



Medical Abortion in Midwifery Scope of Practice: A Qualitative Exploration of the Attitudes of Registered Midwives in British Columbia

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Introduction: Across Canada and internationally, access to abortion remains challenging, particularly for those living in rural and remote communities. International research and policy call for the training of advanced practice clinicians, including midwives, to provide abortion services to fill the ever-increasing access gap. Research in other jurisdictions has examined the attitudes of midwives toward this potential expansion of scope of practice, but such studies have not been undertaken in British Columbia. This qualitative research study explored the attitudes of registered midwives toward expanding their scope of practice to include the provision of medication abortion in British Columbia.

Methods: In-depth qualitative interviews with British Columbia registered midwives were conducted and analyzed using thematic analysis.

Results: Fifteen interviews were conducted. Analysis of the interviews identified 5 primary themes: the incorporation of medication abortion into the midwifery scope of practice to increase access, the congruence of the midwifery model of care and provision of medication abortion, the role of registered midwives as guardians of reproductive rights, the need for a paradigm shift in how the profession is viewed, and the practicalities of potential scope expansion.

Discussion: This study shows some British Columbia registered midwives are interested in including medication abortion in their scope of practice. Midwives have the potential to bridge some of the health care delivery gaps in areas underserved by abortion providers and communities where medication abortion is not available. Further research is needed to more fully understand the perspectives of registered midwives in British Columbia as a whole.

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INTRODUCTION

Induced abortions are a common procedure for Canadians: nearly 1 in 3 women will experience an abortion during their reproductive lifetime.¹ Despite this commonality, abortion access is uneven throughout Canada and British Columbia.^{2–10} Over the past few decades, the number of abortion providers in Canada has decreased, and fewer education programs are offering training in the area.⁶ This phenomenon, described as the *greying effect*, is a major contributing factor to the decline in access to abortion across Canada.^{3,5,10,11} At the same time, the number of abortions provided yearly has not decreased, indicating a higher demand on the current body of abortion providers.^{3,5} Physicians providing abortion in British

Columbia, especially those in rural settings, report challenges to providing abortion care, including high demand for services, hospital and staff logistical challenges, and professional isolation.^{3,5} Rural physicians report feeling unable to meet local requirements for abortion care in a timely manner, with wait times up to 5 weeks in some settings, and face the additional stressor of scarcity of work coverage.^{3,5} By comparison, their urban counterparts feel well resourced to provide abortion care in a timely fashion.^{3,5}

Access to abortion in British Columbia is not equitable. In addition to the increased burden on rural abortion providers, people living in rural and remote areas face more barriers to access than those living in urban settings. Access is a multifaceted issue grounded in geographic proximity but also requires the availability of care without judgment or undue barriers. The Pregnancy Options Service reported a 62% decrease in access to abortion and trained providers in rural British Columbia between 1998 and 2005.¹ Today, 90% of all abortions provided in British Columbia take place in 3 urban centers, whereas 57% of the provinces' reproductive-aged women live in health service delivery areas outside of these centers.³ With only 1 in 4 rural hospitals in British Columbia providing abortion services, many people seeking abortions outside of urban centers must travel great distances to receive care.³ Urban abortion clinics offer specialized care in ambulatory settings with counseling support from allied health professionals and various procedural options.⁵ By contrast, rural abortion care, when offered, is almost exclusively in hospital operating rooms, with fewer procedural options and considerably higher rates of general anesthetic with no access to specialized counseling support.^{7–9,12}

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Quick Points

- ◆ There is a growing body of evidence highlighting a lack of access to maternity care and abortion care in rural communities, with related adverse health and social outcomes. At the same time, midwifery is emerging as a solution to both these challenges.
- ◆ A series of interviews with British Columbian registered midwives assessed their attitudes and beliefs toward expanding their scope of practice to include provision of medication abortion.
- ◆ Respondents felt that including medication abortion in British Columbia registered midwives' scope of practice could increase access to medication abortion, especially in currently underserved communities and rural settings.
- ◆ Respondents expressed that being able to provide medication abortions through the midwifery model of care would provide options consistent with client-centered care, informed decision making, continuity of care, and choice of health care provider, as well as alternative work models for British Columbia registered midwives.

Increasing the availability of medication abortion improves access and people accessing services' satisfaction without compromising safety.^{13,14} According to Dressler et al, only 15% of abortions in Canada are medication abortions.^{5,6} A standard medication abortion is a combination of 200 mg mifepristone and 800 mcg misoprostol, packaged together as Mifegymiso in Canada. In late 2017, Health Canada eased restrictions on this drug regimen, allowing prescription up to 9 weeks' gestation and broadening its provision from physician only to any health care provider with prescription authority through their regulatory college.¹⁵

Expanding the scope of advanced practice clinicians, such as midwives and nurse practitioners, to include abortion services is a key step in increasing access worldwide,^{16–20} with good outcomes demonstrated through research.^{16,17,21–25} A cost-effective analysis found a decreased need for surgical intervention and higher cost-effectiveness with midwifery-led abortion care, compared with standard physician-led care.²³ In Great Britain, France, and Sweden, midwives are involved in the majority of medication abortions provided, in large part because of the established safety of advanced practice clinicians administering mifepristone and misoprostol.²⁶ Based on this body of evidence, the World Health Organization purports that the provision of medication abortion by advanced practice clinicians is an integral piece in addressing the access gap.^{3,17,27,28} The International Confederation of Midwives has added abortion as a core competency for basic midwifery practice, initiating research and policy discussions related to registered midwives as abortion providers in Canada.^{11,29,30} The Society of Obstetricians and Gynecologists of Canada notes that restricting abortion provision to gynecologists alone and failure to train registered midwives is perpetuating a potential access barrier in Canada.^{14,31} Furthermore, the Canadian Association of Midwives released a statement in 2016 in support of reproductive rights for all people, stating that reproductive health care includes access to safe abortion care.³²

Registered midwives in British Columbia are primary care providers whose scope of practice includes prenatal, intrapartum, and postpartum care for low-risk individuals. Registered midwives can undertake additional training and certification for scope expansion including sexually transmitted

infection management, hormonal contraceptive therapy including intrauterine device insertion, and surgical first assist for cesarean births. Registered midwives can consult directly with other health care providers as needed. To practice in British Columbia, registered midwives must complete a 4-year bachelor's degree in midwifery from a recognized program in Canada and be registered with the College of Midwives of British Columbia. Internationally trained midwives must complete a bridging program before practicing in British Columbia. Registered midwifery in British Columbia was regulated into the health care system in 1998.

Although there is research in support of advanced practice clinicians as safe medication abortion providers and a documented need for more abortion providers, few studies have evaluated how advanced practice clinicians feel about providing this care.^{33–35} Studies on midwives' attitudes toward providing abortion care report an overall positive attitude of midwifery participants.^{33,34,36,37} A recent Canadian survey of Ontario registered midwives' attitudes toward abortion provision showed that the majority of Ontario Midwives identify as *pro-choice*: the notion that childbearing people should have the right to determine their own need for reproductive care, including abortion, as opposed to state-mandated decisions. However, participants were divided on whether abortion should be included in their scope of practice.¹¹ Most respondents were increasingly reluctant to provide abortion later in pregnancy, many noting they felt that the skills involved in surgical abortions were outside of their skill level.¹¹ The study called for further examination in different Canadian jurisdictions.

To date, no studies have been conducted on the attitudes of British Columbia registered midwives on the inclusion of medication abortion into their scope of practice. This article reports the findings of a series of interviews with British Columbia registered midwives on their attitudes and beliefs toward expanding their scope of practice to include the provision of medical abortion. Throughout this article, gender-specific terms, such as *woman* and *women*, are used to reflect the research cited, as well as the language used by study participants. The authors acknowledge the limitations of these terms and recognize that gender diverse and nonbinary people also seek abortion care.

METHODS

Interviews were conducted by the 2 primary authors via telephone, skype, or in-person from January to February 2017. All British Columbia registered midwives were invited to participate via a request for engagement through the Midwives Association of British Columbia's email list. The interviews were semistructured, and probes were used to explore topics in more depth. There were 10 lead questions and potential probes included in each interview (see Appendix 1). Demographic information was also collected. Interviews were confidential, and data were anonymized. This was particularly important in rural settings where scarcity of health care providers made participants more vulnerable to identification.

Inductive thematic analysis was selected as an analytical framework because of its appropriateness for semistructured interviews.^{38–40} The intention was to provide a rich, thematic description of the interviews as a set. To do this, the authors looked for patterned responses of meaning and prevalence in the data.³⁸ Data were analyzed on a semantic level, with an attempt to understand the significance of patterns and the implications for this area of practice.³⁸ The authors familiarized themselves with the data by transcribing interviews as they were collected. An initial code book was developed by reviewing, double coding, and comparing results of 4 transcripts. The remaining interviews were coded separately by the authors. Authors gathered all coded data, refined the codes, and created candidate themes and subthemes, which were then compared back against the data set in order to extrapolate the essence of the interviews into the final themes presented here.^{38,40}

The 2 primary authors (M.D. and E.R.) were midwifery students during data collection and analysis; the third author (J.K.) is a health services researcher focused on rural access to maternity care. Data analysis was performed in Nvivo. Ethics board approval was obtained from the University of British Columbia research ethics board.

RESULTS

Fifteen interviews were completed to achieve thematic saturation. All participants were currently practicing as registered midwives in British Columbia, where there were 274 practicing registered midwives at the time of the interviews. Participants had practiced for an average of 5.8 years (median, 3.5 years; range, 1.5 to 19 years). There were 7 participants who identified as urban practitioners, 5 as rural, and 3 in mixed practices. Years of practice and urban-rural classification were the only demographic data collected. Interviews ranged from 21 to 80 minutes in length.

Five primary themes were identified: the incorporation of medication abortion into the midwifery scope of practice to increase access, the congruence of the midwifery model of care and provision of medication abortion, the role of registered midwives as guardians of reproductive rights, the need for a paradigm shift in how the profession is viewed, and the practicalities of potential scope expansion.

Commitment to Increasing Access to Medication Abortion

All participants expressed a desire to expand their scope of practice to include medication abortion and acknowledged that expansion could increase access to services in their communities. Although all urban participants recognized that abortion services were accessible in their communities, most felt that access was still limited in various ways, namely for vulnerable populations (a term used by participants throughout the interviews) or for people seeking a midwifery model of care for abortion services, such as continuity of care or the option of home-based services.

Many participants working in rural locations identified limited access or a lack of access to abortion services as a critical issue. Specifically, it was noted that people living in communities without abortion services faced numerous barriers that had considerable economic and emotional implications, including threats to personal privacy with the need to travel for care, losing continuity with a known care provider, availability of child care, travel and accommodation costs, and potential loss of wages for time off required for travel. One participant sums the experience up in the following comment:

Choosing to terminate a pregnancy... can be really challenging at any time, but particularly in a rural community. And, the issues around privacy and autonomy and sort of making that decision can be quite complex and then the actual logistics in terms of how does that work and what does it mean in the woman's life and just the practicalities. Does she have to go somewhere else, does she have to find child-care, you know employment issues, those sorts of things. As well as being in an unfamiliar place, with unfamiliar care givers, while she is going through a challenging experience.

All rural participants felt that providing medication abortion would increase access in their communities and help alleviate barriers caused by limited access. All health care providers working with vulnerable populations identified similar barriers as those faced by rural communities, with the added risk of "getting lost in the system" and losing trust. Similarly, they believed that offering medication abortion could increase access and decrease barriers.

Most health care providers spoke of a time when they wished they could have provided an abortion, whereas some felt that coverage in their community was sufficient and as such had never felt a critical need to provide this care. Others, primarily in rural locations, identified a substantial gap in care that they would have been able to fill had medication abortion been part of their scope. These same providers saw multiple individuals a month seeking an abortion who were unable to access that care without leaving their community. In addition to increasing access in their own communities, some respondents were interested in providing medication abortion in other British Columbia communities not offering services or where other providers were not willing to provide care.

Congruence of the Midwifery Model of Care and Provision of Medication Abortion

All participants identified congruence between the midwifery model of care and the provision of medication abortion. Several key tenants of the midwifery model were highlighted: informed choice, continuity of care, client-centered care, and nonjudgmental care. The following quote exemplifies this theme:

It seems like it just fits well within how we practice, what we know about, and the ways that we work with families. It's part of the whole life cycle. I just think it's so who we are. The women we work with are exquisitely aware of what they want and how to identify it, and, if our job is just providing access, and increasing the access then I don't really see what the problem is.

All participants felt that informed choice is a fundamental cornerstone of the midwifery model of care and that offering abortion services is an extension of this commitment. Additionally, many participants spoke about the potential benefits of continuity of care, namely the trust that can be formed with those accessing medication abortion services. Many participants felt that if more registered midwives were able to provide medication abortion, there would be less reliance on the provincial system of referring patients to unknown health care providers or out of community care. Almost all participants identified client-centered care as central to the philosophy of midwifery and the model of care. As such, most participants felt well positioned to provide client-centered, nonjudgmental care and identified both as important in abortion provision.

All participants felt well positioned to provide medication abortion thanks, in large part, to registered midwives' existing skills, (eg, management of postpartum hemorrhage, which requires an understanding of the pharmacokinetics of misoprostol). Half of all participants noted that assessment skills are important in medication abortion management, with specific reference to their ability to assess for hemorrhage and seek appropriate consultation for further care. Although it was not the primary focus of the discussion, half of the participants made a correlation between expanding the scope of practice to include medication abortion and the inclusion of care for incomplete early spontaneous abortion. Participants who had completed the Specialized Practice Certification in Contraceptive Prescribing felt they could provide a continuum of care for patients seeking medication abortion, including counseling on contraceptive options if appropriate.

Midwives as Guardians of Reproductive Rights

A prevalent theme woven through the responses was registered midwives as "guardians of reproductive rights." For most participants, this was grounded in the notion that midwifery is, or should be, rooted in women's rights, feminism, and informed decision making.

All participants saw offering abortion services as an extension of the professions' commitment to reproductive rights, thus part of their professional duty. All participants spoke

to the controversial nature of the issue and how, for some registered midwives, offering abortion services would be an extension of their commitment to informed choice, and for others it could be a challenge, as is demonstrated in the following quote: "Midwives are already experts in informed choice. It's what we do. We believe in choice of provider, we believe in choice of birth place... so I don't think it's an enormous leap, given that we do champion women's reproductive rights, but for some individuals, it's an impossible leap."

Some participants noted that it does not matter what their individual ethical or moral perspective is as they were committed to providing informed choice:

Lots of people feel you know once you have seen the beauty of and miracle of a childbirth how could you ever, even think about the idea of abortion, but of course, I provide choice to people. So, that's my bottom line. Whether I agree with abortion or not. I mean I have my feelings about it, but, when it comes to client choice, I put myself aside.

Finally, the current political landscape, namely the actions of the current US administration toward restraining abortion provision both domestically and globally, was highlighted in many interviews by participants as an impetus for their desire to pursue effective methods of increasing access to abortion services both locally and globally. Relatedly, some participants hoped to use the skill set in global health settings and/or for people facing access issues in the United States traveling to Canada for services.

A New Paradigm for Midwifery

Another major theme was the need for a paradigm shift to change the perception of midwives as practitioners who only deal with "birth and babies" to providers of abortion services. Most felt they would be supported in their community but acknowledged it could be alienating for some clients and challenging in certain geographic locations. Specifically, there was concern that the existing perception of midwives as "bringers of life" could be viewed as discordant with abortion provision.

Most participants spoke about the paradigm shift as it relates to the diversity of attitudes within the profession and the potential for backlash within the midwifery community. Resistance was not thought to be solely ethical or moral, but also due to the practical consequences of scope expansions, such as the cost of additional training or the potential increased workload with or without increased compensation, causing disapproval from some members of the profession. However, most practitioners felt that the profession's commitment to informed choice and reproductive rights was the higher value that needed to be honored and that this would be the crux of support within their own clinics and the greater midwifery community.

Most participants acknowledged the potential for inter-professional resistance from obstetricians and family practice physicians, particularly for financial reasons; registered midwives' perceived lack of medical training; and the proximity of the service to full life cycle care. At the same time, many practitioners felt they would be supported by their

interprofessional colleagues in requesting follow-up and consultation as needed based on the strength of current relationships, although a few felt that their existing interprofessional relationships would be challenging to navigate. Some felt that interprofessional colleagues would welcome the support to decrease their workload, increase access in the community, and reduce the risk of being personally targeted for providing abortion care.

Practicalities of Potential Scope Expansion

Participants discussed the following practicalities of this potential scope expansion: the contentious nature of abortion, logistical factors including training, and financial compensation. Participants recognized that some registered midwives might not be comfortable providing medication abortion or with having their profession associated with abortion provision. All participants felt it would be unethical for providers to be required to offer abortion services and that it should be an optional additional training, whereby practitioners could choose whether or not to provide the care. At the same time, several participants felt personally conflicted between their commitment to supporting access to abortion and recognizing other providers' right to conscientious objection. Some participants expressed concern over the perpetuation of inequitable access to abortion if individual practitioners opted out of providing abortion care, particularly if that health care provider was the only one available in the community. Participants felt that this ethical consideration could be navigated with appropriate communication within the midwifery profession. Most participants felt that navigating this issue was no different for midwives than it was any other cadre of abortion care providers.

Many participants identified financial remuneration as a critical issue if medication abortion was added to the scope of practice. Provider fatigue was raised as a concern by some participants should scope expansion occur without appropriate adjustments to work models and remuneration strategies. Other participants were indifferent and felt they would be committed to providing medication abortion care in their setting without additional compensation. Most participants, regardless of where they stood on compensation for medication abortion specifically, identified that scope expansion without compensation contributes to a systemic undervaluing of midwifery care. When talking about scope expansion in general, one participant noted: "[We] continue to expand the services for woman at the expense of midwives. So I do think that our model is problematic. It is a brilliant model, it serves women well, but at the expense of midwives' health."

Many practitioners saw expansion into medication abortion as a natural extension of their existing skill set and believed it could increase their professional autonomy and ability to work to their full potential within the current model of care and/or under alternative models. Many noted that current regulatory requirements for registration are at odds with practitioners' personal and professional needs, such as a desire for less on-call time, part-time work, and more collaborative care options. Respondents mentioned that current limitations in work models for registered midwives result in the loss of

skilled practitioners desiring a reduced workload. Regulatory practice changes that support registered midwives working in different models of care could potentially mediate the above noted restrictions.⁴¹

Most participants discussed personal safety issues related to the provision of abortion. The majority were comfortable with any perceived risk and felt this was a mitigable challenge. Most participants felt supported in their communities and were not concerned about any speculated effect on their business from clients uneasy with them providing the service and were comfortable supporting such clients to seek midwifery care from another health care provider if possible.

DISCUSSION

No prior studies have investigated the attitudes of registered midwives in British Columbia toward expanding their scope of practice to include medication abortion. Our findings suggest the viability of this option and its potential in addressing inequitable abortion access, particularly in rural communities. All participants in this study supported the inclusion of medication abortion into the midwifery scope of practice. Participants felt that the midwifery model of practice uniquely positioned registered midwives to provide abortion care and help to fill the gap created by the current decline of abortion providers in British Columbia.^{3,5,42} Furthermore, participants look to this scope expansion as a way to provide diversity within a profession that has a noted lack of options for care providers outside of the call-based model.

At the same time, this study identified that a paradigm shift would be required for registered midwives to be viewed as something other than pregnancy and birth providers. Many felt this change would be challenging for the profession but believed that this shift is warranted by the profession's values. Respondents expressed that being able to provide medication abortions through the midwifery model of care would provide options consistent with client-centered care, informed decision making, continuity of care, and choice of health care provider.

Although Canadian laws make it feasible for midwives to become abortion providers, abortion remains a contentious issue. In Canada, physicians can choose, through conscientious objection, to provide abortion or not, and we expect the same for registered midwives should this expansion take place. In allowing for provider choice to offer abortion services or not, access to the service might remain vulnerable and provider and community dependent. For example, if all registered midwives decide not to provide medication abortions in a region already lacking in services, access remains an issue.

A strength of this study was its qualitative design, which endorsed an in-depth understanding of some of the critical issues in expanding British Columbia registered midwives' scope of practice to include medication abortion. Open-ended interview questions and probes allowed for the research to be directed by participants, therefore decreasing the influence of interviewer bias. However, the qualitative design also has limitations. As it aimed to understand the

in-depth perspectives of a small number of participants, the results cannot be generalized to the overall population of registered midwives in British Columbia. We acknowledge that because of the nature of this topic and the methodology of this study, participants who favor this expansion may be more likely to participate than those who do not, although we did specifically state we were seeking all points of view in our recruitment materials, including a second recruitment posting especially highlighting the need for diverse perspectives.

From this research alone, we cannot conclude that registered midwives in British Columbia, as a body of professionals, want to provide medication abortions. However, it offers a promising foundation for future research. We recommend a quantitative, representative survey of the greater midwifery body to investigate the attitudes of British Columbia registered midwives about providing medication abortion, including capturing attitudes of those opposed to this expansion to better understand that perspective. There is also a distinct lack of research that aims to understand the experiences of people accessing abortion and the barriers they face. Particularly, research is needed to understand the experiences of those accessing abortion who live in rural and remote communities and those who experience vulnerabilities and systematic barriers to health care.

Access to health care is a fundamental tenet of the Canada Health Act yet is challenging to actualize in some rural, remote and vulnerable populations in Canada, particularly in the area of reproductive health. There is a growing body of evidence highlighting a lack of access to maternity care and abortion care in rural communities and related adverse health and social outcomes.^{3,5,7,43} At the same time, midwifery is emerging as a solution to both these challenges. This study builds on the existing research examining midwives' attitudes toward providing abortion services and provides an important first step in understanding this issue in British Columbia. Expanding British Columbia registered midwives' scope of practice to include medication abortion has the potential to decrease inequity in access to abortion services and increase reproductive choices for those seeking care.

CONFLICT OF INTEREST

The authors have no conflicts of interest to disclose.

REFERENCES

1. Norman WV. Induced abortion in Canada 1974-2005: trends over the first generation with legal access. *Contraception*. 2012;85(2):185-191.
2. Sethna C, Doull M. Spatial disparities and travel to freestanding abortion clinics in Canada. *Womens Stud Int Forum*. 2013;38:52-62.
3. Norman WV, Soon JA, Maughn N, Dressler J. Barriers to rural induced abortion services in Canada: findings of the British Columbia Abortion Providers Survey (BCAPS). *PLoS One*. 2013;8(6):1-8.
4. Norman WV, Soon JA, Maughn N, Dressler J. Canadian rural compared to urban first- and second-trimester abortion services: findings of the British Columbia abortion provider survey. *Contraception*. 2012;86(3):305.
5. Dressler J, Maughn N, Soon JA, Norman WV. The perspective of rural physicians providing abortion in Canada: qualitative findings of the BC Abortion Providers Survey (BCAPS). *PLoS One*. 2013;8(6):e67070.
6. Dressler J, Maughn N, Soon J, Norman W. Experiences of rural versus urban abortion providers in British Columbia: interview findings from the BC abortion providers survey. *Contraception*. 2012;86(3):305.
7. Vogel L. Abortion access grim in English Canada. *CMAJ*. 2015;187(1):17.
8. Sethna C, Palmer B, Ackerman K, Janovicek N. Choice, interrupted: travel and inequality of access to abortion services since the 1960s. *Labour*. 2013;48(71).
9. Johnstone R, Macfarlane E. Public policy, rights, and abortion access in Canada. *Int J Can Stud*. 2015;51:97-120.
10. Downie J, Nassar C. Barriers to access to abortion through a legal lens. *Health Law J*. 2007;15(977):143-173.
11. Handa M, Rosenberg S. Ontario midwives' attitudes about abortion and abortion provision. *Can J Midwifery Res Pract*. 2016;15(1):8-35.
12. Shaw J. *Reality Check: A Closer Look at Accessing Abortion Services in Canadian Hospitals*. Ottawa, Ontario: Canadians for Choice; 2006.
13. Dunn S, Cook R. Medical abortion in Canada: behind the times. *CMAJ*. 2014;186(1):13-14.
14. Costescu D, On H, Guilbert E, et al. Medical abortion [In English and French]. *J Obstet Gynaecol Can*. 2016;38(4):366-389.
15. The Canadian Press. Health Canada eases restrictions on abortion pill Mifegymiso. CBC website. <http://www.cbc.ca/news/health/mifegymiso-abortion-pill-health-canada-1.4391267>. November 7, 2017. Accessed December 18, 2017.
16. Renner RM, Brahma D, Kapp N. Who can provide effective and safe termination of pregnancy care? A systematic review*. *BJOG*. 2013;120(1):23-31.
17. Barnard S, Kim C, Park MH, Ngo TD. Doctors or mid-level providers for abortion. *Cochrane Database Syst Rev*. 2015;(7):CD011242.
18. *The Role of Physician Assistants, Nurse Practitioners, and Nurse-Midwives in Providing Abortions: Strategies for Expanding Abortion Access. Recommendations from a National Symposium*. Atlanta, Georgia; December 13-14, 1996. Washington DC; National Abortion Federation; 1997.
19. Berer M. Provision of abortion by mid-level providers: international policy, practice and perspectives. *Bull World Health Organ*. 2009;87(1):58-63.
20. Rocca CH, Puri M, Shrestha P, et al. Effectiveness and safety of early medication abortion provided in pharmacies by auxiliary nurse-midwives: A non-inferiority study in Nepal. *PLoS One*. 2018;13(1):e0191174.
21. Kopp Kallner H, Gomperts R, Salomonsson E, Johansson M, Marions L, Gemzell-Danielsson K. The efficacy, safety and acceptability of medical termination of pregnancy provided by standard care by doctors or by nurse-midwives: a randomised controlled equivalence trial. *BJOG*. 2015;122(4):510-517.
22. Warriner IK, Wang D, Huang NT, et al. Can midlevel health-care providers administer early medical abortion as safely and effectively as doctors? A randomised controlled equivalence trial in Nepal. *Lancet*. 2011;377(9772):1155-1161.
23. Sjöström S, Kopp Kallner H, Simeonova E, Madestam A, Gemzell-Danielsson K. Medical abortion provided by nurse-midwives or physicians in a high resource setting: a cost-effectiveness analysis. *PLoS One*. 2016;11(6):e0158645.
24. Weitz T, Anderson P, Taylor D. Advancing scope of practice for advanced practice clinicians: more than a matter of access. *Contraception*. 2009;80(2):105-107.
25. Jejeebhoy SJ, Kalyanwala S, Mundle S, et al. Feasibility of expanding the medication abortion provider base in India to include

- ayurvedic physicians and nurses. *Source Int Perspect Sex Reprod Heal.* 2012;38(3):133-142.
26. Jones RK, Henshaw SK. Mifepristone for early medical abortion: experiences in France, Great Britain and Sweden. *Perspect Sex Reprod Health.* 2002;34(3):154-161.
27. Erdman JN, DePiñeres T, Kismódi E. Updated WHO guidance on safe abortion: health and human rights. *Int J Gynecol Obstet.* 2013;120(2):200-203.
28. World Health Organization. *Safe Abortion: Technical and Policy Guidance for Health Systems.* 2nd ed. Geneva, Switzerland; World Health Organization; 2012.
29. Fullerton JT, Thompson JB, Severino R; International Confederation of Midwives. The International Confederation of Midwives essential competencies for basic midwifery practice. an update study 2009-2010. *Midwifery.* 2011;27:399-408.
30. Fullerton J, Butler MM, Aman C, Reid T, Dowler M. Abortion-related care and the role of the midwife: a global perspective. *Int J Womens Health.* 2018;10:751-762.
31. Sabourin JN, Burnett M. A review of therapeutic abortions and related areas of concern in Canada. *J Obstet Gynaecol Canada.* 2012;34(6):532-542.
32. Canadian Association of Midwives. *Reproductive Health Care Position Statement.* Montreal, Quebec: Canadian Association of Midwives; 2015. <https://canadianmidwives.org/wp-content/uploads/2016/06/CAM-ReproCarePS-eng-Feb2016-FINAL.pdf>. Accessed June 15, 2017.
33. Lipp A. A woman centred service in termination of pregnancy: a grounded theory study. *Contemp Nurse.* 2008;31(1):9-19.
34. Lipp A. A review of termination of pregnancy: prevalent health care professional attitudes and ways of influencing them. *J Clin Nurs.* 2008;17(13):1683-1688.
35. Handa M, Rosenberg S. Ontario midwives' attitudes about abortion and abortion provision. *Can J Midwifery Res Pract.* 2016;1:8-35.
36. Lindström M, Jacobsson L, Wulff M, Lalos A. Midwives' experiences of encountering women seeking an abortion. *J Psychosom Obstet Gynaecol.* 2007;28(4):231-237.
37. Hwang AC, Koyama A, Taylor D, Henderson JT, Miller S. Advanced practice clinicians' interest in providing medical abortion: results of a California survey. *Perspect Sex Reprod Health.* 2005;37(2):92-97.
38. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol.* 2006;3(2):77-101.
39. Braun V, Clarke V. What can "thematic analysis" offer health and wellbeing researchers? *Int J Qual Stud Health Well-being.* 2014;9(1):1-2.
40. Joffe H. Thematic analysis. In: Harper D, Thompson AR, eds. *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide For Students and Practitioners.* 1st ed. Hoboken, NJ: John Wiley & Sons Ltd; 2011:209-223.
41. College of Midwives of British Columbia. *Policy on Alternate Practice Arrangements.* Vancouver, BC: College of Midwives of British Columbia; 2018. <https://www.cmbc.bc.ca/wp-content/uploads/2019/03/Policy-on-Alternate-Practice-Arrangements.pdf>. Accessed November 19, 2019.
42. Norman WV. Abortion in British Columbia: trends over 10 years compared to Canada. *Contraception.* 2011;84(3):316.
43. Verstraeten BSE, Mijovic-Kondejewski J, Takeda J, Tanaka S, Olson DM. Canada's pregnancy-related mortality rates: doing well but room for improvement. *Clin Invest Med.* 2015;38(1):E15-E36.

Appendix I: Semistructured Interview Probes

Demographic Questions

- How long have you been practicing?
- Are you currently practicing?
- Do you consider yourself to be an urban, rural or remote provider?

Attitudes

Lead Questions:

- What is your attitude towards expanding scope of practice to include medical abortion?
- Would you feel comfortable performing medical abortions?

Potential Further Probes:

- Would you be comfortable with this being an identified part of Registered Midwives' scope of practice?
- Do you feel there are ethical considerations to providing medical abortion?
- Do you see any benefits to expanding scope of practice in this way?

Barriers

Lead Question:

- Do you see any barriers to including medical abortion in the midwifery scope of practice?

Potential Further Probes:

- Do you foresee any barriers for you as a provider?
- Do you foresee any barriers for the profession?
- Do you see gaining compensation or financial remuneration as a barrier?
- Do you have concerns about visibility or vulnerability if you were to provide this service?

Final Thoughts

Is there anything else you think is important about this topic that we have not talked about, or anything else you would like to share?