Check for updates

Received: 19 May 2021 | Revised: 18 February 2022 | Accepted: 2 March 2022

DOI: 10.1111/jan.15226

ORIGINAL RESEARCH: EMPIRICAL RESEARCH - QUALITATIVE

JAN Leading Global Nursing Research WILEY

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

Lydia Mainey[1] | Catherine O'mullan[2] | Kerry Reid-Searl[1,3]

[1]College of Nursing and Midwifery, CQUniversity, Cairns, Australia

[2]College of Science and Sustainability, CQUniversity, Bundaberg, Australia

[3]Rural and Remote Education, Queensland Health, Rockhampton, Australia

Correspondence
Lydia Mainey, College of Nursing and Midwifery, CQUniversity, Cairns, Australia.
Email: l.mainey@cqu.edu.au

Funding information
This work was supported by the Australian Government Research Training Program.

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 violence (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 continue 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

This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.
© 2022 The Authors. *Journal of Advanced Nursing* published by John Wiley & Sons Ltd.

1 | INTRODUCTION

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 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). 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 verbatim 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 credibility; a self-interview to assist with reflexivity and methodological 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

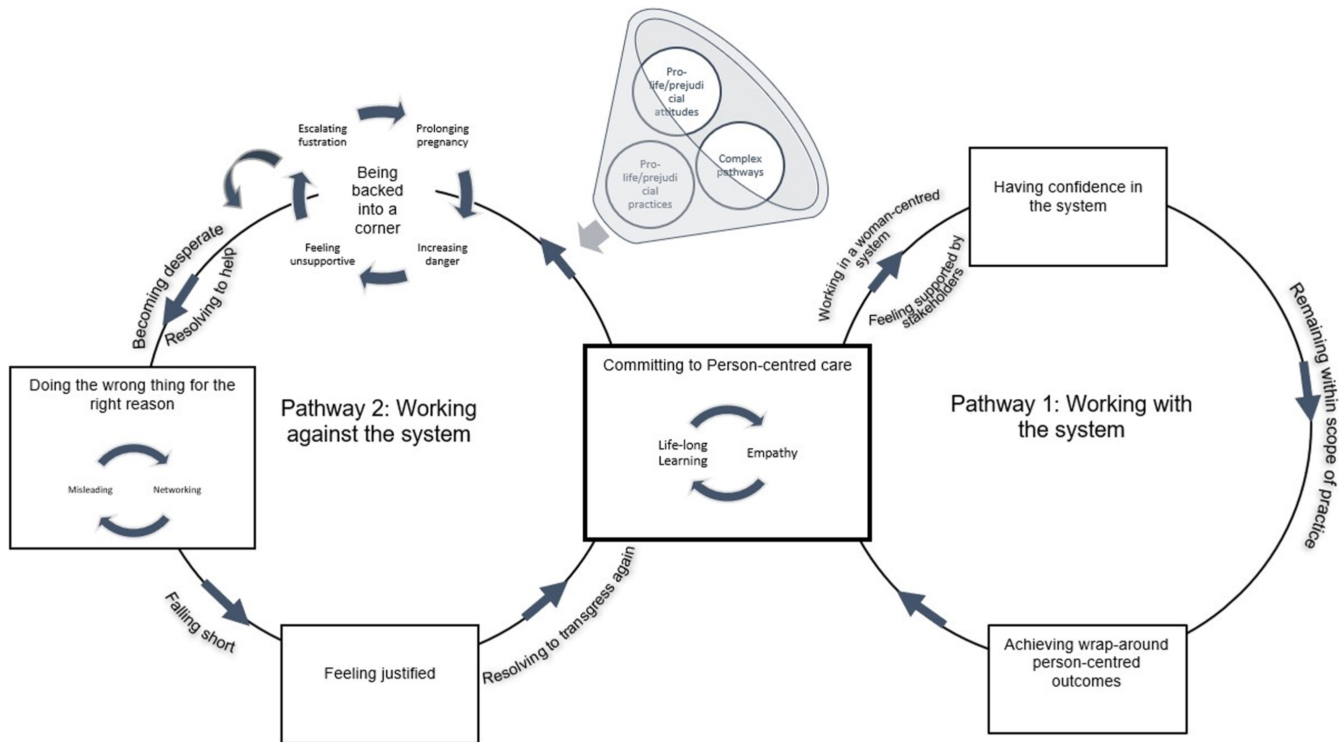

FIGURE 1 Australian nurses' and midwives' process of providing abortion care in the context of gender-based violence

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 *life-long 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 wraparound 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 guidelines. 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 literature 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.

ACKNOWLEDGEMENTS

Open access publishing facilitated by Central Queensland University, as part of the Wiley - Central Queensland University agreement via the Council of Australian University Librarians. [Correction added on 19 May 2022, after first online publication: CAUL funding statement has been added.]

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.

PEER REVIEW

The peer review history for this article is available at https://publons.com/publon/10.1111/jan.15226.

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

ORCID

Lydia Mainey https://orcid.org/0000-0003-1438-8061

TWITTER

Lydia Mainey @LydiaMainey

REFERENCES

Australian Institute of Health and Wellfare [AIHW], Hargreaves, J., Grayson, N., & Sullivan, E. (2005). *Use of routinely collected national*

data sets for reporting on induced abortion in Australia (AIHW Cat. No. PER 30). AIHW. https://www.aihw.gov.au/reports/mothers-babies/use-national-data-sets-reporting-induced-abortion

Ayre, J., Lum On, M., Webster, K., Gourley, M., & Moon, L. (2016). Examination of the health outcomes of intimate partner violence against women. *Landscapes: State of Knowledge*, *2016*(3), 1–63. https://www.anrows.org.au/publication/examination-of-the-health-outcomes-of-intimate-partner-violence-against-women-state-of-knowledge-paper/

Barber, C. (2007). Abuse by care professionals. Part 3: Analysis of characteristics and reasons. *British Journal of Nursing*, *16*(17), 1080–1082. https://doi.org/10.12968/bjon.2007.16.17.27254

Ben Natan, M., Ben Ari, G., Bader, T., & Hallak, M. (2012). Universal screening for domestic violence in a department of obstetrics and gynaecology: A patient and carer perspective. *International Nursing Review*, *59*(1), 108–114. https://doi.org/10.1111/j.1466-7657.2011.00931.x

Biggs, M. A., Brown, K., & Foster, D. G. (2020). Perceived abortion stigma and psychological well-being over five years after receiving or being denied an abortion. *PLoS One*, *15*(1), e0226417. https://doi.org/10.1371/journal.pone.0226417

Birks, M., Hoare, K., & Mills, J. (2019). Grounded theory: The fAQs. *International Journal of Qualitative Methods*, *18*, 1609406919882535. https://doi.org/10.1177/1609406919882535

Birks, M., & Mills, J. (2015). *Grounded theory: A practical guide* (2nd ed.). Sage.

Bleil, M. E., Adler, N. E., Pasch, L. A., Sternfeld, B., Reijo-Pera, R. A., & Cedars, M. I. (2011). Adverse childhood experiences and repeat induced abortion. *American Journal of Obstetrics & Gynecology*, *204*(2), 122.e1–122.e6. https://doi.org/10.1016/j.ajog.2010.09.029

Brüggemann, A. J., & Swahnberg, K. (2013). What contributes to abuse in health care? A grounded theory of female patients' stories. *International Journal of Nursing Studies*, *50*(3), 404–412. https://doi.org/10.1016/j.ijnurstu.2012.10.003

Cappiello, J., Coplon, L., & Carpenter, H. (2017). Systematic review of sexual and reproductive health care content in nursing curricula. *Journal of Obstetric Gynecolic & Neonatal Nursing*, *46*(5), e157–e167. https://doi.org/10.1016/j.jogn.2017.04.132

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). SAGE.

Clarke, A., Friese, C., & Washburn, R. (2016). *Situational analysis in practice: Mapping research with grounded theory*. Routledge Ltd – M.U.A.

Colarossi, L., Breitbart, V., & Betancourt, G. (2010). Barriers to screening for intimate partner violence: A mixed-methods study of providers in family planning clinics. *Perspectives On Sexual & Reproductive Health*, *42*(4), 236–243. https://doi.org/10.1363/4223610

Collins, J. L., Thomas, L., Song, H., Ashcraft, A., & Edwards, C. (2020). Interpersonal violence: What undergraduate nursing students know. *Issues in Mental Health Nursing*, *1–5*, 599–603. https://doi.org/10.1080/01612840.2020.1836539

Cooper, M. (2019). Midwifery: A woman-centred profession in need of woman-centred policy and research. *Women & Birth*, *32*, S39. https://doi.org/10.1016/j.wombi.2019.07.267

Crenshaw, K. (1990). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, *43*, 1241–1299.

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

de Moel-Mandel, C., & Graham, M. (2019). Medical abortion: It is time to lift restrictions. *Medical Journal of Australia*, *211*(9), 428–428.e1. https://doi.org/10.5694/mja2.50363

Doran, F., & Hornibrook, J. (2014). Rural New South Wales women's access to abortion services: Highlights from an exploratory qualitative study: Rural women's access to abortion services. *The Australian Journal of Rural Health*, *22*(3), 121–126. https://doi.org/10.1111/ajr.12096

Du Mont, J., Macdonald, S., White, M., Turner, L., White, D., Kaplan, S., & Smith, T. (2014). Client satisfaction with nursing-led sexual assault and domestic violence services in Ontario. *Journal of Forensic Nursing*, *10*(3), 122–134. https://doi.org/10.1097/JFN.0000000000000035

Essex, R. (2021). Resistance in health and healthcare. *Bioethics*, *35*(5), 480–486. https://doi.org/10.1111/bioe.12862

García-Moreno, C., Hegarty, K., d'Oliveira, A. F. L., Koziol-McLain, J., Colombini, M., & Feder, G. (2015). The health-systems response to violence against women. *The Lancet*, *385*(9977), 1567–1579.

Hutchinson, M., Doran, F., Brown, J., Douglas, T., East, L., Irwin, P., Mainey, L., Saunders, A., Sweet, L., Van De Mortel, T., & Yates, K. (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

International Confederation of Midwives. (2018). *Essential competencies for midwifery practice: 2018 update*. Retrieved September 9, 2021 from https://www.internationalmidwives.org/assets/files/general-files/2018/10/icm-competencies---english-document_final_oct-2018.pdf

Ipas. (2013). In K. L. Turner & A. Huber (Eds.), *Woman-centered, comprehensive abortion care: Reference manual* (2nd ed). Ipas. https://www.ipas.org/wp-content/uploads/2020/06/ACREFE16-WomenCenteredCACReferenceManual.pdf

Kassam, S., Marcellus, L., Clark, N., & O'Mahony, J. (2020). Applying intersectionality with constructive grounded theory as an innovative research approach for studying complex populations: Demonstrating congruency. *International Journal of Qualitative Methods*, *19*, 160940691989892. https://doi.org/10.1177/1609406919898921

Lee-Jen Wu, S., Hui-Man, H., & Hao-Hsien, L. (2014). A comparison of convenience sampling and purposive sampling. *Journal of Nursing*, *61*(3), 105–111. https://doi.org/10.6224/JN.61.3.105

Liamputtong, P. (2007). *Researching the vulnerable: A guide to sensitive research methods*. SAGE Publications.

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

McCloskey, L. A. (2016). The effects of gender-based violence on women's unwanted pregnancy and abortion. *The Yale Journal of Biology and Medicine*, *89*(2), 153–159. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4918882/

Messing, J. T., Thaller, J., & Bagwell, M. (2014). Factors related to sexual abuse and forced sex in a sample of women experiencing police-involved intimate partner violence. *Health & Social Work*, *39*(3), 181–191. https://doi.org/10.1093/hsw/hlu026s

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

Miller, E., & Silverman, J. G. (2010). Reproductive coercion and partner violence: Implications for clinical assessment of unintended pregnancy. *Expert Review of Obstetrics & Gynecology*, *5*, 511–515. https://doi.org/10.1586/eog.10.44

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

Moore, L., Britten, N., Lydahl, D., Naldemirci, Ö., Elam, M., & Wolf, A. (2017). Barriers and facilitators to the implementation of person-centred care in different healthcare contexts. *Scandanavian Journal of Caring Sciences*, *31*(4), 662–673. https://doi.org/10.1111/scs.12376

Moseson, H., Fix, L., Ragosta, S., Forsberg, H., Hastings, J., Stoeffler, A., Lunn, M. R., Flentje, A., Capriotti, M. R., Lubensky, M. E., & Obedin-Maliver, J. (2020). Abortion experiences and preferences of transgender, nonbinary, and gender-expansive people in the United States. *American Journal of Obstetrics & Gynecology*, *224*, 376.e1–376.e11. https://doi.org/10.1016/j.ajog.2020.09.035

Nursing and Midwifery Board of Australia. (2016). *Registered nurse standards for practice*. NMBA. Retrieved April 13, 2021 from https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/registered-nurse-standards-for-practice.aspx

O'Doherty, L., Hegarty, K., Ramsay, J., Davidson, L. L., Feder, G., & Taft, A. (2015). Screening women for intimate partner violence in healthcare settings. *The Cochrane Database of Systematic Reviews*, CD007007. https://doi.org/10.1002/14651858.CD007007.pub3

Pallitto, C. C., García-Moreno, C., Jansen, H. A. F. M., Heise, L., Ellsberg, M., Watts, C., & WHO Multi-Country Study on Women's Health and Domestic Violence. (2013). Intimate partner violence, abortion, and unintended pregnancy: Results from the who multi-country study on women's health and domestic violence. *International Journal of Gynaecology and Obstetrics*, *120*(1), 3–9. https://doi.org/10.1016/j.ijgo.2012.07.003

Perry, R., Murphy, M., Haider, S., & Harwood, B. (2015). "One problem became another": Disclosure of rape-related pregnancy in the abortion care setting. *Women's Health Issues*, *25*(5), 470–475. https://doi.org/10.1016/j.whi.2015.05.004

Perry, R., Murphy, M., Rankin, K. M., Cowett, A., & Harwood, B. (2016). Practices regarding rape-related pregnancy in U.S. Abortion care settings. *Women's Health Issues*, *26*(1), 67–73. https://doi.org/10.1016/j.whi.2015.10.006

Sadler, G. R., Lee, H.-C., Lim, R. S.-H., & Fullerton, J. (2010). Recruitment of hard-to-reach population subgroups via adaptations of the snowball sampling strategy. *Nursing Health Science*, *12*(3), 369–374. https://doi.org/10.1111/j.1442-2018.2010.00541.x

Scheil, W., Jolly, K., Scott, J., Catcherside, B., Sage, L., & Kennare, R. (2016). *Pregnancy outcome in South Australia 2014*. Pregnancy Outcome (Statistics) Unit.

Silverman, J. G., Raj, A., & Clements, K. (2004). Dating violence and associated sexual risk and pregnancy among adolescent girls in the United States. *Pediatrics*, *114*(2), e220–e225. https://doi.org/10.1542/peds.114.2.e220

Snider, C., Webster, D., O'sullivan, C. S., & Campbell, J. (2009). Intimate partner violence: Development of a brief risk assessment for the emergency department. *Academic Emergency Medicine*, *16*(11), 1208–1216. https://doi.org/10.1111/j.1553-2712.2009.00457.x

Spangaro, J. M., Zwi, A. B., Poulos, R. G., & Man, W. Y. N. (2010). Who tells and what happens: Disclosure and health service responses to screening for intimate partner violence. *Health & Social Care in the Community*, *18*(6), 671–680. https://doi.org/10.1111/j.1365-2524.2010.00943.x

Srivastava, A., Singh, D., Montagu, D., & Bhattacharyya, S. (2017). Putting women at the center: A review of Indian policy to address person-centered care in maternal and newborn health, family planning and abortion [Report]. *BMC Public Health*, *18*, 1–10. https://link.gale.com/apps/doc/A507111399/AONE?u=cqu&sid=AONE&xid=fd962132

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

Swahnberg, K., Wijma, B., Wingren, G., Hilden, M., & Schei, B. (2004). Women's perceived experiences of abuse in the health care system: Their relationship to childhood abuse. *British Journal of Obstetrics & Gynaecology*, *111*(12), 1429–1436. https://doi.org/10.1111/j.1471-0528.2004.00292.x

Taft, A. J., & Watson, L. F. (2007). Termination of pregnancy: Associations with partner violence and other factors in a national cohort of young Australian women. *Australian & New Zealand Journal of Public Health*, *31*(2), 135–142. https://doi.org/10.1111/j.1753-6405.2007.00031.x

Victorian Women with Disabilities Network. (2007). *Submission to Victorian law reform commission law on abortion*. VWDN. Retrieved May 4, 2021 from https://www.wdv.org.au/documents/Law%20Reform%20Commission%20Law%20on%20Abortion%20submission%20-%20Final.pdf

Wiebe, E. R., & Janssen, P. (2001). Universal screening for domestic violence in abortion. *Women's Health Issues*, *11*(5), 436–441. https://doi.org/10.1016/S1049-3867(01)00074-3

Wilson, R. L., & Waqanaviti, K. (2021). Navigating first nations social and emotional wllbeing in mainstream mental health services. In O. Best & B. L. Fredericks (Eds.), *Yatdjuligin: Aboriginal and torres strait islander nursing and midwifery care* (3rd ed., pp. 281–306). Cambridge University Press.

Wolfinger, E. (2017). Stereotyping single mothers is not new – its history, and how to challenge it. In *Federal politics, stereotypes, stigma, voices of single mothers*. Council of single mothers and their children. https://www.csmc.org.au/2017/11/stereotyping-single-mothers/

World Health Organization. (2012). *Safe abortion: Technical and policy guidance for health systems* (2nd ed.). WHO. https://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241548434/en/

World Health Organization. (2021). *Fact sheet: Violence against women*. World Health Organization. Retrieved May 4, 2021 from https://www.who.int/news-room/fact-sheets/detail/violence-against-women

How to cite this article: 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*, *00*, 1–13. https://doi.org/10.1111/jan.15226

The *Journal of Advanced Nursing (JAN)* is an international, peer-reviewed, scientific journal. *JAN* contributes to the advancement of evidence-based nursing, midwifery and health care by disseminating high quality research and scholarship of contemporary relevance and with potential to advance knowledge for practice, education, management or policy. *JAN* publishes research reviews, original research reports and methodological and theoretical papers.

For further information, please visit *JAN* on the Wiley Online Library website: www.wileyonlinelibrary.com/journal/jan

Reasons to publish your work in *JAN*:

- **High-impact forum: the world's most cited nursing journal, with an Impact Factor of 2.561 – ranked 6/123 in the 2019 ISI Journal Citation Reports © (Nursing; Social Science).**
- **Most read nursing journal in the world: over 3 million articles downloaded online per year and accessible in over 10,000 libraries worldwide (including over 6,000 in developing countries with free or low cost access).**
- **Fast and easy online submission:** online submission at http://mc.manuscriptcentral.com/jan.
- **Positive publishing experience:** rapid double-blind peer review with constructive feedback.
- **Rapid online publication in five weeks:** average time from final manuscript arriving in production to online publication.
- **Online Open:** the option to pay to make your article freely and openly accessible to non-subscribers upon publication on Wiley Online Library, as well as the option to deposit the article in your own or your funding agency's preferred archive (e.g. PubMed).