impersonated a doctor on a medical referral form. This is because there is only one pro-choice general practitioner in the community (Mainey et al., under review).

Emerging intentionality

Essex’s conceptualisation of resistance diverges from other scholars around the argument of intent. He contends that in healthcare especially, one may not be cognisant that their actions are acts of resistance. In this regard he agrees with Baaz et al. (2016) and Ferrell (2019) that intent is not critical to acts of resistance and that intent evolves or is something viewed in retrospect. In our study we found cases of both intentional and evolving resistance. Most participants knew that they were acting in opposition to structural injustice, in fact many described how their anger at the system incited them to act and felt justified when they broke the rules (Mainey, et al., 2022b). However, one participant had difficulty connecting her actions to resistance behaviour which we describe in vignette 6.

Vignette 6: A nurse practitioner pre-signs ultrasound request forms for her midwifery colleague to prevent marginalised patients bouncing between healthcare providers.

Discussion

We considered several theoretical frameworks to unify the findings of this doctoral research project. In the initial stages of the study, we were drawn to Anarchism (Chomsky, 2013) – any form of authority or coercive power must justify itself and if it cannot, it should be illegitimated and dismantled. While participants unanimously believed restrictive abortion

laws, policies and social mores were wrong, for the most part we observed clinicians who undermined the system but didn't dismantle it. We then broadened our search to literature on collective human behaviour and identified "Will to fight" theory (Gómez et al., 2017) which describes a process whereby group interests become sacred and non-negotiable ideologies which eclipse personal safety and gain. "Will to fight" is observed in members of combatant groups who have ideological power and are more willing to engage in conflict than those with material power (Gómez et al., 2017). We wondered if this metaphor could be applied to nurses and midwives, whose lack of power did not seem to dissuade them from action. However, "Will to fight" did not help us to explain the transgressive actions that were designed to go unnoticed. We had a similar issue with Civil Disobedience (Atilgan, 2019), which relies on acts of resistance to draw attention to a social injustice. Again, this concept did not explain our data which demonstrated that participants rarely wanted to draw attention to their social justice transgressive activities.

However, Essex's conceptualisation of RHH pushed political action beyond the binaries (e.g. industrial action or protests, board membership, policy development) and removed constraints about how we thought about the transgressive acts that stood out in the research data. RHH captured the nuances of resistance by nurses, midwives, and others who provided and blocked abortion care to people victimised by GBV, specifically by drawing attention to acts that went unnoticed and as part of everyday acts of patient care (Essex, 2021). In applying his conceptualisation to our findings, we hope to have broadened the understanding of resistance undertaken in abortion care. And while we do not hold ourselves up to be resistance scholars, we found the three questions Essex posed at the end of his paper – What makes resistance when undertaken by healthcare professionals unique? What is the purpose of resistance? Is resistance justified? – aligned with the greater questions we were asking of our study findings.

From what we have observed in our findings we concur with Essex that resistance carried out by healthcare professionals is more difficult to delegitimise than other types of resistance. We also agree that the positioning of healthcare professionals allows them to

observe healthcare injustice, and that resistance often goes undetected (Essex, 2021). We would add that access to specific technologies (e.g. the operating room), as well as to marginalised groups (e.g. people seeking abortions who are victimised by GBV) is a unique feature of RHH. We also suspect the language of healthcare, which can be used to obfuscate, may be another unique feature, however this requires further investigation.

We put forward the purposes of RHH might be used to resolve “dual loyalty” issues. Dual loyalty is a term used to describe a conflict between professional values and the values of another authority (International Council of Nurses, 1998) such as the law, employer, religion, or professional body. Perhaps clinicians, who make ethical decisions moment to moment in the course of their daily work, simplify their decision-making by choosing to commit to one value system over any others. In our study, we observed that the central values that drove RHH in abortion care were to either assist marginalised people access person-centred abortion care, or to conscientiously object to abortion. In our first article on the process undertaken by individual nurses and midwives, we commented on how unsurprised we were that person-centred care was the central impetus for transgressive actions given it is a requirement of the Nursing and Midwifery Board of Australia to provide person-centred care (Nursing and Midwifery Board of Australia, 2016). We went on to note that person-centred care often put nurses and midwives in conflict with the Board’s requirement to “compl(y) with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions” (Nursing and Midwifery Board of Australia, 2016).

It might be naïve, but we contend that the justification of RHH is a matter of positionality. As intersectional feminists, we believe assisting marginalised people to access reproductive health care such as abortion, which is a human right and a procedure that they are entitled, by law, to access in Australia, is justified. We also acknowledge our colleagues who wish to abstain from work that causes them moral distress, though find it unreasonable that they deprive some patients of essential services. Furthermore, the future of abortion care in Australia is likely to incorporate nurse-led models care, especially in rural and remote

Australia where access to abortion is currently limited (de Moel-Mandel et al., 2019). Consequently, we may see RHH from the medical fraternity who are unwilling to relinquish some of their power in this space. To those of us who value removing barriers to abortion care, this would also be unjustifiable.

We have confidence that RHH could have broader reach in nursing and midwifery research and may explain events that many nurses and midwives reading along have encountered throughout their careers. Compelled by our professional codes and standards to uphold the values of the profession, we are frequently positioned at the crossroads of doing what is right, what is policy and what is lawful. As such, providing nursing and midwifery care is laden with political decision and acts. Yet, these acts go unaccounted for because the publicity of our actions is constrained by our limited structural power, the strict regulation of our practice by national boards, and the covenant of confidentiality we hold with our patients. Little time has been devoted to this, what Laako and Sánchez-Ramírez (2021) call “situated politics” – the various intersections, unsettled relations and contexts in which nurses and midwives are positioned. We offer RHH as one tool to assist nursing and midwifery scholars to unpack our situated politics.

Also, used as a postmodern feminist device, RHH may assist us to disrupt the grip of the *political apathy* narrative that plagues our professions, and emancipate us from “oppressive versions of reality” (Gannon & Davies, 2011, p. 66). We lament that our voices and actions are not heard or visible in public, policy, and political spheres (Fackler et al., 2015), yet take relatively little time to acknowledge, and protect each other from, the costs attributed to such action. Moreover, not nearly enough time is spent critiquing the structures, such as continuing class and gender oppression (Latimer, 2014), neoliberalism (Rafferty, 2018), and the encroachment of the medical “gaze” (Kim, 2015) that fuel this narrative. Using RHH to tell the important stories of nurses and midwives who provide abortion care offers them anonymity while situating their actions as political. RHH could also help free us from what Thorne (2018) describes as the masculine and nostalgic views of power and

success that aggrandise and glorify the work of individual nursing and midwifery icons without acknowledgement of the collectives that brought them their success.

Conclusion

Nurses and midwives who provide abortion care to people victimised by GBV take part in everyday political acts termed Resistance in Health and Healthcare. RHH is characterised by positionality, active oppositionality, varying recognisability and emergent intentionality (Essex, 2021). Unlike other resistance theories and frameworks, RHH provides an alternative narrative for understanding the political work of nurses and midwives and captures the nuances of resistive action performed in the abortion arena. Used as a postmodern feminist research tool RHH may assist us to disrupt the notion that nurses and midwives are politically apathetic.

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CHAPTER 6: IMPLICATIONS, RECOMMENDATIONS AND CONCLUSION

In the previous chapters I presented the need for this thesis study, the study design, and the study findings. In this final chapter I explain how the study aims were addressed, the importance and implications of the findings and recommendations for future research and practice.

How the aims were addressed

When I commenced this thesis project, there was considerable literature emerging on the association between GBV and abortion (Aston & Bewley, 2009; Gee et al., 2009; Hall et al., 2014; Pallitto et al., 2013; Taft & Watson, 2007). Despite the momentum to change the narrative around GBV, improve early intervention, support people victimised by DV and better coordinate community and government response (State of Victoria, 2016), I observed this had not filtered down to abortion care. In the absence of guidance or policy, I wondered what nurses and midwives who provided abortion were doing when patients disclosed GBV. A scoping review of the literature of the role and scope of nurses in the provision of abortion care (Paper 1), confirmed my understanding that abortion care is provided by clinicians across a range of health care settings, is delivered to people in complex psycho-social situations and is complicated by law and local policy. In the discussion section of the review, I made the brief observation that few articles provided a framework of person-centred abortion care which inadvertently foreshadowed some of the study findings.

Aim 1: To explain the process through which Australian nurses and midwives provide abortion care to people victimised by GBV.

The first aim of this thesis was to explain the process through which nurses and midwives provide abortion care to people victimised by GBV. I devised to meet this aim through a CGT study. Through the analysis I determined the main concern for the nurses and midwives I interviewed was *committing to person-centred care*. They believed it was the

central aspect of their clinical practice and they wanted pregnant people to feel empowered throughout their abortion process. The process through which they provided abortion care to people victimised by GBV took two cyclical pathways contingent on the work environment. On pathway 1, *working with the (woman-centred) system,* which was straightforward, clinicians had confidence in the system and remained within their scope of practice. They viewed that the system provided wrap-around care that led to *achieving person-centred outcomes*. Across space and time, participants came back to the commitment to person-centred abortion care. In other words, if they changed employer or if some condition in the organisation changed, they flipped to Pathway 2: working against the system.

On pathway 2, *working against the system*, a period of *being backed into a corner* due to increasing gestation as well as health and safety risk led to *doing the wrong thing for the right reason*. This involved resolving to help pregnant people seeking abortion in the context of GBV, networking with likeminded people. The nurses and midwives who worked against the system often felt they fell short of achieving person-centred care and worried about the outcomes of people who were left to navigate through the complex health care system, bear the expense of the costly procedure, or return home to a potentially dangerous environment. Nonetheless they were left *feeling justified* because they felt they had done the right thing by placing the patient at the centre of their decisions. The primacy of providing person-centred abortion care – even by breaking the rules – meant *resolving to transgress again* which they carried through when required. This was discussed in detail in Paper 3, “Working with or against the system: Nurses’ and midwives’ process of providing abortion care in the context of gender-based violence in Australia.”

Aim 2: To explore how the elements of the broader situation affect the provision of abortion care to people victimised by GBV.

The second aim of this thesis was to map the elements of the broader health care situation that affect the provision of abortion care in the context of GBV. I used the analytical method, SA, to meet this study aim, first using situational mapping and then social

worlds/arena mapping with CGT coding. The findings reported in Paper 4 (“Unfit for purpose: A situational analysis of abortion care and gender-based violence”) identified that nurses and midwives that I interviewed believed the overarching theme we constructed from the Situational Analysis was *mostly uncatered for,* referring to the fact that the healthcare environment rarely takes abortion seriously – particularly in the picture of gender-based violence. Three critical elements of the healthcare system affected abortion care for victims of gender-based violence. These were reported as *inadequate skill mix, convoluted care pathways,* and p*hysical safety concerns.*

I used social worlds/arenas mapping combined with CGT analysis (another analytical tool from the SA “theory/methods package” (Clarke et al., 2018)) to move the analysis to the collective social action level. The findings in Paper 5 (“Reproductive power and justice: An Australian social worlds/arenas analysis of abortion and gender-based violence care”) identify some of the many worlds that collaborate, collide, and exert power over access to abortion and women's safety. The findings demonstrate that the Australian abortion arena is a complex network of competing or allied worlds that increase or reduce the marginalisation of victims of GBV. I focussed the CGT analysis on the actions of four important worlds – *Smuggler, Navigator, Marie Stopes Australia,* and the *Family Safety Framework* – which attempt to incorporate reproductive justice responses into their processes. The findings call attention to pro- and anti-abortion worlds that continue to influence abortion care in Australia.

Together the findings depicted a healthcare ecology that oppressed some people who seek and provide abortion care. Furthermore, the findings unearthed underground action by pro- and anti-abortion individuals and groups which undermined practice guidelines, policy, and the law and highlighted risks to professionals who involved themselves in these transgressive actions. These widespread acts of defiance sit in juxtaposition to the numerous articles that have been written on the low uptake of political action by frontline nurses and midwives. Through theoretical coding I used Essex’s conceptualisation of *Resistance in Health and Healthcare* (Essex, 2021) to unify the findings of the study and tell a cohesive story about nurses’ and midwives’ political action in the

abortion arena. This was discussed in detail in Paper 6, “Resistance in the abortion arena: Applying Essex conceptualisation to a multi-phased study on the experiences of Australian nurses and midwives who provide abortion care to people victimised by gender-based violence.”

Implications for practice and future research

I set out to create research that was beneficial to women, pregnant people, nurses, and midwives. *Resistance in the abortion arena* legitimises diverse nursing and midwifery perspectives, liberates their subjugated knowledge, and highlights how the world around pregnant people, nurses and midwives influences their perspectives and knowledge and how they, in turn, influence the world.

To my knowledge, this is the first research of its kind in Australia and is positioned to make a valuable contribution to comprehensive abortion care in the wake of decriminalisation. However, I remain pragmatic and recall that within my lifetime the National Health and Medical Research Council (NHMRC) withdrew a report on abortion due to its perceived feminist agenda (i.e. it recommended decriminalisation and treating abortion as a health issue) (Mackinnon, 1998, as cited in Baird, 2006). It is yet to be seen if the same social, racial and gendered power anxieties that drove the NHMRC decision (Baird, 2006) still prevail. What follows is a synthesis and extension of the discussion sections of the findings papers. I then propose 23 recommendations. I have grouped the recommendations under the following categories:

- Person-centred care and dual loyalty
- Person-centred care and complex care pathways
- Skill-mix and reorientation of services
- Politics and political acts

Category 1: Person-centred care and dual loyalty

Person-centred care is central to the Nursing and Midwifery Board of Australia's expectations of clinicians (Nursing and Midwifery Board of Australia, 2016), so it was unremarkable that during the CGT analysis (Paper 1) I found it was the main concern for participants. However, I did not anticipate that it was the catalyst for two unique cyclical care processes. Participants who worked with the system, perceived patients received person-centred care through holistic and wrap-around services. Consequently, their process of care was one of compliance with their scope of practice and the policies of the workplace. I also discovered that person-centred care put many participants in conflict with the Board's requirement to "compl(y) with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions" (Nursing and Midwifery Board of Australia, 2016). Clinicians working in systems that were not person-centred felt many laws and policies they came up against were paternalistic and unnecessary. The extent to which clinicians felt their ability to provide person-centred care was stymied was an important revelation of this research and helped to contextualise their reasons for working against the system, undermining the law, local policy, and institutional culture. Moreover, they felt justified and prepared to carry on transgressing if required.

Dual loyalty is a term used to describe a conflict between professional values and the values of another authority (International Council of Nurses, 1998) such as the law, employer, religion, or professional body. I theorised that the theoretical code *Resistance in the abortion arena* resolved "dual loyalty" issues. Perhaps clinicians, who make ethical decisions moment to moment in the course of their daily work, simplify their decision-making by choosing to commit to one value system over any others. I observed the central values that drove *Resistance in the abortion arena* were to either assist marginalised people access person-centred abortion care, or to conscientiously object to abortion.

Because abortion care is just one of the many roles carried out by nurses and midwives, *Resistance* likely has broader reach than abortion care, and the findings of this

thesis study ought to catch the attention of health administration and legislators. I suggest that policy and legislation, antithetical to health practitioners' codes of conduct (particularly those linked to documents such as the Universal Declaration of Human Rights), will not be adhered to, and transgressions will mostly go unrecognised to protect patients and health care providers. As there is very little documented about these types of healthcare transgressions (Essex, 2021), further research is required in this area**.**

- **Recommendation 1**: The Nursing and Midwifery Board of Australia changes the wording of their direction to: "complies with legislation, regulations, policies, guidelines and other standards or requirements relevant to the context of practice when making decisions *except where these would violate human rights or rights of Indigenous peoples*".
- **Recommendation 2**: The thesis is transformed into a report and disseminated to peak Australian Nursing and Midwifery, Family Violence and Abortion care bodies.
- **Recommendation 3:** Further research into the actions of nurses and midwives when policy and legislation is antithetical to person-centred care.

Category 2: Person-centred care and complex care pathways

Clinicians, especially midwives, are cognisant of the imposition of medical domination, over-cautious care, and policy and guidelines which revoke autonomy and choice for pregnant people (Cooper, 2019). The wide implementation of the Interprofessional Practice model, along with weakening of nursing and midwifery leadership systems and associated losses of senior nurses and midwives (Thorne, 2018), weakens social justice advocacy (Thorne, 2018), perpetuates the dominant (medical) established practice (Freshwater et al., 2014) and creates tension between nursing, midwifery and corporate values (Duncan et al., 2015)

Moore et al.'s (2017) study on the barriers and facilitators of person-centred care in different health care settings in Sweden and England found that the heavy machinery of the health care system, built around the biomedical paradigm, was inflexible to patient needs.

I suggest that health care environments require a cultural shift to embrace a paradigm to cater for diversity and offer flexibility of care, power sharing and abortion options. A study which reviewed Indian policy to address person-centred care in abortion found that the Indian government under it's "maternal and newborn health, family planning, and abortion strategy", provided national comprehensive abortion care guidelines. Their intent was that every health care service should be able to provide comprehensive abortion care (Srivastava et al., 2017).

- **Recommendation 4**: Development of national abortion care guidelines based on the World Health Organisation's technical and policy guidance for safe abortion (World Health Organization, 2012) and the Woman-centred, comprehensive abortion care reference manual (Turner & Huber, 2013).

Category 3: Skill mix and reorientation of services

With few exceptions, clinicians painted a concerning picture of how ill-prepared the healthcare environment is to provide comprehensive abortion care. In a highly developed country like Australia, which purports to have one of the best healthcare systems globally (Australian Department of Health, 2019), the healthcare environment lets down vulnerable people. When accounting for this, we can begin to understand participants' transgressive practices.

Some participants sought out their own education because they did not feel adequately prepared by their undergraduate studies. This might pierce to the heart of the problem: the healthcare workforce is unqualified to provide care to people seeking abortion, especially in the context of GBV, and may explain why many participants witnessed the retraumatisation of patients by the health system. Knowledge regarding how and if nursing and midwifery students are taught abortion care is limited, though it would seem to

correspond with the participants' experiences. Two international studies (Cappiello et al., 2017; Mizuno, 2014) found that abortion-related curriculum is most often taught in ethics, rather than evidence-based practice. Contemporary Australian and international literature regarding domestic violence education, finds it is not widespread with corresponding lack of student confidence in providing care related to domestic violence (Collins et al., 2020; Hutchinson et al., 2020).

The hit-and-miss nature of abortion and GBV education is disappointing. First, the role of midwives (and nurses who work in relevant contexts) is not solely to care for people with planned and wanted pregnancies. Providing care to people with unintended or mistimed pregnancies, including abortion care, is a core competency for basic entry-level midwifery practice (International Confederation of Midwives, 2018). On the face of it, universities that omit abortion care from their curriculum, on religious grounds or not, are doing both their students and the public a disservice. Second, evidence-based education leads to more positive views towards abortion and GBV care which could lead to more person-centred services. A cross-sectional multicentre survey conducted in Poland (Michalik et al., 2019) compared the attitudes of first- and final-year midwifery students towards abortion care. Significant intergroup differences in willingness to participate in abortion care, in the context of health, rape and severe foetal defect, were noted between the groups, with third-year students' willingness being significantly higher. A mixed methods study by Colarossi et al. (2010) found that abortion-care clinicians who had undergone training around domestic violence and sexual assault had more positive attitudes towards screening for domestic violence and sexual assault and felt more prepared to discuss current and historical violence compared to those without training.

- **Recommendation 5**: Australian midwifery course accreditation standards to specifically include abortion care.
- **Recommendation 6:** Australian nursing course accreditation standards to specifically include GBV care.

Repeatedly participants felt that the lack of appropriately skilled pro-abortion providers was a major barrier to person-centred abortion care. In Australia, where limited access to abortion care is compounded by a tyranny of distance, nurses and midwives have a relatively conservative scope of practice. My scoping review found that nurses and midwives are underutilised in their role and, if trained appropriately, are as safe in performing medical and surgical abortions as medical personnel. A nurse or midwife-led approach to medical abortion, particularly in primary care, may address the provider shortfall (Dawson et al., 2016; de Moel-Mandel & Graham, 2019). Task-sharing and task-shifting efforts can include removing arbitrary constraints on clinicians' scopes of practice and the training of clinicians to offer all aspects of abortion care (Turner & Huber, 2013). de Moel-Mandel et al. (2019) used a Delphi process to develop a nurse-led model of care for the Australian primary care setting. She also recommends shared care models with telemedicine providers in areas where there are barriers to pharmacy access. Action such as competency-based training (de Moel-Mandel et al., 2019) is needed to get models such as these off the ground and rolled out on a national level. Once, again, much of this could be done at a policy level by incorporating the WHO's technical and policy guidelines for abortion care (World Health Organization, 2012) and Ipas' guidance on comprehensive abortion care (Turner & Huber, 2013). Such changes, however, would require amendments to regulatory structures, funding models and relaxation of prescribing and abortion procurement restrictions.

- **Recommendation 7:** Revision of the Therapeutic Goods Administration risk management profile of RU486 (mifepristone) to enable medical standing orders and Nurse Practitioner prescribing.
- **Recommendation 8:** Amend legislation to allow nurses and midwives with extended scopes of practice to perform surgical abortions.
- **Recommendation 9:** Provision of accessible competency-based training for nurses and midwives to provide surgical abortion.

- **Recommendation 10:** Trial and implementation of nurse and midwife-led models of medical abortion care for the Australian primary care setting.

Abortion is a very safe and straightforward procedure. However, my study found that the interconnectedness of time sensitivity, stigma, shifting legal landscapes, and high rates of gender-based violence mean that it is probably more complex than the Australian health sector credits.

- **Recommendation 11:** Health services perform a ground-level Work Complexity Assessment (WCA) to re-evaluate work processes, delegation relationships (Weydt, 2009) and educational needs in their contexts.

It was also evident that conscientious objectors and people who held unfavourable views towards people seeking abortions reduced the skill mix available to patients receiving abortion care and added to the workloads of pro-choice nurses and midwives. My social worlds/arenas analysis showed that anti-abortion worlds continue to have a broad reach inside of the abortion arena. Conspicuously, these occur as Christian and anti-abortion health services while they also include conscientious objectors within the primary and tertiary public health sectors more discreetly. A recent study of abortion experts conducted in Victoria, Australia, found evidence of some misuse of conscientious objector law; however, overall, it tended to protect people's access to abortion (Keogh et al., 2019). My findings suggest that, nationwide, the negative impact of conscientious objectors might be more significant than what was found in the Victorian study. Furthermore, if not for the transgressive actions of smuggler and navigator worlds, some people would be denied access to abortion care because of conscientious objectors.

- **Recommendation 12**: Healthcare services providing abortion care have pro-choice hiring policies. If this is not feasible, another approach is to quantify the number of conscientious objectors working in areas that provide abortion care to inform WCA and workload allocation models (see the previous recommendation).

This second approach in the above recommendation is a novel research direction, and no doubt will be challenging in the current context of high staff turnover. Moreover, it is unlikely to decrease a culture of abortion stigma within work units.

- **Recommendation 13:** An immediate review of the state of abortion access in Australia.

Care pathways could streamline abortion access and care. A cross-institution integrated care pathway would assist pregnant people's progress through the health system in an appropriate timeframe, reducing their risk of "bouncing around" or falling through the cracks. Such pathways should be evidence-based and trauma-informed and embed the WHO and IPAS abortion care guidelines. Graham et al. (2010) investigated the use of an integrated abortion care pathway across two hospitals in the UK. They found that the pathway was useful for high-quality record keeping and maintaining high-quality care. They proposed the addition of a post-abortion care component to the pathway to enhance care further.

- **Recommendation 14**: Trial and implementation of a cross-institutional comprehensive abortion care pathway.

In Paper 5, the social worlds/arena analysis, I asserted that GBV does not exist at the edges of the abortion arena; the gendered nature of both abortion and GBV mean that they are co-constitutive of each other. As such, many primary care services, regional and tertiary hospitals that offer abortion care, and stand-alone abortion clinics, need a strengthened GBV response. A Lancet review of evidence from global north countries (Ellsberg et al., 2015) found that successful GBV healthcare interventions frequently involved routine enquiry, psychosocial support by healthcare providers (including danger assessment, safety planning, information sharing and referral to specialised services), advocacy, counselling and home visitation. People who received psychosocial support showed reduced rates of re-victimisation. Those who received more intense and longer-term support had lower rates of re-victimisation three years after the intervention. The World Health Organization (2017) recommends that all health services provide care pathways for

survivors of GBV that reduce the number of visits and number of providers the patient has to interact with, in a manner that respects confidentiality and prioritises safety.

Many of the research participants discussed the disruption that occurred to their work areas due to GBV disclosures. In their study of universal screening at a free-standing abortion clinic in North America, Wiebe and Janssen (2001) identified that while screening was part of organisational policy and screening protocols were in place, approximately half of the women presenting for abortions were not screened. This was due to a perceived lack of time, lack of interpreting services or protocols regarding partner presence in the interview room.

Participants also discussed the traumatising affect the healthcare system had upon patients. Trauma-informed domestic violence and sexual assault screening, which respects patient autonomy, should be a key component of the integrated care pathway and link with action-oriented outcomes such as safety planning, lethality assessment, and referrals. Evidence suggests that clinicians require direction and support in this regard (Sutherland et al., 2014) and also with documenting associated mental and physical injuries and symptoms (Colarossi et al., 2010). Perry et al. (2016) found that most healthcare professionals learnt about sexual assault through the voluntary disclosures of patients. If used at all, screening tools were variable in how they were applied. Perry et al. (2016) also found that most participants were unaware of protocols in use to screen and refer participants. We therefore recommend that the design of clinical pathways to compel the clinician to follow such protocols.

- **Recommendation 15:** Skill mix must be supported by workload allocation models that allow clinicians to help victims – domestic violence disclosures should not be a clinical variance.
- **Recommendation 16:** Trial and implement of an action-oriented, trauma-informed screening algorithm with an associated care pathway to reduce the time clinicians spend with patients, reassure them that they have provided appropriate support and improve patient outcomes.

Finally, the physical safety of abortion care services (including telehealth clinicians), requires immediate review. Participants described troubling situations where colleagues put themselves in risky situations with aggressive perpetrators. As Ford (2010) asserts, it is unsafe to isolate clinicians and aggressive partners or patients together, inside or outside the clinical environment.

- **Recommendation 17:** Abortion care environments to develop protocols to address aggression with regular training of staff regarding managing aggression in the workplace.
- **Recommendation 18:** Non-intrusive security enhancements, such as swipe access security doors to enhance the safety of the health care environment (Ford, 2010).

With respect to telehealth clinicians, a recent synthesis and adaption of evidence-based domestic violence guidelines for telehealth reiterated that bearing witness to gender-based violence, even over the phone or the internet, may cause vicarious trauma (Jack et al., 2021). Organisations should provide proactive and reactive care to mitigate vicarious trauma.

- **Recommendation 19:** Organisations to integrate trauma-informed policies that acknowledge historical trauma experienced by staff, clinical supervision, caseload management and regular screening for vicarious trauma (Jack et al., 2021).
- **Recommendation 20:** Development of a plan when a consultation is suddenly disconnected, including ringing a support person or the police, and having a unique code that patients can use if they are in danger.

Category 5: Politics and political acts

The social worlds/arena analysis mapped some of the worlds that operate at the intersection of abortion and gender-based violence in Australia, exposing official and unofficial power structures that facilitate or restrict meaningful care to marginalised people.

Like most countries, abortion care is highly politicised, and I observed how this impacts meaningful care to people victimised by GBV. On the one hand, under the auspices of the South Australian Department of Women, the multiagency Family Safety Framework provided comprehensive, wrap-around legal, social, economic and health support for people at high risk of GBV, including free abortion. On the other hand, the not-for-profit organisation Marie Stopes Australia, a political juggernaut in terms of abortion access, relies on full fee-paying patients and donations to subsidise abortions for people experiencing hardship (such as those fleeing domestic violence). Funding is a significant consideration for the organisation and constrains the level of support available to GBV victims.

- **Recommendation 21:** Sufficient funding and cross-institutional care pathways (see Recommendation 15) for wrap-around care, to be provided where governments and health districts enter into partnerships with MSA (or other community-based or private abortion services), due to public hospital conscientious objection.

The theoretical code of *Resistance in the abortion arena* pushed political action beyond the binaries (e.g. industrial action and protests, board membership and policy development) and removed constraints about how I thought about the transgressive acts that stood out in the research data. *Resistance in the abortion arena* captured the nuances of resistance by nurses, midwives, and others who both provided and blocked abortion care to people victimised by GBV, specifically by drawing attention to acts that went unnoticed by managers and administration, and as part of everyday acts of patient care. I found consistent evidence of this type of grassroots political action across all social worlds.

However, nurses and midwives are rarely regarded as politically astute or motivated (Shariff, 2014; Vandenhouten et al., 2011). Most likely this is because we represent over 70% of the female workforce and our professions encounter gendered experiences that impede our capacity to influence healthcare policy (World Health Organization, 2020). I suggest that measuring power and political acumen at the executive level applies a male

gaze to how power is exercised and overlooks the political action of women, and other marginalised people, who do not have equal access to boardrooms.

- **Recommendation 22:** Nurses and midwives who are charged with operationalising health care policy to be heavily involved in the creation of the policy.

This is a new governance direction and may challenge official and unofficial health service power structures and standard operating procedures. It will require policy makers to regularly meet with nurses and midwives at the ward level, during (paid) work hours, as many women simply do not have the time or resources to volunteer their time on boards.

Limitations

The limitations of this thesis study, described in Papers 2 to 5, are synthesised and extended upon below. First, the literature review and extended multiple method CGT study were conducted between 2018 and 2022 and, during this time, abortion law changed in three Australian States. Some minor findings in the scoping literature review (Paper 1) that relate to abortion law, are already outdated. The abortion landscape continues to shift and, as such, my findings need to be regularly revised, updated or discarded in the face of change.

In terms of the scoping literature review (Paper 1), I completed the literature search after the first round of database searching. This indicates that some articles may have been missed. However, Nussbaumer-Streit et al. (2018) suggest that when 10 or more studies are combined, there is a reduced risk that conclusions may be false; I found 74 articles. They also found that combining two separate databases (I 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. I believe that the inclusion of 74 articles indicates that most relevant studies were identified. The second limitation to the scoping review is that it consolidated findings from varied research topics, study populations, methods and findings and readers should be cautious in drawing generalisations from the study.

The two-phased extended multiple method CGT study findings are primarily drawn from a sample of 18 Australian clinicians who were recruited through pro-choice organisations and networks. In the case of the social worlds/arenas, the data were also collected from a small amount of pre-produced material. Guest et al. (2006, as cited in Charmaz, 2014, p. 106) determined that 12 interviews suffice for most GT research among homogenous people. However, mine was not a homogenous group of people and, more importantly, Charmaz (2014) considers this insufficient for theory construction, studies of controversial research topics with “secrets and silences” (p. 107), or studies which uncover provocative findings. While I would have preferred to conduct more than 18 interviews, the participants’ stories were rich, and a clear basic social process was evident in the CGT analysis (Paper 3). In the context of a pandemic, I carried on pragmatically. Despite the limited number of interviews, I feel that the range and depth of my experience in the study area (Chapter 2) acted as a strong foundation from which I was able to conceptualise the research data. Therefore, despite being theoretical, the findings of the CGT study should not be assumed to explain the experiences of all clinicians working at the nexus of abortion care and GBV; further research is required in this area.

- **Recommendation 23:** Further research to explain the experiences of clinicians working at the nexus of abortion care and GBV.

Likewise, the social worlds/arena study offers an analysis of the social worlds central to abortion care and GBV in Australia. It was not my intention to provide an exhaustive overview of all existing worlds and arenas in the substantive area.

While the recruitment strategy yielded a group of participants from diverse clinical contexts, they were all women, largely monocultural (white) and recruited through pro-choice

organisations. A more diverse sample (such as correctional health nurses and midwives, or nurses attached to child and family welfare units) may have led to more nuanced findings.

Finally, while we report on people victimised by GBV, this paper aims not to paint people who access abortion as “victims in distress”. Feminist scholars present abortion as an unproblematic procedure beneficial to women (Baird & Millar, 2019), a point on which I thoroughly agree. We would extend this sentiment to include pregnancy-capable people who do not identify as women.

Conclusion

People who seek abortions are more likely to be victims of GBV than those who continue with their pregnancies. Most people who seek abortions in the context of GBV will receive care from a nurse or midwife. In fact, nurses and midwives are at the frontline of abortion care. Yet, how they go about providing abortion care to victims of GBV in complex work environments is underreported. This study has made a significant contribution to this identified gap by (i) explaining the process through which Australian nurses and midwives provide abortion care to people victimised by GBV and (ii) mapping the elements of the broader health care situation that affect the provision of abortion care to people affected by GBV. We now know that nurses and midwives undertake *Resistance in in the abortion arena* to achieve their main concern, person-centred abortion care. Resistance in the abortion arena seems to be driven by a complex network of competing or allied worlds that increase or reduce the marginalisation of victims of gender-based violence and a health care environment that does not usually cater for people who require abortion care generally and GBV care more specifically.

This valuable insight can be used to challenge national nursing and midwifery standards that direct nurses and midwives to comply with legislation, policies and guidelines which are not in line with the ethics of the professions or the Declaration of Human Rights. This insight should also be used to compel policy makers to involve nurses and midwives actively and genuinely in the creation of the policy. The findings are also useful to health

services charged with upskilling staff in the face of abortion law reform, creating wrap-around abortion care pathways, and recalculating the complexity of abortion care in the context of GBV and the cost of conscientiously objecting on their workload allocation models. It is evident from this research that integrated comprehensive abortion care models are not currently implemented in most Australian health systems. Recommendations have been made on how to go about this. An important next step will be to incorporate this new knowledge at the practice level.

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APPENDIX A: ETHICS

Application reference: 0000021264
Title: Australian nurses' experiences of providing domestic violence or sexual assault care to women who present for abortion-related services

This project has now been approved by the Human Research Ethics Committee, either at a full committee meeting, or via the low risk review process.

The period of human ethics approval will be from 04/12/2018 to 31/10/2024.

The standard conditions of approval for this research project are that:

(a)you conduct the research project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments required to be made to the proposal by the Human Research Ethics Committee;

(b)you advise the Human Research Ethics Committee (email ethics@cqu.edu.au) immediately if any complaints are made, or expressions of concern are raised, or any other issue in relation to the project which may warrant review of ethics approval of the project. (A written report detailing the adverse occurrence or unforeseen event must be submitted to the Committee Chair within one working day after the event.)

(c)you make submission to the Human Research Ethics Committee for approval of any proposed variations or modifications to the approved project before making any such changes;

(d)you provide the Human Research Ethics Committee with a written Annual Report on each anniversary date of approval (for projects of greater than 12 months) and Final Report by no later than one (1) month after the approval expiry date;

(e) you accept that the Human Research Ethics Committee reserves the right to conduct scheduled or random inspections to confirm that the project is being conducted in accordance to its approval. Inspections may include asking questions of the research team, inspecting all consent documents and records and being guided through any physical experiments associated with the project

(f) if the research project is discontinued, you advise the Committee in writing within five (5) working days of the discontinuation;

(g) A copy of the Statement of Findings is provided to the Human Research Ethics Committee when it is forwarded to participants.

Please note that failure to comply with the conditions of approval and the National Statement on Ethical Conduct in Human Research may result in withdrawal of approval for the project.

You are required to advise the Secretary in writing if this project does not proceed for any reason. In the event that you require an extension of ethics approval for this project, please make written application in advance of the end-date of this approval. The research cannot continue beyond the end date of approval unless the Committee has granted an extension of ethics approval. Extensions of approval cannot be granted retrospectively. Should you need an extension but not apply for this

before the end-date of the approval then a full new application for approval must be submitted to the Secretary for the Committee to consider.

The Human Research Ethics Committee wishes to support researchers in achieving positive research outcomes. If you require an approval letter on university letterhead, please do not hesitate to contact the ethics officers, Sue Evans or Suzanne Harten or myself.

Yours sincerely,

Ms Susan Evans
Senior Ethics Officer
on behalf of the Chair, Human Research Ethics Committee Research Division - Central Queensland University

APPENDIX B: IMPACT

Marie Stopes Australia Submission to the Joint Select Committee on Coercive Control, Parliament of NSW (abridged)

Submission

COERCIVE CONTROL IN DOMESTIC RELATIONSHIPS

Organisation: Marie Stopes Australia

Date Received: 29 January 2021

MARIE STOPES AUSTRALIA

29 January 2021

The Joint Select Committee on Coercive Control
Parliament of New South Wales
Submitted online via coercivecontrol@parliament.nsw.gov.au

To Whom It May Concern,

RE: Submission to the Joint Select Committee on Coercive Control in New South Wales

The Joint Select Committee on Coercive Control in domestic relationships is currently considering the NSW Government discussion paper on coercive control. Marie Stopes Australia appreciates the opportunity to contribute to discussions regarding the criminalisation of coercive control in New South Wales (NSW).

Background

Marie Stopes Australia is an independent, non-profit organisation dedicated to ensuring sexual and reproductive health services are equally accessible to all people living in Australia. Marie Stopes Australia is the only national accredited provider of abortion, contraception and vasectomy services, and the country's longest running provider of teleabortion. Our holistic, client-centred approach empowers individuals to control their reproductive health safely, and with dignity, regardless of their circumstances. Through active partnerships with healthcare providers, researchers and communities, our models of care ensure the total wellbeing of our clients is supported at every stage. We have three clinics in metropolitan NSW and a state wide teleabortion service. We work collaboratively with the NSW Government to support sexual and reproductive health access for all.

Response to discussion paper

Coercive control is a form of gender-based violence that requires strategic prevention and response mechanisms across jurisdictions in Australia. This submission is structured to address selected questions in the discussion paper. Regarding the broader questions, Marie Stopes Australia supports any submissions and the position paper on Coercive Control by the Australian Women Against Violence Alliance.[1]

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Registered Charity Name
Marie Stopes Australia

Australian Business Number
63 093 595 19

1. What would be an appropriate definition of coercive control?

Definitions of coercive control should incorporate the concept of reproductive coercion. Pregnancy can be the direct result of coercion, and can tie the woman to an abusive partner for her lifetime. It is critical that reproductive coercion be named to, at the very least, acknowledge these victim-survivor experiences.

Reproductive coercion is defined as any behaviour that has the intention of controlling or constraining another person's reproductive health decision-making.[2] It can include:

- sabotage of another person's contraception
- pressuring another person into pregnancy
- controlling the outcome of another person's pregnancy
- forcing or coercing another person into sterilisation
- any other behaviour that interferes with the autonomy of a person to make decisions about their reproductive health.

Reproductive coercion can be interpersonal and structural. Interpersonal reproductive coercion is more likely to occur within contexts of structural coercion. [3] Reproductive coercion is a form of violence with an extensive resource base of evidence. [4]

People present at Marie Stopes Australia clinics with experiences of sexual and reproductive coercion.[5] Women and pregnant people are currently experiencing coercion linked to poverty and financial hardship, which is linked to unemployment and economic insecurity due to the pandemic.[6] People who already have restricted bodily autonomy are facing uniquely coercive contexts, for example people with disability, people on temporary visas, people who are incarcerated and people in state care. People accessing abortion care may also be at higher risk of intimate partner violence than the general population.[7]

7. What are the advantages and/or disadvantages of creating an offence of coercive control?

Coercive control should never be condoned. This is not to say that criminalisation is the answer. In order to conduct client centred and informed decision making processes, our staff need to sensitively enquire about risk of harm to self and risk of harm to others.[8] This sensitive inquiry process is critical to assess risk, enable space for disclosure and to determine if informed consent can be granted. In addition to this, it enables us to consider and support clients in accessing relevant referral pathways for ongoing care. Any moves to criminalise coercion should be mindful of the risk of creating additional barriers for disclosure between a client and their healthcare professional.

Criminalisation of coercive control also risks reducing agency for people with disability and other intersections of oppression. It is critical that legislative reforms on coercive control do not risk increasing systemic discrimination or inequity.[9]

15. What non-legislative activities are needed to improve the identification of and response to coercive and controlling behaviours both within the criminal justice system and more broadly?

The health system has key responsibilities for the prevention of and response to coercive control, yet lacks strategy, investment and resourcing. Australia does have two national gendered health strategies, the *National Women's Health Strategy (2020-2030) and a National Men's Health Strategy (2020-2030)*. Both include measures that prevent and respond to violence, yet neither strategy is adequately resourced. Since they were published, the pandemic has influenced regression rather than progression in healthcare access and equity.[10] In addition to health policy, is critical that a *National Plan to Reduce Violence Against Women and Their Children* beyond 2022 be strategised, resourced and implemented to enable long term prevention, support and recovery.

Aboriginal and Torres Strait Islander populations need community-led, researched and funded initiatives. [11] Aboriginal and Torres Strait Islander women are at higher risk of reproductive coercion than non-Indigenous women, and are more likely to experience barriers of access and equity when seeking sexual and reproductive health care. [12] We support any submissions by the National Aboriginal Community Controlled Health Organisation as a community led voice in Aboriginal and Torres Strait Islander health care. [13]

Respectful relationships education in schools should be expanded or re-aligned to include comprehensive relationships and sexuality education, which encompasses protective behaviours, bodily autonomy, enthusiastic consent, pride in identity and culture and community responsive health care. [14] This would better provide protective measures for children and young people to make informed decision-making and access networks of support, particularly if they or a peer were living in contexts of coercive control. [15]

If you wish to discuss the details of this submission further, please contact Bonney Corbin, Head of Policy at [redacted]

Sincerely,

[redacted]

Jamal Hakim

- Managing Director – Marie Stopes Australia

2020 at https://law.adelaide.edu.au/system/files/media/documents/2019-12/Abortion%20Report%20281119.pdf.

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Impact email from Desert Blue Connect

From: Sharon H [redacted]

Sent: Tuesday, October 26, 2021 5:08:57 PM

To: Lydia Mainey [redacted]

Subject: [redacted]

Hi Lydia,

Additional to our phone call today I wanted to say **Thank You** for doing your research and hopefully opening many eyes in the community to the realities that challenge many women, old and young, when faced with an Unplanned/Unwanted Pregnancy in Australia today.

While I have yet to hear your presentation Monica, our Community Initiatives Manager, has, and will be including in our proposal submission for our Women's Wellness Centre your findings regarding the need for a swipe card security access in our new location. Your findings will help support our argument towards additional security measures.

Thank you and good luck with your studies. Please let me know if you wish for any further feedback.

Kind Regards
Sharon ☺

Sharon [redacted]
Pronouns: She/Her/Hers
Women's Health Nurse

Desert Blue Connect

E [redacted]
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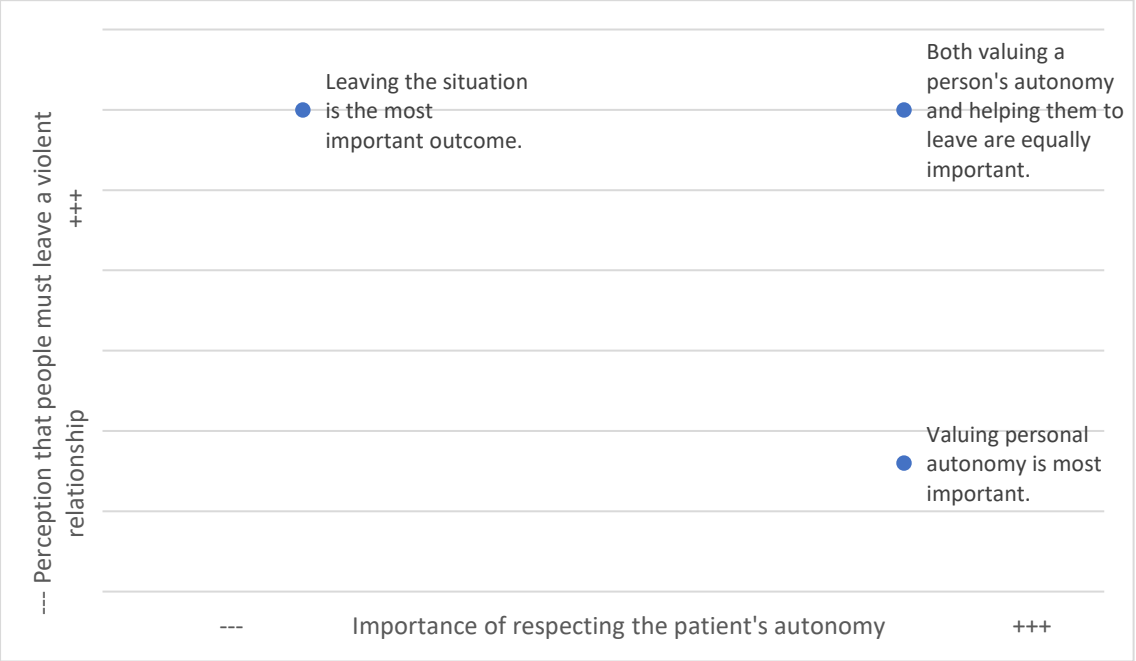
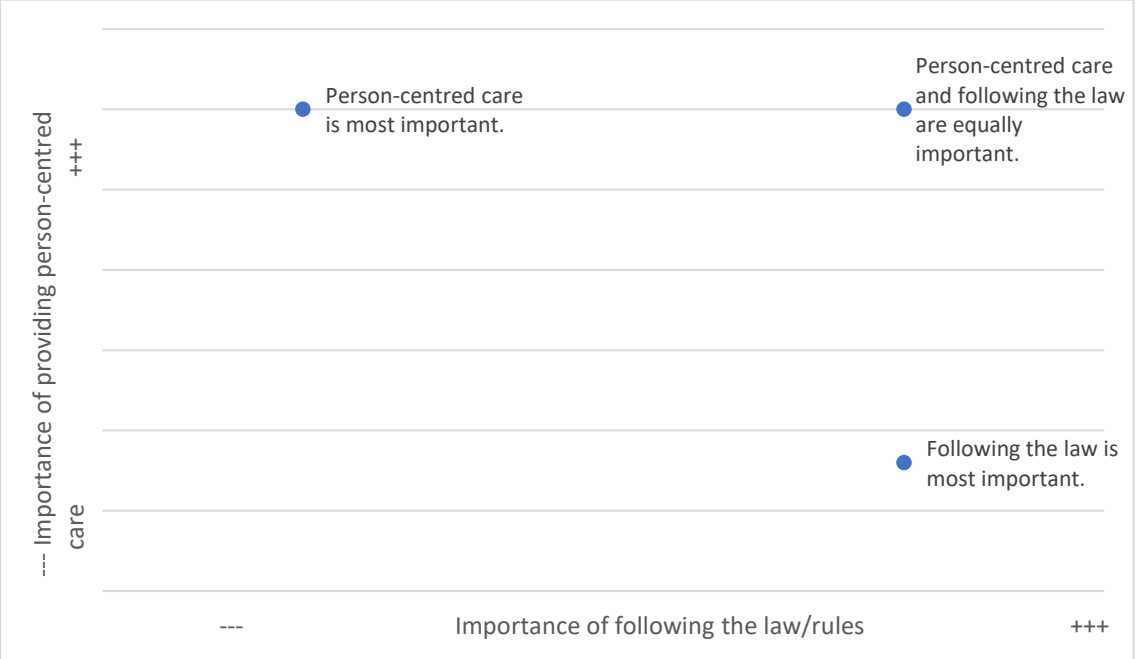
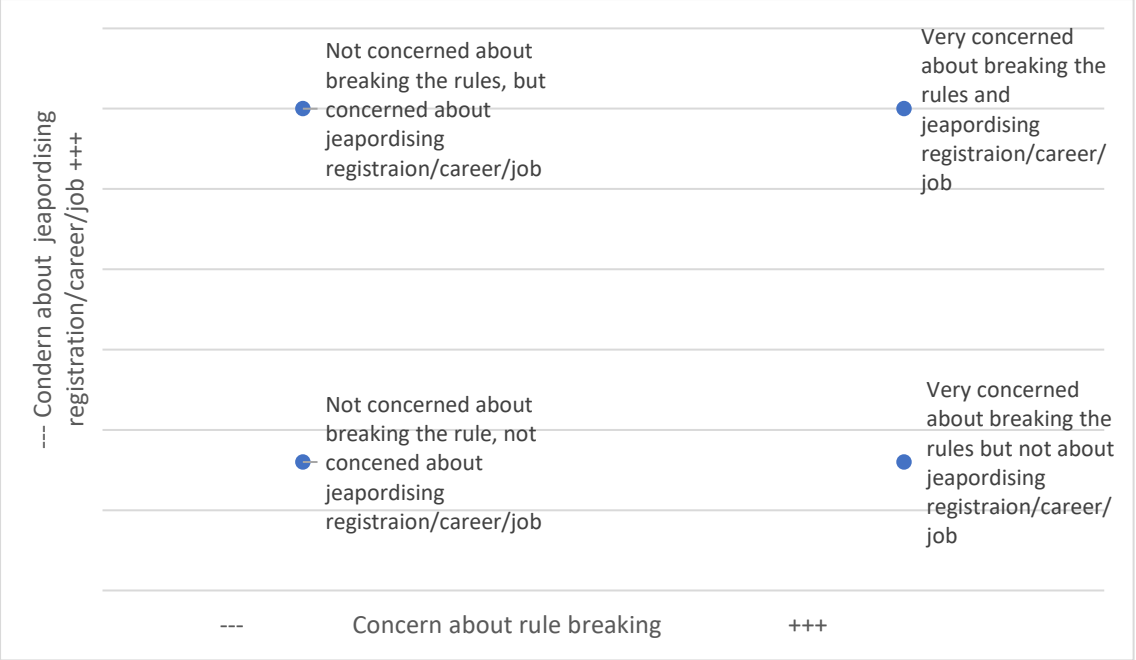
PO Box 472 Geraldton WA 6531
www.desertblueconnect.org.au

Desert Blue Connect would like to acknowledge the South Yamaji people, the traditional custodians of the land on which we perform our work. We would also like to acknowledge all Aboriginal and Torres Strait Islander people who reside within this area.

APPENDIX C: POSITIONAL MAP






--- Condern about jeapordising registration/career/job +++
Not concerned about breaking the rules, but concerned about jeapordising registraion/career/job
Very concerned about breaking the rules and jeapordising registraion/career/ job
Not concerned about breaking the rule, not concened about jeapordising registraion/career/job
Very concerned about breaking the rules but not about jeapordising registraion/career/ job
---
Concern about rule breaking
+++