ARTICLE

Ontario Midwives' Attitudes About Abortion and Abortion Provision

Manavi Handa, RM, MHSc, and Simone Rosenberg, RM

ABSTRACT

Objective: In Ontario and across Canada, midwives do not provide pregnancy termination but provide referrals and support for clients. This differs from a number of international jurisdictions where abortion has been added to the midwifery scope of practice, resulting in safe outcomes for women and improved access to services. This study sought to survey Ontario midwives' general attitudes towards abortion and willingness to incorporate abortion into the midwifery scope of practice. Ethics approval for the study was obtained from the Ryerson University Research Ethics Board.

Methods: An Internet-based cross-sectional survey was sent to all registered midwives in Ontario via the Association of Ontario Midwives. The survey consisted of seven sections, with a total of 43 Likert scale questions, 17 general questions, and space for open-ended comments at the end of each section. Comments were coded and analyzed for common themes.

Results: The survey was distributed to 523 midwives, all of the midwives registered in Ontario at the time of the study (2011). A total of 359 midwives participated, representing a response rate of 68% of all registered midwives in Ontario. The majority of respondents identified themselves as pro-choice; however, there were "limits to choice" expressed by many participants. Abortion was considered less acceptable at later gestations or for specific reasons such as gender selection or minor fetal anomalies. Study participants were divided over whether abortion should be added to midwifery scope of practice. Comfort with providing abortion services decreased as procedures were perceived to be more invasive or as requiring more medical expertise. The addition of misoprostol to Ontario midwives' pharmacopoeia for early medical terminations was the most favoured expansion for midwifery scope of practice. Respondents were less willing to add surgical techniques to midwifery scope of practice. Midwives identified the current models of compensation and practice in Ontario, issues related to hospital integration, and opposition from clients as significant barriers to the provision of abortion services. Limited education about abortion during midwifery training and the desire for more learning opportunities were additional themes that emerged in this study.

Conclusion: This is the first study in Canada about midwives' attitudes towards abortion and the inclusion of abortion within midwifery scope of practice. Further research in other Canadian jurisdictions would be useful to examine systemic issues, barriers, and attitudes at a national level. For abortion to be included within the scope of practice of Ontario midwives, issues related to the current model of care, compensation, and supplemental education would need to be addressed.

KEYWORDS

abortion, therapeutic abortion, attitudes, midwifery

This article has been peer reviewed.

ARTICLE

Attitudes des sages-femmes de l'Ontario à l'égard de l'avortement et de la prestation des services d'avortement

Manavi Handa, s.-f. aut., MHSc, et Simone Rosenberg, s.-f. aut.

RÉSUMÉ

Objectif : En Ontario et dans tout le Canada, les sages-femmes ne pratiquent aucune interruption de grossesse, mais elles orientent leurs clientes et leur offrent du soutien en la matière. La situation diffère de celle qui prévaut dans de nombreux territoires de compétence internationaux où l'on a ajouté l'avortement au champ d'exercice des sages-femmes, mesure ayant mené à des interventions sûres pour les femmes et amélioré leur accès aux services. Cette étude visait à déterminer les attitudes générales des sages-femmes de l'Ontario à l'égard de l'avortement, ainsi que leur volonté d'intégrer cette pratique à leur champ d'exercice. L'étude a reçu l'approbation déontologique du comité d'éthique de la recherche de l'Université Ryerson.

Méthodes : Nous avons fait parvenir un questionnaire d'enquête transversale sur Internet à toutes les sages femmes autorisées de l'Ontario, par l'intermédiaire de l'Association of Ontario Midwives. L'enquête comprenait sept sections. Elle comptait 43 questions fondées sur l'échelle de Likert et 17 questions d'ordre général, au total. La fin de chaque section comprenait également un espace réservé aux commentaires, que nous avons codés et analysés en fonction de thèmes communs.

Résultats : Nous avons distribué le questionnaire d'enquête à 523 sages-femmes, soit l'ensemble des sages-femmes autorisées de l'Ontario au moment de l'étude (2011). Au total, 359 sages-femmes ont participé à cette enquête; ce nombre correspond à un taux de réponse de 68 % parmi les sages-femmes autorisées de l'Ontario. La majorité des répondantes se sont déclarées pro-choix. Cependant, de nombreuses participantes ont mentionné certains « aspects limitant le choix ». Ainsi, l'avortement était considéré comme étant moins acceptable aux stades plus avancés de la grossesse ou lorsqu'il était mené pour des motifs spécifiques (comme la sélection du sexe ou des anomalies fœtales mineures). Par ailleurs, l'inclusion de l'avortement au champ d'exercice des sages-femmes divisait les participantes de l'étude. Leur malaise à l'égard de la prestation des services d'avortement augmentait, si elles considéraient cette intervention comme étant plus effractive ou exigeant une plus grande expertise médicale. L'ajout du misoprostol à la pharmacopée des sages-femmes de l'Ontario, en vue des interruptions médicales précoces, constituait l'expansion la plus favorisée en ce qui a trait au champ d'exercice. À l'opposé, les répondantes étaient moins favorables à l'inclusion de certaines techniques chirurgicales. Par ailleurs, des sages femmes ont cité les modèles actuels de rémunération et de pratique en Ontario, les enjeux liés à leur intégration en milieu hospitalier, ainsi que l'opposition des clientes comme des obstacles significatifs à la prestation des services d'avortement. L'acquisition de notions limitées sur l'avortement en cours de formation et le souhait de bénéficier de plus nombreuses possibilités d'apprentissage comptent parmi les autres thèmes ayant émergé de cette étude.

Conclusion : Il s'agit de la première étude menée au Canada sur les attitudes des sages-femmes à l'égard de l'avortement et de son inclusion à leur champ d'exercice. Il serait utile de mener des recherches approfondies dans d'autres territoires de compétence canadiens afin d'examiner les enjeux, les obstacles et les attitudes systémiques à l'échelle nationale. Avant d'inclure l'avortement au champ d'exercice des sages-femmes de l'Ontario, il serait également nécessaire d'aborder les questions liées au modèle actuel de soins, à la rémunération et à la formation complémentaire.

MOTS CLÉS

avortement, avortement thérapeutique, attitudes, pratique sage-femme

Cet article a été soumis à l'examen collégial.

INTRODUCTION

Lack of access to abortion continues to be a major barrier to maternal health and safety worldwide.[1–3] Internationally, abortion access is declining, and this trend is being mirrored in Canada. Despite the decriminalization of abortion in Canada in 1988, a variety of policy and structural barriers continue to limit abortion access and service provision.[4–10] Over the past two decades, the number of doctors providing abortions in Canada has declined by approximately 20%.[11] At the same time, fewer university medical programs are offering abortion education, and fewer medical students are choosing to become providers.[2,8,11–13] The result is a "greying effect": current abortion providers are retiring or leaving practice without there being enough new physician practitioners to replace them and maintain current rates of abortion service, let alone increase access in underserviced areas.[14]

Nationwide, 70% of abortion procedures are performed in hospitals; however, less than 16% of Canadian hospitals provide abortion services.[8,11] The remaining 30% of abortions in Canada are performed at free-standing clinics, and there has been a trend towards an increased number of abortions in this setting over the past several decades.[4,12] Obtaining services at clinics can present additional barriers. Procedures at clinics may be cost prohibitive, and clinics are not available in many communities, resulting in many women having to travel considerable distances to access services. In addition, clinics are more likely to be targeted by anti-abortion activists.[1,4,11,12,14]

Whereas access to abortion services has diminished across all jurisdictions in Canada, rural areas and the Maritime provinces have the greatest barriers to access, due to an overall lack of physicians and hospitals.[4,8,9,11,12] As a result, "today, 25 years after the Supreme Court of Canada struck down the abortion law, abortion services are uneven at best and unattainable at worst in different regions of the country."[12]

Research and advocacy groups suggest that improving abortion access hinges on encouraging more doctors to become providers, as well as adding abortion to the scope of other practitioners, such as midwives.[2,9,11,13,15] Over the last several decades, abortion procedures have become safer, less invasive, and reliant on fewer technical and surgical skills.[16–18] In 2009, the World Health Organization proposed that midwives in all jurisdictions be trained and empowered to perform abortions.[18] Midwives have many of the necessary skills to perform abortion and thus require little supplemental education.[19] In addition, midwives are available in many global regions where doctors are scarce or unwilling to provide abortion services.[2,16,18] Literature has indicated that the expansion of midwives' scope of practice to include first-term medical abortion is appropriate to midwives' skills, significantly increases women's access to abortion, and particularly benefits underserved populations.[3,20]

Manavi Handa, *RM, MHSc, has been a practicing midwife in Toronto for the past 15 years. She is a graduate of the Ryerson University Midwifery Education Program, of which she has been a faculty member for the past five years. Manavi's midwifery practice and research have focused primarily on marginalized communities, particularly newcomers, new immigrants, and women without health insurance. Her scholarly interests include the ethics of midwifery care, normal birth, and collaborative care models to address the social determinants of health. She is a founding practice partner at West End Midwives, serving the diverse communities of northwest Toronto.*

Simone Rosenberg*, RM, completed the Ryerson Midwifery Education Program in 2014, receiving the Graduation Excellence Award. Her student placements have included the Choice in Health Abortion Clinic, Northern Options for Women, and Fort Smith Midwifery Services. She earned her bachelor of fine arts at the Nova Scotia College of Art and Design and currently works at the Midwives' Clinic of East York–Don Mills, in Toronto.*

Research has also shown that midwives achieve good outcomes and low complication rates when appropriately trained to provide abortion services.[19,21–23] Jurisdictions such as South Africa, Ethiopia, and Bangladesh have already included abortion in the scope of midwives and other midlevel service providers as a successful health care strategy to reduce maternal morbidity and mortality and to increase access to abortion.[16,24–29]

In a 2012 publication, the Society of Obstetricians and Gynaecologists of Canada stated that restricting midwives and other "midlevel providers" from providing abortion services poses a potential barrier to abortion access in Canada.[8,12] Canada may be an ideal setting for midwives to provide abortion services. In other jurisdictions, midwives with scopes of practice and skills similar to those in Canada are already extensively involved in providing abortion services. In Britain, Sweden, and France, for example, midwives or nurse-midwives are responsible for administering drugs, attending women during terminations, and counselling, whereas physicians are responsible for determining gestational age and prescribing medications.[30,31] Of interest, the role of physicians is largely nominal and is kept in place to navigate "physician-only" laws that prohibit other providers, such as midwives, from independently providing abortion services. Physician-only laws were originally established to protect women from unsafe practitioners; however, they are considered to be based on dated premises and contribute to barriers to women's access to abortion services.[3,27,30,32] Canada does not have physician-only laws stating that abortion services can be provided only by physicians.[4,9] In addition, midwives in most provinces and territories are autonomous primary health care providers.[33] Therefore, allowing midwives to perform abortions would require changes to midwives' scope of practice but would not require complex legislative changes. The issue of abortion provision by midwives in Canada is timely, as both midwifery's involvement in general reproductive health care and the inclusion of abortion as integral to reproductive health have gained increasing attention in recent years.[34–37] The Association of Ontario Midwives and the Canadian Association of Midwives have both iterated that reproductive health care, including safe abortion, is integral to maternal health and is a fundamental right of women.[36,37] This national trend of including or reaffirming abortion provision as part of midwifery scope of practice is also supported internationally, as evidenced by the International Confederation of Midwives, which in 2009 added abortion provision to its list of core competencies.[38]

When considering the feasibility of abortion provision by midwives in Canada, an important first step is to explore midwives' attitudes towards abortion and their willingness to provide abortion services. To date there have been no Canadian studies examining these issues. In addition, irrespective of issues regarding scope of practice, such research is important because midwives currently

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Simone Rosenberg, *s.-f. aut., a terminé sa formation de sage-femme à l'Université Ryerson en 2014 et est lauréate du prix d'excellence des diplômés. En tant qu'étudiante, elle a occupé des emplois à la clinique d'avortement Choice in Health, à Northern Options for Women et à Fort Smith Midwifery Services. Titulaire d'un baccalauréat en beaux-arts du Nova Scotia College of Art and Design, elle travaille actuellement à la Midwives' Clinic of East York–Don Mills, établie à Toronto.*

provide support and referrals for women seeking termination of pregnancy.[39] Ontario was chosen for this study because it has had legalized midwifery services longer than any other province or territory and has the largest number of practicing midwives in Canada.[40]

SCOPE OF MIDWIFERY PRACTICE IN ONTARIO

In Ontario, the College of Midwives of Ontario regulates the scope of midwifery practice and outlines specific drugs midwives are allowed to use and for what purpose. Unlike midwives in many other provinces, midwives in Ontario are allowed to use specific drugs, rather than classes of drugs, for specific purposes. For example, misoprostol can be prescribed and administered for the specific purpose of treating postpartum hemorrhage.

The majority of respondents (71%) agreed that increased compensation would be necessary to add abortion to midwifery scope of practice.

Similarly, although midwives can use oxytocin for postpartum hemorrhage, only by order of a physician may they use this drug for induction or augmentation. Hospital integration issues continue to be challenging and have resulted in only 50% of Ontario midwives' being able to maintain primary care in cases of oxytocin induction or augmentation, or after epidural analgesia. Regarding compensation models, midwives in Ontario are neither fee-for-service nor salaried employees; rather, Ontario midwives are considered independent contractors who are paid a set amount for each complete course of care (generally antenatal, intrapartum, and postpartum). Under this model, midwives in Ontario are paid only if a client is under midwifery care for a minimum of 12 weeks or if the midwife attends the birth. As a result, there is currently no mechanism for compensating midwives for caring less than 12 weeks for a client who elects to have a therapeutic abortion (i.e., who does not have an intrapartum period). More information on the midwifery scope of practice in Ontario can be found on the websites of the Association of Ontario Midwives and the College of Midwives of Ontario.

STUDY METHODOLOGY

We conducted an Internet-based survey to explore Ontario midwives' general attitudes towards abortion and their attitudes towards the inclusion of abortion services within the midwifery scope of practice. The study was designed as an anonymous and voluntary online survey delivered via SurveyMonkey (Palo Alto, CA) and approved by the Ryerson Research Ethics Board. The survey was distributed to all registered midwives in Ontario through the Association of Ontario Midwives in the summer and fall of 2011. The survey was sent to 532 midwives; 359 participants responded, resulting in a response rate of 68%. Participants had the option to refrain from answering any questions they chose or to discontinue the survey anytime. All surveys that were returned were included in the study's results, regardless of the number of questions answered.

The survey's format, sections, and questions were developed after a literature review of caregivers' attitudes towards abortion and after research on caregiver's attitudes towards a variety of health issues in general.[17,29,41–53] Based on the literature review, questions regarding education and personal experience with abortion were included along with questions about attitudes towards abortion, as previous research indicated that these issues may be important factors in caregiver perception.[46] The six sections in the study respectively explored the following: (1) demographics, (2) attitudes about abortion, (3) attitudes about the inclusion of abortion in midwifery scope of practice, (4) willingness to include different abortion procedures within midwifery scope of practice, (5) concerns about including abortion within midwifery practice, and (6) personal and educational experiences with abortion. In addition to the 43 Likert scale questions, there

Table 1. *All Likert Scale Statements and Responses*

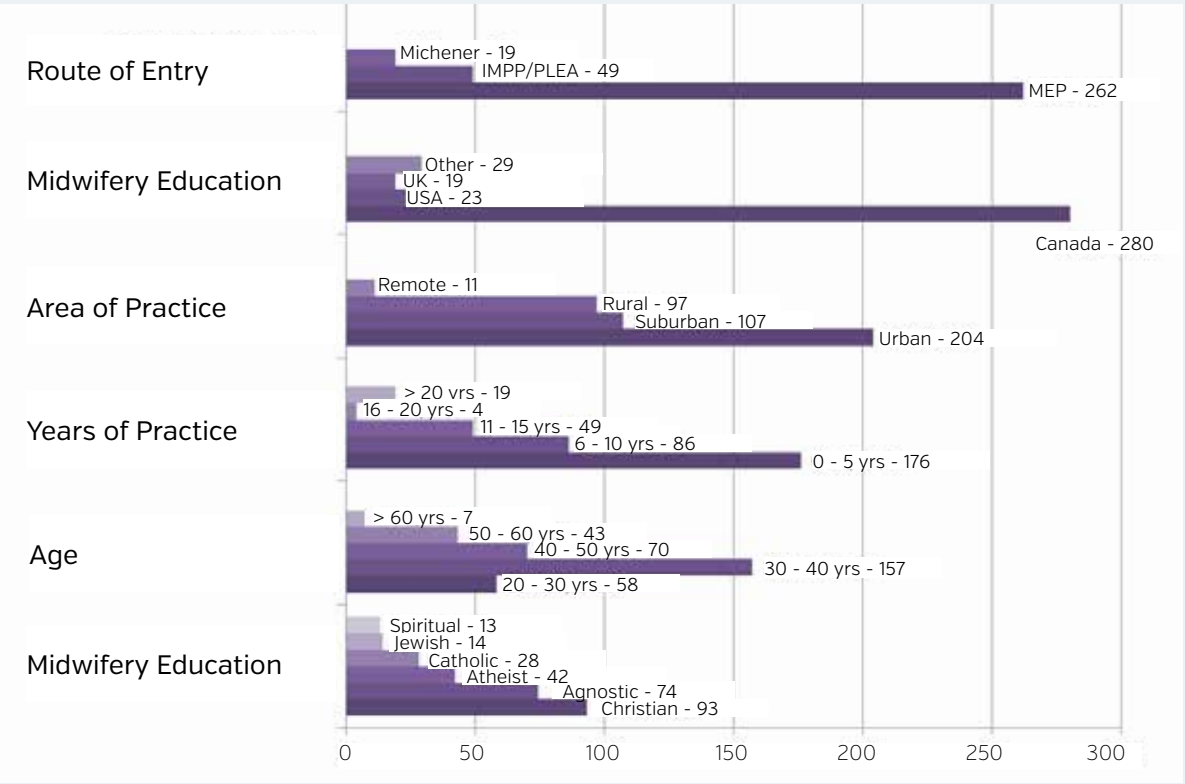
	Responses					
Question/Statement	**Strongly Disagree**	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**	**Total Responses**
Please indicate whether you agree or disagree with the following statements:						
Abortion is acceptable when there are maternal health concerns.	11	7	20	67	221	326
Abortion is acceptable when there are severe fetal anomalies.	18	17	17	65	210	327
Abortion is acceptable under specific social circumstances (e.g., conception as a result of rape).	23	26	6	62	209	326
Abortion is acceptable for any reason a woman chooses.	41	22	27	63	174	327
Abortion is acceptable in the first trimester.	36	13	8	77	193	327
Abortion is acceptable in the second trimester.	38	26	48	97	112	321
Abortion is acceptable only until the age of fetal viability.	70	81	72	66	33	322
Abortion is acceptable at any point in pregnancy.	83	88	78	38	38	325
Women in Ontario have adequate access to abortion.	38	109	100	66	13	326
Women in the community where I provide midwifery services have adequate access to abortion.	32	61	73	134	26	326
Mortality and morbidity related to inadequate abortion/self-abortion is not an issue in Canada.	40	129	111	39	7	326
I consider myself pro-choice.	22	19	10	88	185	324
I consider myself opposed to abortion.	195	72	11	15	31	324
I consider myself neither pro-choice nor opposed to abortion.	154	83	32	13	8	290
I would need increased compensation to add abortion to my scope of practice.	32	20	38	92	131	313
Abortion should be included in the scope of practice of Ontario midwives.	66	36	99	69	49	319
Misoprostol for abortion should be included in the pharmacopoeia of Ontario midwives.	59	26	67	98	68	318
I would be willing to provide first-trimester medical abortion (e.g., via drug administration).	64	25	46	107	76	318
I would be willing to provide MVA abortion.	104	57	71	54	34	320
I would be willing to provide D & C for abortion (with or without consultation).	121	83	61	37	18	320
I would be willing to provide saline induction for abortion (with or without consultation).	135	74	68	28	15	320
I would only be willing to provide abortion services in the case of maternal health concerns.	152	117	28	13	7	317

continued on next page

Table 1. *All Likert Scale Statements and Responses*

continued from	**Responses**					
Question/Statement	**Strongly Disagree**	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**	**Total Responses**
I would only be willing to provide abortion services in the case of maternal or fetal health issues.	153	104	31	24	7	319
I would only be willing to provide abortion services in the case of special circumstances (e.g., conception by rape).	159	110	28	17	5	319
I would be willing to provide abortion services for any reason the woman chooses.	78	36	54	81	70	319
I would not be willing to provide abortion services under any circumstances.	128	71	43	19	54	315
I would not provide abortion services myself, but I would refer a woman to a clinician who would.	45	79	40	81	69	314
I would not provide abortion services myself, and I would not refer a woman to a clinician who does.	206	76	14	9	12	317
I would assist another practitioner during an abortion procedure.	59	31	41	96	91	318
It would be emotionally difficult for me to provide abortion services.	25	59	72	90	72	318
Abortion is part of women's reproductive health care and a natural expansion of midwifery care.	62	44	73	84	56	319
Abortion practice is not consistent with my philosophy of midwifery.	103	88	45	34	47	317
I would provide abortion services if they were needed in my community.	58	24	49	113	73	317
I have religious objections to providing abortion services.	176	75	12	15	38	316
I have moral objections to providing abortion services.	130	86	25	28	49	318
Adding abortion to my scope of practice would increase my medico-legal risk.	14	20	96	110	73	313
Providing abortion services requires skills that are too complex to be included in midwifery scope of practice.	61	80	94	47	33	315
The following would be of concern to me if I provided abortion services:						
Opposition from my clientele	83	83	51	60	34	311
Threats to my personal safety	64	99	43	62	43	311
Safety of those around me (family, friends, etc.)	79	84	51	51	44	309
Disapproval from my friends/family/community	146	57	22	47	39	311
Disapproval from my midwifery colleagues	173	54	43	29	12	311
Disapproval from my interprofessional colleagues	169	56	47	25	13	310

Table 2. *Demographics*



IMPP, International Midwifery Pre-registration Program; MEP, Midwifery Education Program; PLEA, Prior Learning and Experience Assessment process

were seven demographic questions, three questions about personal or professional experiences with abortion, and seven questions about education (Table 1). There was space for open-ended comments at the end of each section. These comments were coded and analyzed for major themes related to each section of the survey.

STUDY RESULTS

Demographics

Most respondents were between 30 and 40 years of age, have children, and were trained as midwives in Canada. More than half of respondents indicated having worked in Ontario for five years or less, and the majority had practiced for fewer than 10 years. It was assumed that all respondents were female, as there were no registered male midwives in Ontario at the time of the survey. However, it should be noted that "gender" identification was not one of the demographic question asked of participants; thus, this study does not account for potential differences or similarities among midwives who may identify themselves as transgendered, gender fluid, or nongendered. The most common religious categories were Christian, agnostic, and atheist, although the question on religion was skipped by more participants than was any other question in the survey (299 responses in total). Most respondents worked in urban and suburban practices; only 3.5% worked in remote settings. The demographics of the respondents generally reflect the demographics of midwives in Ontario.[54] Responses to demographic questions are displayed in Table 2.

Attitudes Towards Abortion

As shown in Table 3, 84% of midwife respondents identified themselves as pro-choice, 13% were opposed to abortion, and 3% were undecided. When presented with the statement "abortion is acceptable for any reason a woman chooses," the

Table 3. *Attitudes Towards Abortion*

Statement	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
I consider myself pro-choice	7%	6%	3%	27%	57%
I consider myself opposed to abortion	60%	22%	3%	5%	10%
I consider myself neither pro-choice nor opposed to abortion	53%	29%	11%	4%	3%
Abortion should be included in the scope of practice of Ontario midwives	21%	11%	31%	22%	15%
Abortion is part of women's reproductive health care and a natural expansion for midwifery care	19%	14%	23%	26%	18%
Abortion practice is not consistent with my philosophy of midwifery	32%	28%	14%	11%	15%
Abortion is acceptable when there are maternal health concerns	3%	2%	6%	21%	68%
Abortion is acceptable when there are severe fetal anomalies	6%	5%	5%	20%	64%
Abortion is acceptable under specific social circumstances (e.g. conception as a result of incest or rape)	7%	8%	2%	19%	64%
Abortion is acceptable for any reason a woman chooses	13%	7%	8%	19%	53%
Abortion is acceptable in the first trimester	11%	4%	2%	24%	59%
Abortion is acceptable in the second trimester	12%	8%	15%	30%	35%
Abortion is acceptable only until the age of viability	22%	25%	22%	20%	10%
Abortion is acceptable at any point in pregnancy	26%	27%	24%	12%	12%

number decreased to 72%, indicating some nuances within the pro-choice perspective. Participants' responses indicated that there were some "limits to choice." For example, the reason for termination affected the acceptability of the procedure. Maternal health concerns were the most acceptable reasons for termination, followed closely by severe fetal anomalies or social circumstances (such as conception from nonconsensual sex). Midwives indicated that termination was less acceptable the more advanced the gestational age; 83% agreed that termination was acceptable in the first trimester, 65% felt it was acceptable in the second trimester, and 23% felt it was acceptable at any point in pregnancy. The concept of limits to choice was a theme that also emerged from the qualitative analysis of comments such as "I am pro-choice but find second-trimester abortion acceptable within a more limited range of circumstances and not for any reason a woman chooses" and "Abortion is absolutely not acceptable when there is desire for particular gender."

Abortion and the Midwifery Scope of Practice

Respondents were evenly divided over whether abortion should be included in the scope of practice of Ontario midwives. The majority agreed that abortion was consistent with their philosophy of midwifery care, but far fewer felt that abortion was a natural expansion of midwifery practice.

Three themes emerged from comments about abortion and the midwifery scope of practice:

1. Support for providing abortion services as a natural extension of midwifery's commitment to women's choice and reproductive care.
2. Support for choice but disagreement that abortion provision is a "natural" extension of midwifery care.

Table 4. *Examples of Comments Agreeing and Disagreeing about Abortion and Midwifery*

Support for Abortion As Part of Midwifery and for Its Consistency with Definition of Midwifery	Agreement That Abortion Falls within Definition of Reproductive Health but Disagreement That It Is a Natural Extension of Midwifery	Disagreement That Abortion Should Be Part of Midwifery or That It Falls within Definition of Midwifery
"I think midwives should be able to offer women well-women care, including forms of contraception, abortion."	*"'Abortion practice' and a woman's choice of whether to abort or not are two different issues."*	*"Midwifery is a health care profession in which providers offer care to child-bearing women during pregnancy, labour, and birth, and during the postpartum period. In the midwifery history, there is nothing to do with abortion… keep it simple and happy."*
"With adequate training and regulatory changes, this is an obvious extension of midwifery scope."	*"I do believe that abortion is part of women's reproductive health care, but I don't think that necessarily means abortion is a natural expansion of [midwifery]-any more than I would believe that providing fertility treatments or in vitro would be an extension of midwifery because it relates to reproductive health. But also, just because I don't believe it to be a natural expansion, that doesn't mean I would refuse to do it. I would do it, but not because it's some kind of natural extension of midwifery."*	*"Midwifery should remain under the definition of 'midwifery,' which is normal child-bearing."*
"This is a skill and a service I have always wanted to learn and be able to provide to women".		*"I think abortion is way beyond what midwifery is all about. I see us as practitioners who are assisting mothers, families, to bring new life into the world. We do prenatal care in order to have a healthy mother and baby at term. I find it hard to think of us as choosing to turn around and assist in killing babies. Other practitioners can do that, if they wish to take it on."*
		"Abortion does not fall under the scope of low risk/healthy/normal."

3. Opposition to the inclusion of abortion within midwifery as well as disagreement that abortion falls within the definition of midwifery.

Table 4 gives examples of comments about each of these themes. In addition, the section on attitudes towards abortion and midwifery care indicated that some midwives were personally opposed to abortion but still believed in choice and access for clients, as shown by the following two responses:

> *Although I hold strong beliefs about abortion, I do not judge anyone who chooses this option.*

> *I disagree with abortion as an act because I believe that a life is being taken, and I do not think or feel that is an ideal choice. That being said, we do not live in an ideal world, and therefore, as much as I dislike the option of abortion, I support it as a choice and think women should have safe access to it because of all of the complex and sometimes awful situations that women live in, in our society and in other societies. Women need to make their own choices about their personal situations and what they can or can't handle.*

Willingness to Provide Abortion Services

Table 5 illustrates the results of 14 questions asked about midwives' willingness to provide abortion services. When midwives were asked if they agreed or disagreed with performing a termination

Table 5. *General Willingness to Provide Abortion Services*

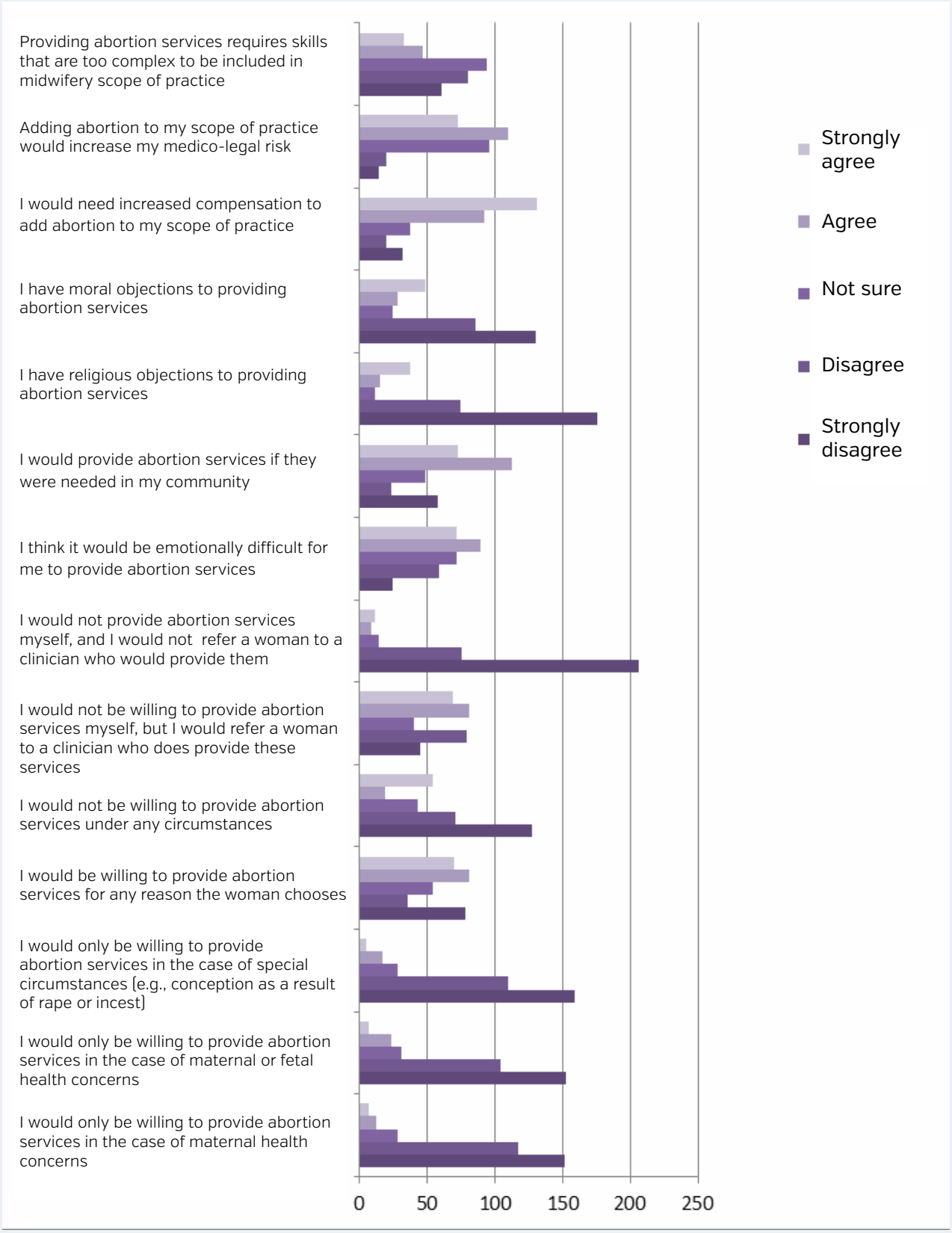
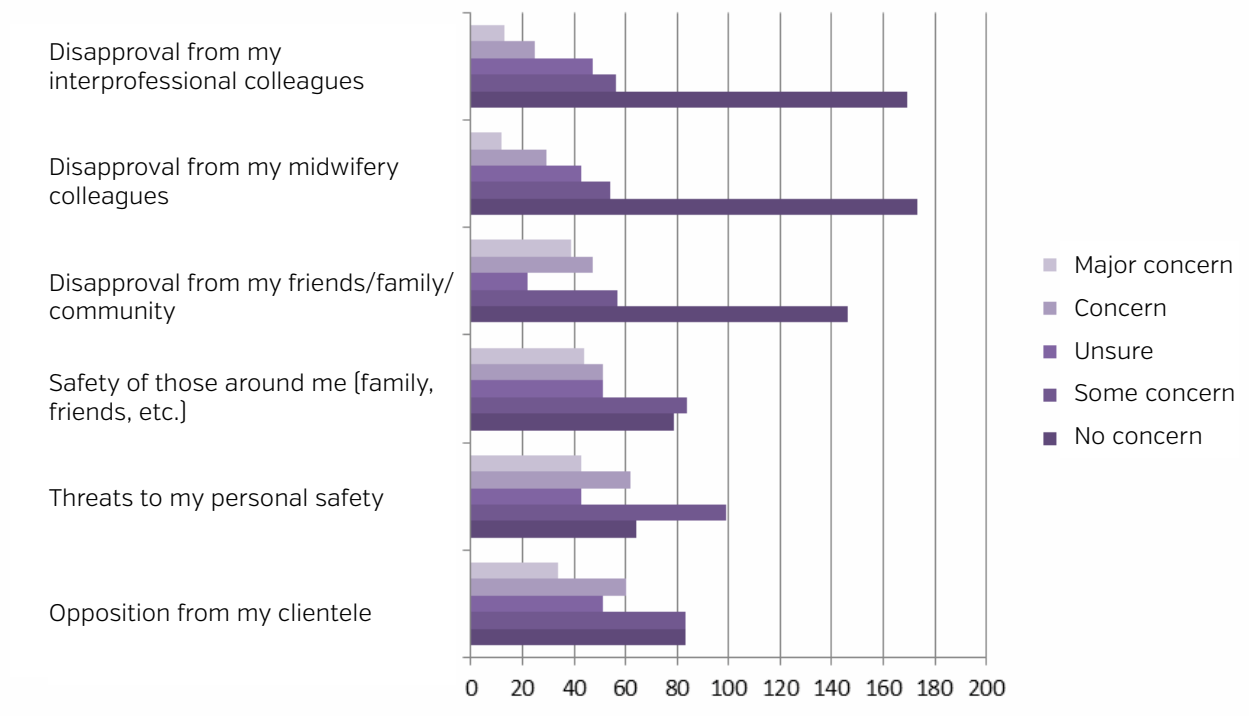


Table 6. *Issues of Concern to Midwives Providing Abortion ServicesScope of Practice*



for any reason a woman chooses, 47% agreed and 35% disagreed. Similar to general attitudes about the acceptability of abortion, midwives' willingness to provide abortion was influenced by gestational age and the reasons for abortion, as shown by the following two responses:

> *I would be willing to provide abortion services for any reason the woman chooses, up to a certain point in the pregnancy. After that point, I would only be willing to provide these services if there were a fetal or maternal health concern [i.e., I would not be willing to provide abortion services for a healthy woman and fetus at 30 weeks of pregnancy].*

> *My response to late-pregnancy abortion was more ambiguous, and this has to do with some tension I feel about abortion during late pregnancy over "minor fetal imperfections." Where a fetus is likely to die before birth or shortly after, I do not feel this tension.*

Seventeen percent of midwives indicated they would not provide abortion under any circumstances; 79% of midwives indicated they had no religious objection to providing abortion services [whereas ethical objections were of slightly more concern]; 6% indicated that they would be unwilling to provide an abortion under any circumstances and would also be unwilling to refer a client to a clinician who would; and 58% felt that adding abortion to the scope of practice would increase medico-legal risk, although several stated that this would not necessarily deter them from providing abortion services.

Several themes emerged from the qualitative analysis of comments related to this section. The first qualitative theme was concern from midwives about being "forced" to provide abortion services.

> *Fine to be part of midwifery scope of practice, but would not provide abortion services or want to be forced to provide abortion services.*

An additional theme that emerged was related to the current model of practice and issues of

compensation. The majority of respondents (71%) agreed that increased compensation would be necessary to add abortion to midwifery scope of practice. However, midwives who were unwilling to provide abortion services indicated that compensation was not a relevant factor and would not affect their decision. For example, one such midwife responded with "Compensation is a nonfactor in my resolve to never provide these services as a midwife or otherwise," and another said, "Increased compensation? Can't answer, as I wouldn't be doing it."

Many respondents who were concerned about compensation indicated that the issue was not simply monetary compensation but larger changes to the current midwifery billing structure and practice model in Ontario.

> *Under current billing structure, midwives would not be compensated for these services; clients are not generally in care at the early stage, when most of the options listed would be viable. Midwifery provision of these services would be more tenable if midwives worked under a more comprehensive, well-woman model and were compensated accordingly.*

An additional theme was related to scope of practice and issues of integration as obstacles to adding the provision of abortion to midwifery practice, as shown by the following responses:

> *I wonder why we are talking about expanding to this. We don't have "full scope"–ability to manage women with epidurals/oxytocin inductions/augments.... there is so much we are unable to do within our scope and so many women who want midwives...why would we even think of pursuing adding abortion provider to our practice?...Now we are proposing competing with surgeons for OR time to provide D & C [dilatation and curettage] and MVA [manual vacuum aspiration]...Do we not already have enough opposition within the maternal health field?...I want to work in a supportive hospital with an OB who respects my training and nurses who will follow written orders...and trying to say midwives should do abortions is definitely going to threaten them even more!*

> *Ontario midwives are already struggling to practice the skills they currently possess and to meet the needs of their current clientele, and adding abortion services would increase the burden of care.*

Issues of Concern

In terms of perceived challenges or barriers to providing abortion care, most issues mentioned in the study were generally viewed as being of "some level of concern" (Table 6). No specific issue was perceived as a "major concern" by more than 14% of respondents. Sixty-four percent of respondents considered threats to personal safety to be of some concern, and 57% had some concern for the safety of their families and communities. More than half of midwife participants felt that opposition from their clientele was an issue that would affect their decision to provide abortion.

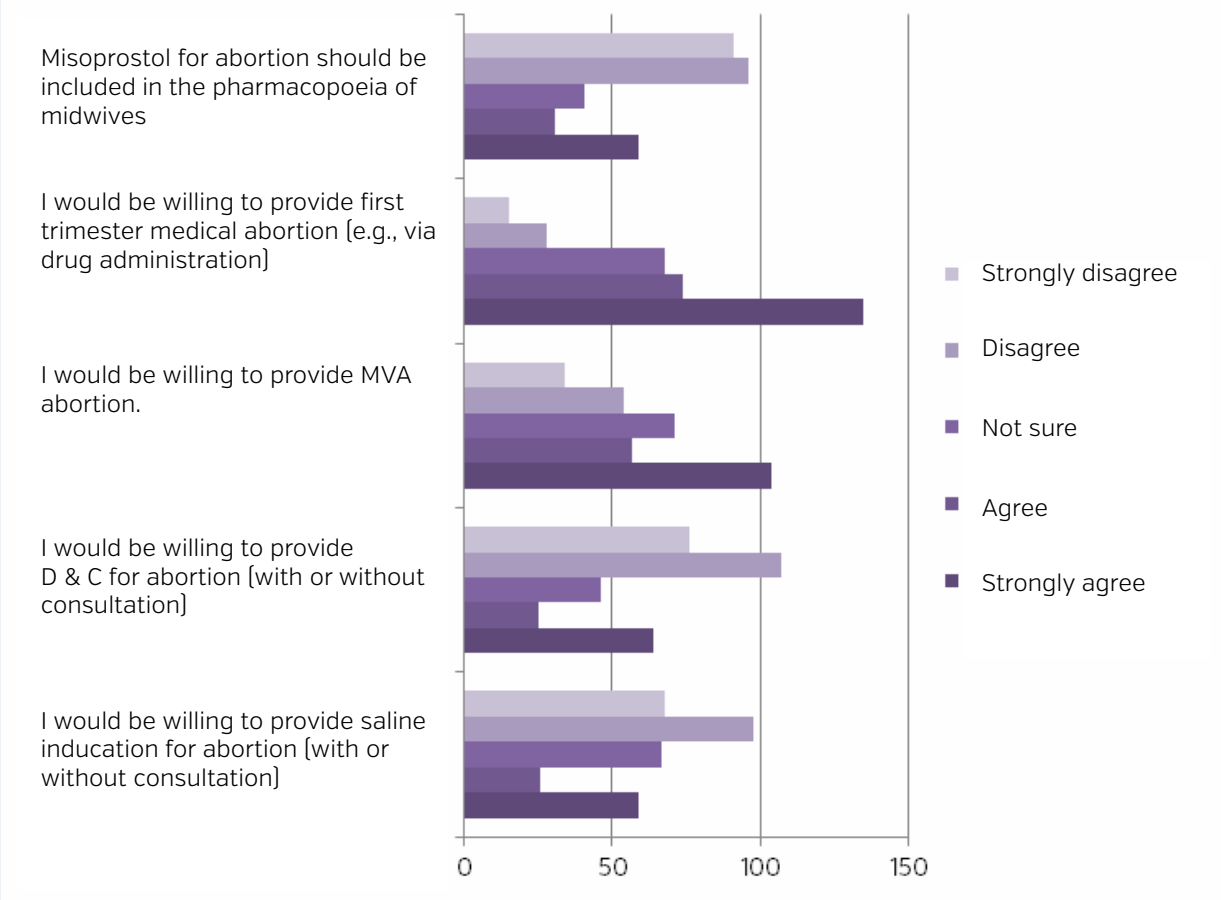
> *While I am aware that I would lose some of my clientele if I were to provide abortion services, this would not be a hindrance to my willingness to provide these services.*

> *The majority of my clientele are from religious groups that are opposed to abortion. It would significantly affect my ability to work in this community if I provided abortion services. If I worked in a different location in Ontario, my feelings towards this would be very different.*

Disapproval from friends, family, community, and midwifery and interprofessional colleagues was ranked as of no or low concern by most respondents. However, a recurrent theme that emerged from comments was midwives' concern for their clients' safety and comfort. Several respondents felt their midwifery clinic would not be an appropriate place to provide abortion services.

> *If I were to provide abortion services*

Table 7. *Willingness to Provide Specific Abortion Procedures*



they would absolutely have to take place somewhere other than my primary midwifery clinic. First of all, I'm not going to ask someone who is terminating a pregnancy to come and sit with women who have big, round bellies or are bouncing happy babies on their laps! Insensitive. Secondly, I would advertise that part of my scope separately from my birthing services as I do think it would put off a considerable section of my clients.

Because of the polarization and organized opposition to abortion, I feel the good work I do providing pregnancy and birth care to women would be overshadowed and harmed if I were to offer abortions. There is no way to offer abortions secretly. It would become known, and it would be picketed. The safest place I know for women to have abortions in … hospital. Because people are not allowed to picket on hospital grounds and the clinic that women go to for an abortion is not segregated–no one knows which people are having an abortion. A midwifery clinic does not offer this kind of protection.

Willingness to Provide Specific Abortion Procedures

Table 7 shows the results of this section of the survey. A desire to have misoprostol added to the midwifery pharmacopoeia was expressed by 52% of participants, and 57% indicated they would

be willing to provide first-trimester abortion. The 5% difference may be attributed to a difference in the number of respondents who want access to misoprostol for incomplete miscarriage but not for termination. Although this survey did not include questions about the use of misoprostol for reasons other than termination, the issue emerged as a theme in the following comments:

> *I would like to be able to use misoprostol for missed abortion/miscarriage but not to induce an abortion.*

> *I would be willing to provide medical abortion for women who have a missed abortion only; for this reason, I agree that misoprostol should be included in the midwifery pharmacopoeia.*

Several midwives felt the that the administration of misoprostol was within their skill set and did not perceive it as requiring increased skill or being a high-intervention procedure when used for early abortion.

> *It would be great to help women with missed abortions with misoprostol, and I could see that expanding to abortion as well. I would not feel comfortable doing surgical procedures.*

> *Beyond first-trimester abortion via misoprostol, surgical skill and knowledge are required. I see this as the role of an OB/GYN [obstetrician-gynaecologist], not a midwife, as to perform these procedures safely would require an extreme expansion of knowledge and skill set.*

Midwives' willingness to provide termination decreased as the skills involved in the procedure became more complex or were perceived to be more complex. However, some respondents indicated a willingness to provide surgical procedures if they had additional training.

> *I disagree that providing abortion services requires skills that are too complex for first-trimester abortions. I am less sure about second-trimester abortions, but I would be willing to undergo additional training if necessary.*

> *While I would in theory be willing to provide MVA, D & C, and saline inductions, I would need significant training in order to feel confident that I was able to do these things safely.*

It is also significant that nearly 60% of the midwives were willing to provide abortion services if these services were needed in their community. That is slightly more than were willing to provide medical abortion and significantly more than were willing to perform the other procedures, which indicates midwife participants' consideration for client and community needs.

> *I like the concept of allowing midwives to expand their scope as needed to serve their community. I support having the option to gain special skills as desired/needed through our legislation and regulatory body….I do feel it may be a very valuable addition for some midwives in some communities.*

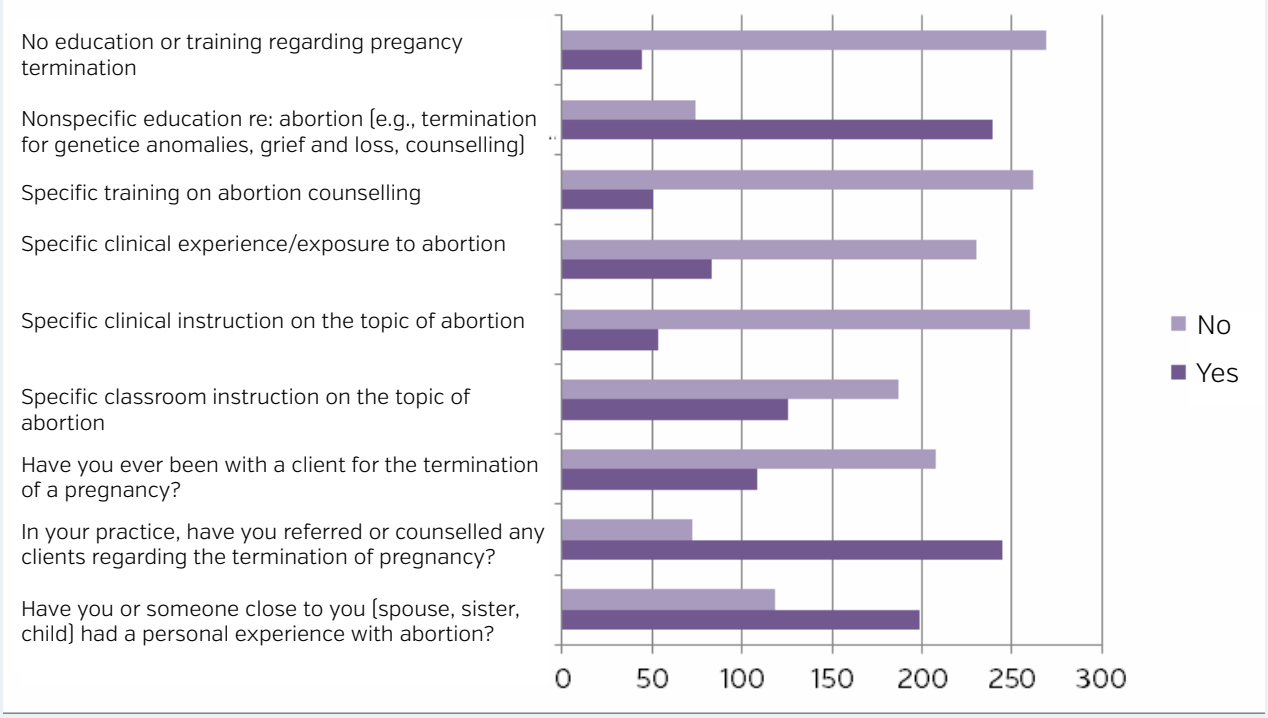
> *I feel particularly strongly that midwives be able to provide abortion services in rural and remote areas or any situation in which women do not presently have access to safe and timely abortion.*

Personal, Professional, and Educational Experience with Abortion

Table 8 outlines questions and answers about general knowledge and education about abortion. Participating midwives indicated that they were more knowledgeable about abortion access within their own communities than at the broader provincial or federal level. Half of respondents felt that women have adequate access to abortion in the communities in which they work. Half felt that maternal morbidity and mortality from inadequate abortion or self-abortion are issues of concern in Canada.

The majority (77%) of respondents had given referrals to clients or had counselled clients

Table 8. *Knowledge and Education about Abortion*



regarding termination of pregnancy. A third (34%) of respondents had attended a client's termination of pregnancy, and 63% indicated having had a personal experience of abortion, either first-hand or through someone close to them such as a spouse, sister, or child.

Eighty-five percent of respondents were educated in a Canadian midwifery education program (MEP). Although some respondents had international education experience, responses about education in abortion generally reflected experiences in a Canadian MEP. Of respondents, 76% indicated having had in-class education in termination for genetic anomalies and in abortion-related counselling, 40% had received lecture-based instruction in abortion techniques, 25% had been exposed to abortion in clinical settings, and 14% indicated that they had received no education or training related to termination of pregnancy.

Although their scope of practice does not currently include the provision of abortion, midwives in Ontario currently provide secondary abortion care in the form of counselling, referrals, and attending terminations with clients. A major theme that emerged from comments was the desire for more education in abortion. Three of the comments were, "I felt my education was incomplete around pregnancy termination," "MEP would certainly benefit from more pointed training on the subject of abortion counselling," and "I wish I had more specific clinical instruction on abortion and genetic terminations and also on abortion counselling to help me in my practice when it comes up."

Respondents also stated that their exposure to and knowledge about abortion was obtained not in an MEP classroom but through clinical placements or through educational experiences outside of Canada.

> *I received training and experience with this only through a clinical placement with an OB and not within MEP.*
>
> *It was part of my training in Europe.*
>
> *My midwifery education in Canada did not include any of the above. However, my previous education and training in another country included education and training*

regarding termination of pregnancy and extensive clinical training and exposure. I used to perform terminations of pregnancies [misoprostol, vacuum aspiration, D & C] under supervision.

Some respondents suggested that abortion training could be added to the midwifery scope of practice as an advanced practice skill that midwives could opt to acquire.

I would support a postgraduate course for experienced midwives who choose to do it. I would consider acquiring this skill myself if needed in the community where I work. I do not support anything other than medical abortion in the basic BHSc midwifery.

The majority of Ontario midwives are pro-choice but are evenly divided on whether abortion should be added to the scope of practice of midwifery in Ontario.

DISCUSSION AND SUMMARY OF FINDINGS

The vast majority of Ontario midwife respondents identified themselves as pro-choice. However, midwives were evenly divided as to whether or not abortion should be added to the scope of practice. In general, midwives who were willing to provide abortions were willing to do so regardless of the client's reason for termination, and those who were unwilling to offer abortion services were unwilling to do so regardless of the reasons, compensation, or scope-of-practice issues. Among midwives who were willing to provide services, there were some "limits to choice" - circumstances that were concerning or that would potentially make them unwilling to provide abortions. These circumstances included abortion for gender selection or minor fetal anomalies. The willingness to provide abortion services also decreased as a pregnancy advanced and with the complexity of the procedure.

The level of skill required to perform abortions was of concern to many midwives, and most respondents felt they would need increased compensation to provide abortion services. Beyond these issues, respondents felt that incorporating abortion into the current care model in Ontario would pose challenging issues, including current challenges to hospital integration, the inability to secure full scope [management of oxytocin and epidural] in some settings, and midwifery already being a demanding profession. Practical issues, such as where the service would be provided, were also raised, the primary concern being clients' emotional and physical safety. It appears that many midwives would prefer to provide abortions in a space separate from their usual clinic; this would allow them to provide these services away from clients who are planning to continue with pregnancy. Services could be offered either in a different building or on different clinic days. Some respondents felt that providing abortion services in hospital settings rather than at midwifery clinics would potentially protect clients from anti-abortion activists and provide increased anonymity both for clients and for midwives.

The majority of respondents considered neither public or professional judgements nor fear for the safety of themselves or their families to be major obstacles to providing abortion care. However, midwives felt that their clients' opposition to abortion would possibly deter them from providing abortion services, and they were concerned that providing abortions would alienate them from these clients.

Most midwives indicated a willingness to have misoprostol added to the midwifery pharmacopoeia in order to provide first-trimester abortion - although again, there were concerns about compensation and about the current scope of practice were midwives to provide this service. In Ontario, a midwife is currently not compensated unless a woman has been in care for at least 12 weeks or the midwife attends the birth. As a result, if first-trimester abortions were added to the midwifery scope of practice, no current mechanism would provide that midwives be paid for these services.

continued on page 32 ....

art feature

Elaine Carty, MSN, CNM, DSc(hc)

Birth Trays *(Desco da Parto)*

Pregnancy and birth are almost always valued, celebrated and desired in a society. In Canada today where birth outcomes are among the best in the world, a birth is often commemorated with a baby quilt, a needlework piece, a hand-made toy, or a belly cast.

Times were quite different for birthing women during the Renaissance (14th-17th C). Because of continued outbreaks of plague and the catastrophic impact on the populations of many European countries there was an extraordinary emphasis on the importance of procreation. Women and children were dying from plague at the same time that many were dying during the process of childbirth. It is estimated that as many as 10% of women would die in childbirth with an even higher rate for infants.

It is not surprising then that numerous objects were used to encourage, honour and celebrate childbirth. One birth object that has survived and which can be observed in many museums around the world is the wooden painted birth tray (desco da parto) from Italy.

Figure 1
The Triumph of Fame; (reverse) Impresa of the Medici Family and Arms of the Medici and Tornabuoni Families

Giovanni di ser Giovanni Guidi (called Scheggia) (Italian, San Giovanni Valdarno 1406–1486 Florence)
ca. 1449
Tempera, silver, and gold on wood

Figure 2
Desco da parto [birth tray]: Birthing Chamber Scene (obverse view)

Bartolomeo di Fruosino, painter
Isola Bella, Borromeo Collection,
Northern Italy

Wealthy families usually commissioned the birth trays; they were often lavishly painted on both sides of the tray, often with a confinement scene on one side and other literary or mythological themes, family coats of arms, or board games on the other side. The tray was usually round or multi sided and measured around 20 to 24 inches. To promote a healthy birth and even to influence the sex of the baby, an expectant mother was encouraged to reflect on the narrative of her desco. Immediately following the birth, the tray was laden with nourishing food, and presented to the mother for her swift recovery. (See Figure 4.) It had both a spiritual and practical function. Trays are visible in many Renaissance birth paintings of the Birth of Mary, the Birth of Saint John the Baptist, and the Nativity.

There are three birth trays on display in the Metropolitan Museum of Art in New York. The most famous is one from the Medeci Family in Florence.

"The Triumph of Fame" (Figure 1) is described as follows:

> *This commemorative birth tray (desco da parto) celebrates the birth of Lorenzo de' Medici (1449–1492), the most celebrated ruler of his day as well as an important poet and a major patron of the arts. Knights extend their hands in allegiance to an allegorical figure of Fame, who holds a sword and winged cupid (symbolizing celebrity through arms and love). Winged trumpets sound Fame's triumph. Captives are bound to the elaborate support. The three-colored ostrich feathers around the rim are a heraldic device of Lorenzo's father, Piero de' Medici. Painted by the younger brother of Masaccio, it was kept in Lorenzo's private quarters in the Medici palace in Florence.*

The reverse illustration is described:

> *The armorial device is that of Lorenzo de' Medici's father, Piero de' Medici: a diamond ring with three ostrich feathers and a banderole with the motto SEMPER (forever). The device is much worn and the silver is oxidized. Piero de' Medici married Lucrezia Tornabuoni in 1444 and their first*

Figure 3
Desco da parto

Bartolomeo di Fruosino, 1428
New York Historical Society
Tempera on wood panel

> *son, Lorenzo, was born in 1449; the two families' coats of arms are in the upper left and right. The tradition of commissioning circular trays or salvers to commemorate a birth derived from the custom of presenting sweetmeats to the new mother.*[1]

The tray shown in Figure 2 was used to carry refreshments into a birthing chamber during the new mother's month of confinement following birth. Here the mother sits upright in bed. In the upper section of the scene plants can be seen on the roof. At the bottom of the picture three steps lead to a meadow in which stand a stork and a hoopoe (birds that were believed to care for their aged parents and which therefore were models of filial devotion). A serving maid pours water into a basin so that the mother can wash her hands. A midwife sits with the newborn on her lap while another prepares the baby's bath. Three female visitors stand at the foot of the bed.[2]

Figure 3 depicts:

> *The birth scene on the recto of this tray is a faithful copy of a drawing by Lorenzo Monaco representing the birth and naming of St John the Baptist.*[3]

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2. https://inpress.lib.uiowa.edu/feminae/DetailsPage.aspx?Feminae_ID=28816
3. Web Gallery of Art

Figure 4
Birth of John the Baptist (Partial) showing woman carrying the birth tray with food

Domenico Ghirlandaio
1485-1490
Santa Maria Novella, Florence
Fresco

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ABOUT THE AUTHOR

Elaine Carty is Professor Emerita and founding director of the Midwifery Education Program at the University of British Columbia. Her career spans multiple disciplines as a practicing nurse, midwife, administrator, and educator. Her research has focused on women's health, attitudes about childbearing, and the humanities (art, poetry and literature) in health education and practice. She developed a groundbreaking course—"Birth and its Meanings"—exploring the artistic expression of birth in art.

Elaine has received numerous awards for her work, including the Distinguished Alumnae Award from the Yale University School of Nursing, and the Award of Excellence in Nursing from the Registered Nurses Association of British Columbia. She is an honorary life member of the Midwives Association of British Columbia and holds the first honourary registration with the College of Midwives of British Columbia. She was conferred an honorary doctorate at McMaster University in 2013 for outstanding achievement in the pure and applied sciences.

Elaine is a regular contributor to the *Canadian Journal of Midwifery Research and Practice,* including the feature on Alice Neel (1900-1984) in the Fall 2015 issue and and Fertility in Summer 2015 issue (the Journal erroneously omitted her name on those articles).

poetry feature

Chris Sternberg, RM

Claire Harris

Claire Harris was born in Trinidad, the West Indies, in 1937. She was educated in Dublin and Jamaica, and moved to Canada in 1966 where she taught high school English. During a year of study abroad in Nigeria, she was encouraged to write seriously by the poet JP Clark and subsequently published her first book of poems, *Fables from the Women's Quarters*, in 1984, which received the Commonwealth Poetry Prize. She has published a total of eight books of poetry and her work has been included in more than 70 anthologies. She has been active in the literary community in Calgary through her work at literary magazines and for other poetry initiatives. Her book, *Drawing Down a Daughter*, from which the accompanying poem was taken, was a finalist for the Governor General's Award for English-language poetry in 1993.

Like the journal a woman might keep during pregnancy, "Drawing Down a Daughter" addresses universal experiences such as feeling the movements of the baby, the awkwardness of the woman's growing body and her concerns about a change of role and loss of independence. But, though a journal is spontaneously put on paper, this is a carefully crafted work. In the following excerpt, the woman is struck by the miracle of life within her body:

...then hastens to her notebooks
hand on a belly that flutters
pierced by tenderness she is
for a moment holy

Harris uses a variety of poetic and narrative forms, including real-time events, dreams, recollections of childhood, storytelling, dialogue, and even a recipe to explore this particular woman's experience. In another excerpt, the words appear to swim across the page:

O my darling daughter
my little fish swim
fiercely into life
Its monotony
Its dailiness & i
shall armour you
In love
and it will be almost enough

Her unique context—she is a poet, woman of colour and an immigrant to Canada—leads to personal and political concerns about racism, present-day famine and the legacy of slavery. Her experience includes a rich cultural heritage and language, and the contrasting landscapes of the lush tropics and the frigid Albertan winter. She grapples with the decision of whether to return to her native Trinidad to bring up her daughter, where they would enjoy the warmth of the people, the support of family, and a society where they are not defined by race. She feels pressured by her Canadian-born husband to return, although she feels Canada may offer more opportunity to herself as a writer, and therefore, potentially to their daughter. Reprinted here is most of the poem which ends the book. Written as she begins labour contractions, the narrator addresses again her contradictory feelings of loss of autonomy versus connection to both her partner and the coming baby. Sharing song and laughter with her partner and drawn into the beauty of the new day, she seems to embrace the transformation just beginning.

Poem from *Drawing Down a Daughter*

by Claire Harris [Goose Lane Editions, 1992]

She wakes to find him watching her ‘okay?’
she nods he means well but how okay can
you be carrying thirty pounds about the middle
thirty kicking pounds Girl you might as
well face it they don’t let us play football
he hands her the cup of tea ‘my woman!
finished your blues yet?’
she struggles up in bed the child low heavy
she is thinking of all his ‘my’
as if he had somehow acquired her for all time
as if theirs was not a contract of gift
renewable from moment to moment
she still herself’s
on loan to her daughter to him
as they were on loan to her

in the judo robe his dark chocolate chest
Afro-smooth delicious
Girl his body my brain

she decides to sing for him
Daughter we’re in this together
might as well go laughing

besides Sunday’s child is full of grace
a blues riff haunting defiant rises in her

oooooooooooobabeeeeeeeeeeeeaaaaaaababeeee
.....

he is laughing and clapping they are both roaring
as if she weren’t pregnant
as if ole pain wasn’t caved in her gut
crouched to spring
it rips through her so suddenly
shaking her

flinging her
breathless
against cliffs
he is saying don't fight it
go with it
breathe come on girl breathe

she lies limp
he phones the doctor calls the hospital

she goes out to the glass wall looks out over Calgary
finds her line seizes the morning

in the continuous comeliness of Earth dawn sun
knifes the river light brilliant and dire
dribbles into gouts and pools but the water
seems not to move
daughter there are sundrifts now as in a dream
your face drifts too just out of sight
though we are roped to each other
I picture your hair spring black brushing my chin
delicate as spiders
It incites me
as if already you bend over me knowing a husk when you see one I imagine your hands
easily your father's perfect half-moon nails
grasp the air casually taking your own self back
as if all my striving to order existence with your birth
were less even than this view: grey pink clouds/trees/
river/thin frill of ice/she drowned city
small of all I hold for you
the sun gathers wings draws back his blade
morning bleeds into the river
inside you thrash out i hug my belly in the helpless dawn
For a moment i am
as the stunned slave under the whip

While not explicitly asked about the use of misoprostol for missed abortions or for inducing labour in cases of fetal demise, several midwives stated they would be willing to have the drug added to the midwifery pharmacopoeia for these purposes only and not for the provision of abortions.

As stated earlier, midwives were generally reluctant to provide abortion in later pregnancy; many indicated that they felt the skills involved were too complex. Much of the global literature on the provision of abortion services by midwives refers to their providing first-trimester abortion through the use of medical agents.[3,16,30,31,55,56] Therefore, it is possible that midwives in Ontario and elsewhere in Canada could include abortion within the midwifery scope of practice by simply providing medical abortions.

The current literature indicates that midwives and other midlevel care providers can safely be involved in the provision of abortion procedures.[20,21,23,28,29,46,55,57–61] Yarnall succinctly points out that "most components of medical and surgical abortion are common… including verification of pregnancy, counselling, management of complications, and referral to higher levels of care where necessary."[17] Midlevel providers, particularly midwives, are trained in all these skills already. Furthermore, medical abortion requires no surgical skills and is not restricted to a sterile environment.[16] Expanding to midwives would mean that medical abortion could be provided in home or clinic settings, both being environments where Canadian midwives already practice.

The Canadian Association of Midwives has stated that midwifery is fundamental to women's health care in Canada and that access to safe abortion services is vital to reproductive health.

This study showed that more midwives were willing to provide D & C than to perform MVA, despite the fact that MVA is considered a safer and less invasive procedure that arguably requires less skill. In addition, more midwives were uncertain about the provision of MVA versus D & C. The reasons for these responses may be related to the lack of familiarity with MVA. Midwives are more likely to have been exposed to or to have witnessed D & C, as it is commonly employed for retained products of conception, missed abortion, and removal of a retained placenta. These responses may also stem from the lack of education about–and lack of exposure to–abortion, as many midwives indicated. In terms of clinical and educational experience, many respondents had encountered abortion in their clinical practice through client counselling or through attending a client's termination. When it came to abortion counselling, however, most had only broad, in-classroom education. Less than half indicated having received lecture-based instruction on abortion techniques, and very few had clinical experience in or exposure to abortion. Those who did typically encountered abortion in an interprofessional placement. Previous studies of abortion-provider attitudes found that medical professionals who had had clinical exposure to abortion during their education felt more positively towards providing abortion services. This research also indicated that clinical exposure to and training in abortion provision had more influence on whether students were willing to be providers and on their personal or moral beliefs about abortion.[62] These responses may have implications for midwifery education programs.

Seventeen percent of midwives indicated that they would be unwilling to provide abortion under any circumstance, and a number of comments reflected midwives' concerns about being "required" to provide abortion services. This speaks to the importance of leaving space within midwifery for conscientious objection to abortion provision–which is generally well accepted in medicine.[63,64] It is worth noting that 6% of midwives stated that they would neither provide abortion services nor refer clients to clinicians who would, which contravenes general

ethical principles about conscientious objection and access to care and may speak to the need for more education about this issue. This small percentage is of note because practitioners who are unwilling to provide a service are still expected to refer clients to an appropriate, willing service provider.[6,64,65]

One respondent proposed offering training in termination skills through an optional postgraduate clinical-skill class that midwives could choose to add to the scope of their midwifery practice. This could allow midwives who are interested in providing abortion to do so, perhaps under a different compensatory model, and could allow midwives who conscientiously object to abortion (or who object to it for other reasons) to exclude it from their midwifery practice. Making abortion procedures an optional skill rather than a core competency may allow those midwives who desire the ability to add it to scope of practice to do so and may also be agreeable to midwives who object to performing terminations.

CONCLUSION

This study is the first of its kind in either Ontario or Canada that focuses on the attitudes of midwives towards abortion and their willingness to include abortion within the midwifery scope of practice. This research shows that the majority of Ontario midwives are pro-choice but are evenly divided on whether abortion should be added to the scope of practice of midwifery in Ontario.

Canada does not have laws that restrict abortion provision to physicians. Therefore, adding abortion to midwifery services in Ontario would require changes to midwifery scope of practice but would not require larger legislative changes. However, this survey identified obstacles that would need to be addressed to add abortion to the midwifery scope of practice in Ontario. New methods of compensation would have to be established, and midwives may prefer to offer these services outside their regular clinics.

Misoprostol administration, both for abortion and missed abortion, was the expansion most favoured by midwife respondents. Several international jurisdictions already use misoprostal for first-trimester abortions conducted by midwives, and research has shown that this use of misoprostal has safe outcomes and increases women's access to abortion services. Misoprostol has recently been added to the Ontario midwifery pharmacopoeia for postpartum hemorrhage; thus, its use for first-trimester abortions would not require substantive changes.

This study also showed that some midwives are reluctant to provide abortion services with the perception of intervention or skill and that to do so would require additional training. Midwife respondents also expressed a general desire for increased training and knowledge about abortions and noted a lack of education about this issue, responses that may be important for midwifery education programs to consider when designing curriculums.

Although this study was conducted in Ontario, where the majority of Canadian midwives currently practice, it may be useful to conduct similar research at a national level. The Canadian Association of Midwives has stated that midwifery is fundamental to women's health care in Canada and that access to safe abortion services is vital to reproductive health. Perhaps these two philosophies could be merged and taken a step further to envision midwives as abortion providers. More extensive national research would need to be done to determine if this were desirable in terms of national midwifery philosophy and scope of practice.

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