

EMPIRICAL RESEARCH QUALITATIVE OPEN ACCESS

Failed by the System: A Content Analysis of Midwives' Experiences and Challenges When Providing Termination of Pregnancy Care

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ABSTRACT

Aim: To explore the experiences of midwives' when caring for women undergoing pregnancy termination after 14 weeks in Australia and New Zealand and the challenges they encounter.

Design and Methods: Content analysis was used to analyse 1389 responses to 10 open text questions embedded in a web-based cross-sectional survey. Current understandings of grief and stigma were applied to the data. The SRQR guideline was used for reporting.

Results: Data were grouped into four main categories: 'Failed by the system', 'Emotionally and morally challenged', 'Midwifery at the core' and 'Caring for myself'. Midwives strongly supported women's reproductive health choices and described delivering compassionate, woman-centred care during pregnancy termination. Midwives reported receiving minimal pre-registration education. Grief and sadness were prevalent emotions. Midwives described witnessing and experiencing abortion stigma. Other challenges that affected midwives' experiences included a lack of emotional and practical support. Self-care strategies did not provide enough relief to midwives to overcome the emotional impact of providing care.

Conclusion: Midwives believe they deliver the very best of midwifery care to women who undergo pregnancy termination after 14 weeks but are affected by significant grief. Midwives not only witness stigma but also experience this as care providers. Failed by the healthcare systems that employ them, they lack appropriate support to overcome the emotional and moral challenges they encounter.

Patient or Public Contribution: No patient or public involvement.

1 | Introduction

Caring for women and families undergoing termination of pregnancy (TOP) is an essential part of midwives' role and scope of practice (Fullerton et al. 2018; International Confederation of Midwives 2023) (The term 'woman' is used throughout this document. Individual parents and families may use different words and we respect their preferred terminology). Midwifery care for women having a termination of

pregnancy (TOP) involves providing compassionate, skilled and evidence-based support to women and families (Armour et al. 2021). In Australia and Aotearoa New Zealand (NZ) midwives work within a multidisciplinary team, although they are the main care providers for TOP over 20 weeks' gestation during labour, birth and postpartum. Key elements of midwifery care for TOP are counselling and education, emotional support, physical care, pain management, attending to the baby, memory making and postpartum care. Midwives'

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Summary

- Problem
 - Providing TOP care is part of midwives' scope of practice. Midwives are poorly supported in the role.
- What this paper adds
 - Midwives provide the very best of midwifery care to women who undergo TOP after 14 weeks but are affected by significant grief. Midwives not only witness stigma but also experience this as care providers.
- Impact
 - Study adds new knowledge to current literature about the experiences of midwives who provide termination of pregnancy care and the challenges they encounter. Midwives experience grief and stigma in this role.
 - Findings show an urgent need for healthcare organisations to tackle abortion stigma, increase psychological support for midwives to minimise grief and distress, and address the lack of pre- and post-registration education.
 - This research benefits midwives, managers, healthcare organisations, universities and professional bodies.

woman-centred philosophy and values are essential in ensuring women receive holistic, safe care during a significant and often traumatic time in their lives (Jones et al. 2017).

The vast majority of TOP happens in the first 14 weeks of gestation either through medication or vacuum aspiration (Fullerton et al. 2018; Mainey et al. 2020; RANZCOG 2023). After 24 weeks of gestation, TOP is less common. In Australia, there is no standardised data collection and reporting of TOP statistics, although in 2023, South Australia Health reported a rate of 10.5% for TOP > 14 weeks and 0.96% for TOP after 22 + 6 weeks (South Australian Abortion Reporting Committee 2024). In New Zealand, the rate of TOP > 20 weeks was 3% in 2021 and has been stable for some years (Perinatal and Maternal Mortality Review Committee 2022).

Fetal genetic or structural anomalies remain the most common reasons for TOP > 14 weeks, although there may also be maternal health complications and non-medical reasons including gender-based violence, delays in accessing services or decision-making, socioeconomic disadvantage and other psychosocial concerns that negatively affect women's mental health (Hayes et al. 2020; Kimport 2022; Riquin et al. 2021; Rosser et al. 2022). For TOP after 20 weeks' gestation, labour is induced or a caesarean section is performed, either with or without prior feticide (Rosser et al. 2022). Women who access TOP after 14 weeks continue to experience stigma (Hayes et al. 2020). Legal frameworks in Australia and NZ have decriminalised TOP; however, special clauses that regulate TOP after 20 weeks remain (Armour et al. 2024).

Midwives have described caring for people having a TOP after 14 weeks as challenging and an emotional burden, despite a strong identification with the role, support for reproductive

autonomy and job satisfaction (Armour et al. 2023; Malek et al. 2024). The complexities that may accompany TOP > 14 weeks can be difficult to navigate, and TOP for psychosocial reasons may become morally confronting for midwives (Malek et al. 2024). Grief, anxiety, sadness, confusion and isolation have been reported in midwives who provide TOP care (Armour et al. 2023; Qian et al. 2021). A recent study suggests that TOP care results in higher levels of personal and work-related burn-out as well as compassion fatigue (Armour et al. 2024). Despite calls for action, midwives remain undervalued and unsupported in this role (Armour et al. 2023). Globally, there is still little research that has addressed this particular area of midwifery. Understanding experiences of Australian and NZ midwives with TOP care > 14 weeks, exploring their wellbeing, support needs, and challenges they face is critical. Identifying key areas where resources need to be directed, care delivery may be strengthened, and guidelines and policies are required will ensure women have ongoing access to high-quality, safe and effective TOP care.

1.1 | Research Aim

The aim of this paper was to explore the experiences of midwives' when caring for women undergoing TOP after 14 weeks in Australia and NZ and explore the challenges they encounter.

2 | Methods

To explore the experiences of midwives reported through open text comments, we employed a qualitative research approach in our study. Qualitative research can help us understand how people experience the world. We used inductive content analysis to analyse the data (Elo and Kyngäs 2008). This is an appropriate approach to identify meaning, themes, and patterns when analysing open text responses. With roots in both qualitative and quantitative methods, content analysis was mostly used for coding, analysis, and statistical description of text data in quantitative research (Graneheim et al. 2017; Hsieh 2005). It has been adapted to allow for the exploration and interpretation of meaning contained in text and is therefore not only an extraction of words and phrases (Graneheim et al. 2017; Hsieh 2005; Zhang and Wildemuth 2016).

2.1 | Study Design

A web-based cross-sectional survey collected data between June and October 2022 and was open to midwives in Australia and NZ. Our survey was the first phase of a larger, mixed methods study that used pragmatism as its underpinning framework. Our survey was designed to explore midwifery care for TOP after 14 weeks, the emotional impact, the support midwives have available and the support strategies they might need in this role. A total of 63 questions were asked. These included demographic questions, the Copenhagen Burnout Inventory (Kristensen et al. 2005) and the Professional Quality of Life Scale (Stamm 2010) to assess midwives' wellbeing as well as 10 questions requiring open text responses. Survey questions were informed by previous research that explored NZ midwives' lived

experience when providing TOP care after 20 weeks' gestation (Armour et al. 2021). The previous work found that TOP care was a specialised role in midwifery that required a specific skill set. Midwives aimed to facilitate the most positive birthing experience within a space where birth and death meet. Previous findings also showed that midwives were emotionally and clinically unprepared and significantly affected by their work, with grief lasting from weeks to years (Armour et al. 2021). Our survey was piloted with 5 midwives who specialise in complex pregnancies, pregnancy loss, and TOP. Their feedback was incorporated before the final version of our survey was released.

The 10 open text questions explored aspects of TOP care (positive, negative and most difficult), emotional impact, reasons for providing care, education, self-care strategies and barriers to accessing support (Supplementary file 1). The data collected through the 10 open text questions were analysed for this paper. The standards for reporting qualitative research (SRQR checklist (Supplementary file 2)) were used for reporting (O'Brien et al. 2014).

2.2 | Data Collection

Qualtrics was used for data collection (Qualtrics 2023). A dedicated social media page was created (Midwives: let's talk about TOP 2022) for recruitment (Facebook, Instagram and Twitter/X). Advertising for the study was shared by professional bodies, not-for-profit organisations, other researchers, and midwives in Australia and NZ. No identifying information was collected.

2.3 | Framing the Study Using Contemporary Grief and Stigma Understanding

Data were analysed through the lens of grief and stigma. Our rationale was the ongoing stigmatisation of TOP as well as the experience of grief as a prevalent but poorly recognised emotion midwives experience when they work with women undergoing a TOP (Armour et al. 2023). Grief arises out of close human connection and is described as 'the range of reactions to the experience of loss. It is normal, natural and inevitable' (Rosenberg and Yates 2021, 1363). There are physical, cognitive, emotional, cultural, spiritual and social aspects to grief (Neimeyer 2014). Grief experts suggest that the majority of those who experience the loss of a loved one have enough resilience and capacity, together with a supportive social network, to grieve healthily without needing complex intervention. While grief in nurses who work with dying people has received recent attention (Finnan 2023), grief in midwives remains poorly acknowledged and investigated.

Kumar et al. (2009) defined abortion stigma as a social phenomenon that is reconstructed based on local socio-political, cultural and economic context. It seeks to taint those seeking TOP "internally and/or externally as inferior to the ideals of womanhood" (Kumar et al. 2009, 628). Abortion stigma is deeply contextual, dynamic and increasingly viewed as a demonstration and legitimisation of power (Millar 2020; Tyler and Slater 2018). Social media use, religiosity within families and immigration status are predictors for anticipated abortion stigma, although women's actual, individual experience of abortion stigma is low for early TOP (Valluri 2023). Abortion

stigma, however, does not just affect those seeking TOP, but also those who provide care. By association, midwives may be either directly or indirectly stigmatised for caring for women undergoing TOP (Aniteye et al. 2016; Makleff et al. 2023; Yang et al. 2016).

2.4 | Respondents

Midwives who were at least 21 years of age, had provided TOP care beyond 14 weeks within the last 5 years, and were living in Australia and NZ were eligible to participate. Eligibility criteria were assessed at the start of the survey, and midwives who did not meet these were taken to the end of the survey. Participant information was provided at the start of the survey. Information on how to access counselling and mental health support was provided in the information sheet in case responding midwives required support after taking the survey. Consent was collected through a yes/no question, and respondents who did not consent to participating were taken to the end of the survey. There were 221 completed surveys. The respondents were all female, between 21 and 63 years of age, and 31 were living in NZ, while 190 were in Australia. There were representative numbers of midwives from all states and territories in Australia. Demographic data and midwifery workforce characteristics have been provided in Tables 1 and 2 originally cited in (Armour et al. 2024).

2.5 | Content Analysis

To analyse the data, we used inductive content analysis. This method enables the condensing of copious raw data into categories using inference and interpretation. There were 1389 responses to the 10 open text questions from the 221 survey respondents. Some quotes contained several concepts, and these were separated out under different headings, leading to 1705 items of coding. NVivo (Lumivero 2023) was used to assist with the organisation and coding of the data. Elo and Kyngäs (2008) describe three main phases of content analysis: Preparation, organising and reporting. After familiarisation with the data, an initial coding framework of headings and sub-categories was created by two of the authors. The sub-categories were created by identifying key phrases and words within the data that belonged together. Mind mapping was used to visually support analysis and discussions. Through analytic engagement with the data and regular discussions, sub-categories were grouped together, collapsed where text and meaning were related and main categories refined until consensus amongst the authors was reached. We have narratively reported the final categories to describe the phenomenon and have provided the frequency of responses (number count).

2.6 | Ethics

Ethics approval was obtained from Western Sydney University Human Ethics Research Committee (H14855). Guided by Te Ara Tika Guidelines for Māori research ethics (2019) consultation was sought with Māori to ensure the research design was respectful of Te Tiriti o Waitangi, the founding document of NZ. This is recommended practice when conducting

TABLE 1 | Midwives' demographics.

| | n = 221 | Percentage % |
|--|----------------|---------------------|
| Age range (years) | | |
| 21–29 | 42 | 19.0 |
| 30–39 | 68 | 30.8 |
| 40–49 | 60 | 27.1 |
| 50–59 | 36 | 16.3 |
| Over 60 | 15 | 6.8 |
| Sex | | |
| Female | 221 | 100.0 |
| Highest level of education | | |
| Hospital-trained | 6 | 2.7 |
| Polytech | 3 | 1.4 |
| Graduate Diploma | 78 | 35.3 |
| Bachelor of Midwifery | 87 | 39.4 |
| Postgraduate (PhD/Masters/ Honours) | 47 | 21.3 |
| Country of birth | | |
| Australia | 163 | 73.8 |
| New Zealand | 29 | 13.1 |
| United Kingdom | 15 | 6.4 |
| Other Europe | 6 | 2.9 |
| Otherworld (Chile/USA/ China/SA/Fiji) | 8 | 3.8 |
| Number of women cared for per month | | |
| < 1 | 113 | 51.1 |
| 1–6 | 104 | 47.1 |
| > 6 | 4 | 1.8 |
| Last time TOP care provided | | |
| Last 28 days | 97 | 43.9 |
| < 6 months | 48 | 21.7 |
| 6–12 months | 29 | 13.1 |
| 1–5 years | 47 | 21.3 |
| Latest gestational age provided care for (weeks) | | |
| 13–19 | 17 | 7.7 |
| 20–24 | 80 | 36.2 |
| 25–28 | 61 | 27.6 |
| 29–40 | 63 | 28.5 |

research in NZ and especially when Māori midwives might be participating (Hudson et al. 2019). During discussions with Māori midwifery experts from Te Wakahuia o Hine, a national independent Māori midwifery organisation, indigenous

TABLE 2 | Midwifery workforce characteristics.

| Australian midwifery workforce | n = 190 | Percentage % |
|---|----------------|---------------------|
| Location of work | | |
| Remote | 3 | 1.6 |
| Rural | 31 | 16.3 |
| Urban | 156 | 82.1 |
| State and Territories working ^b | | |
| New South Wales | 88 | 46.3 |
| Australian Capital Territory | 5 | 2.6 |
| Northern Territory | 9 | 4.7 |
| Queensland | 29 | 15.3 |
| South Australia | 5 | 5 |
| Tasmania | 1 | 0.5 |
| Victoria | 40 | 21.1 |
| Western Australia | 13 | 6.8 |
| Midwife status | | |
| Clinical Midwifery Consultant | 4 | 2.1 |
| Clinical Midwifery Specialist | 20 | 10.5 |
| Clinical Midwifery Educator | 11 | 5.8 |
| Maternity Unit Manager | 7 | 3.7 |
| Antenatal care | 14 | 7.4 |
| Labour & Birth care | 25 | 13.2 |
| Postnatal care only | 5 | 2.6 |
| Working across scope but not in the Continuity of Care model | 81 | 42.6 |
| Private midwife visiting rights | 1 | 0.5 |
| Private midwife has no visiting rights | 3 | 1.6 |
| Continuity of Care model | 19 | 10 |
| Workplace setting | | |
| Public hospital | 165 | 86.8 |
| Private hospital | 8 | 4.2 |
| Birth Centre | 3 | 1.6 |
| Community/Private midwife | 4 | 2.1 |
| Other (Agency, Dept Health manager, private caseload, MOETS ^c , General Practitioner, mixed) | 10 | 5.3 |
| New Zealand midwifery workforce | n = 31 | Percentage |
| Location of work | | |
| Remote | 1 | 3.2 |
| Rural | 3 | 9.7 |
| Urban | 27 | 87.1 |

(Continues)

TABLE 2 | (Continued)

| New Zealand midwifery workforce | n = 31 | Percentage |
|--|--------|------------|
| Midwife status | | |
| Caseload DHB ^d employed | 1 | 3.2 |
| LMC ^a self-employed | 9 | 29.0 |
| Core midwife (Primary/secondary/tertiary) | 21 | 67.7 |
| Workplace setting | | |
| Birthing unit/Women's Assessment Unit | 11 | 35.5 |
| Community LMC | 9 | 29.0 |
| Clinical charge midwife | 2 | 6.5 |
| Maternal Fetal Medicine | 1 | 3.2 |
| Bereavement midwife | 1 | 3.2 |
| Antenatal ward | 3 | 9.7 |
| Other (CMS ^e TOP services, community Midwife Ante-/Postnatal, lecturer, MQSP ^f) | 4 | 9.7 |

^aLead Maternity Carer is the named health practitioner who provides and coordinates care during pregnancy, intrapartum and postpartum.

^bLocation of workplace not collected for New Zealand midwives to maintain confidentiality.

^cMidwifery and Obstetrics Emergency Telehealth Service.

^dDistrict Health Board.

^eClinical Midwifery Specialist Termination of Pregnancy Services.

^fMaternity Quality and Safety Programme (New Zealand).

knowledge regarding bereavement care and possible impact on Māori midwives was shared. The possibility of researcher distress due to the sensitive nature of the research was identified during the research planning stage. Individual self-care strategies, like regular breaks, days off and social support within the author team were identified and utilised during data analysis and reporting.

2.7 | Rigour and Reflexivity

All authors are midwives and midwifery academics with extensive clinical midwifery experience. The first author has a special background in high-risk maternity care and maternal–fetal medicine. She has provided TOP care to women throughout her career. Her lived experience inspired this study. The first author's pre-understandings were identified during the conception of the study and created an awareness that informed the data analysis process and the interpretation of findings. Regular discussions, reflections and mind maps ensured that the midwives' experiences contained in the data remained the focus of the analysis.

3 | Findings

Four main categories resulted that described midwives' experiences when providing TOP care: 'Failed by the system', 'Morally

challenged and emotionally drained', 'Midwifery at the core' and 'Caring for myself' Each category also has several subcategories (see Table 3).

3.1 | Failed by the System

The largest category with 554 responses included quotes that described midwives' experiences of working in a healthcare system that fails them by not recognising and responding to their needs. Systemic issues that had a negative impact included ad hoc pre- and post-registration education and orientation to the role, abortion stigma, minimal support from employers, barriers to accessing emotional support, and other matters that affected care delivery. This midwife summarised this category:

'Honestly I have lost trust with supportive systems from within healthcare'. (P76AU).

3.1.1 | Ad-Hoc Education and Orientation

There was a general lack of grounding, pre-registration education about all aspects of TOP care as well as a lack of orientation to the role. Some midwives reported that no education was provided about sexual and reproductive healthcare at all: 'I attended a catholic university and it was stated they would not teach TOP care on campus'. (P22AU).

Any education on TOP varied greatly between universities. Experiences ranged from 'it was mentioned' (P215AU) to 'it was a casual conversation with 2 lecturers' (P87NZ) to 'lectures around the subject of TOP, including legal, social aspects and patient experience' (P77NZ). Students were generally not involved in TOP care during clinical either to protect the woman or the student. This midwife had no education on TOP care and had to gain skills through clinical practice, with limited support from her workplace: 'It has been one of the most difficult parts of my career, and definitely took an emotional toll on me'. (P212AU).

Some midwives described positive experiences of learning during their training. These were rare and dependent on individual midwives who were passionate about TOP care: 'Student midwife at [...] we worked specially with the midwife who looked after these women for a week. A small introduction to what can happen but enough to realise how important this role would be'. (P69AU) This midwife was grateful that she had been encouraged to be part of indirect care: 'We were not directly involved with the woman to respect her space, but they would talk us through the paperwork, processes, formalities, and allowed us to view/observe and handle the baby where appropriate. I believe this took a lot of the shock factor away'. (P23AU).

Orientation to TOP care was equally ad hoc. 'See one, do one, teach one' (P76AU) was an experience one midwife described, while most had to find their own way and learn while working clinically: 'I have asked multiple times for help and support and orientation on TOPs. Especially the paperwork! No one had ever made the effort to do an orientation/walk through/in-service on how to correctly do a TOP'. (P8AU).

TABLE 3 | Categories and subcategory coding frame with frequency of responses ($n = 1705$).

| Category | Subcategory | Number of quotes | % Coverage |
|--|---|------------------|------------|
| Failed by the system | | 554 | 33% |
| | Ad-hoc education and orientation | 167 | 10% |
| | Frustrated at the system | 156 | 9% |
| | Barriers to receiving help and support | 134 | 8% |
| | Judgement and abortion stigma | 97 | 5% |
| Morally challenged and emotionally drained | | 530 | 31% |
| | Emotional toll | 426 | 15% |
| | Caring for a baby | 68 | 4% |
| | Complex situations | 36 | 2% |
| Midwifery at the core | | 428 | 25% |
| | Giving compassionate care | 197 | 11% |
| | Providing woman-centred care across the scope of practice | 120 | 8% |
| | Supporting choice and reproductive autonomy | 109 | 6% |
| Caring for myself | | 193 | 11% |
| | Selfcare | 111 | 6.5% |
| | Making sense | 82 | 4.5% |
| Total | | 1705 | 100% |

3.1.2 | Frustrated at the System

Midwives described a range of experiences that demonstrated a healthcare system that had failed themselves as well as the women and families undergoing TOP through a range of deficits '[I am] Frustrated at our system'. (P198AU) The ongoing significant workforce shortages and the lack of continuity of care led to dissatisfaction with the care they had provided: 'I really lean into the philosophy of being with woman [...], listening and finding out is difficult when working in a fragmented model of care. If I knew these women and their circumstances during the pregnancy I think it would be much easier'. (P210AU).

Feelings of powerlessness regarding whether or not to provide TOP care and a lack of genuine choice meant midwives felt pressured without being able to opt out. This midwife wrote:

'I was never explicitly given a choice to express conscientious objection, and if I was given the choice I may have expressed it. However as a young and new midwife I was nervous that expressing that objection would deem me as an unwilling and uncooperative employee and team member which would affect my career'. (P38AU).

Paperwork was described as an overwhelming part of TOP care. Documentation must be completed while providing care, often under extreme time constraints. Any errors can result in trauma

and difficulties for the family, making this is an extremely challenging task: 'The administrative/paperwork side of managing a late term TOP with autopsy is extremely onerous/detailed/time consuming. These clients should receive 1:1 care but often midwives are juggling this very complex care along with other cases'. (P195AU).

Other challenging shortcomings that led to frustration were the lack of clear guidelines and policies, a lack of consultation with midwives during legislative changes and service planning and inappropriate workplace politics.

With women's experiences at the forefront of their concern midwives described systemic failures that placed women and families at risk. Respondents described a lack of dedicated spaces for TOP care in hospitals: 'Providing TOP care on a maternity ward I struggle with as it is so unfair on the woman and family to be around other mothers and babies, hearing babies crying, seeing them in corridors etc. I find it very frustrating and stressful as I try to protect women and families from being exposed to these things but this is basically impossible'. (P16AU).

Frustration was also expressed at the lack of culturally safe healthcare for indigenous families 'seeing whānau navigate the system that's not made for them' (P85NZ) Table 4. Other systemic issues directly affecting women included a lack of universal access to early TOP and poor integration of services that affect timely, seamless delivery of care.

TABLE 4 | Meanings of customary Te Reo Māori phrases in NZ.

| | |
|----------------------|---|
| Whānau | Whānau is a crucial concept in Māori culture and based on Māori and tribal world views. It is a dynamic, multi-layered and flexible expression of a collective of people connected by a common ancestor. Originally encompassing three generations, in contemporary society whānau may relate to a group of people that are not related but are working together for a common purpose. Through whānau traditions, values and histories are adapted for modern day world (Walker 2017). |
| Tangi/ Tangihanga | Tangi, or Tangihanga, is an enduring traditional Māori ceremony for someone who has died. Death is a natural event in Māori worldview. Tangi describes the societal expectations of participating in the end-of-life rituals for the deceased through mourning. Life is celebrated and grief is shared through gathering, speeches, storytelling, crying and lamenting to release emotions and begin the healing process. In most cases it is appropriate and culturally safe for Māori health professionals to attend the tangi of someone they provided care for. |
| Marae | Marae is a communal and spiritual meeting ground that is a central point for Māori communities throughout NZ. It is fundamental to Māori cultural identity. |

3.1.3 | Judgement and Abortion Stigma

Midwives described experiences of abortion stigma, either witnessed as substandard care from other healthcare practitioners or directed at themselves. This midwife wrote about one case where she witnessed mistreatment of a woman in her care by an obstetrician: 'As a midwife I felt disempowered. I didn't feel I was able to provide the support and advocacy I would with a birthing woman and certainly felt I had no autonomy in the situation. I have had other experiences of frustration at the way some women having TOPs were cared for'. (P125AU).

Abortion stigma had also been directed towards midwife respondents by their wider teams and direct line managers: 'I cared for a woman who had a 36-week TOP due to minimal care and late finding of a chromosome abnormality. Most of my colleagues refused to care for her and I felt unfairly judged by volunteering. [...] In that moment I felt so alone and unsupported, I wasn't even the one going through it'. (P64AU).

Perpetuation of abortion stigma by health organisations and authorities was experienced through a lack of open discussion and midwifery consultation regarding TOP services: 'It's designed to be awkward and that starts from the top. Our Health Depts and Ministers set the trend for TOP to be seen as a necessary evil that we hide in a policy manual'. (P99AU).

This midwife summed up midwifery care for TOP within the wider social belief system: 'It's a taboo subject within society. It's like a secret midwifery code'. (P2AU).

3.1.4 | Barriers to Receiving Help and Support

Respondents described a number of reasons why they did not seek emotional support. Most commonly midwives regarded the experiences as too traumatic to share with others. Only midwifery friends and trusted colleagues who had lived experience were seen as safe to debrief with: 'It is not something that the majority of people are able to hear. It could traumatise them' (P95AU). Professional responsibility to maintain women's privacy and confidentiality stopped midwives from debriefing or seeking counselling. Employee Assistance Program (EAP) counselling was not seen as a viable option, generally due to previous poor experience: 'I've used EAP twice and found it absolutely useless' (P33AU). The limited free sessions before management approval were required, fear of being reported to management if more treatment was required and judgement or fear of passing on the trauma were some of the examples given. Fear of judgement for 'appearing weak'(P71AU) was another concern as this midwife explained: 'There is a martyr culture that exists and it prevents personal and professional growths and leads to burn out. Some midwives like to be seen as heroes or saviours and boast loudly about never taking sick days. So if you struggle you are ostracized'. (P53AU) Other barriers to accessing support were time, financial cost and lack of availability of private psychology appointments.

Midwives described an overall lack of support offered by their employers and managers in this role: 'I have requested supervision with management 7 years ago [...] No support has been offered by District Health Board (DHB)'. (P80NZ) Midwives wanted time to be able to process their experiences, debrief with management, and have strategies for letting go and moving on. They had also asked for practical help from experienced midwives yet received none. This midwife recalled her 'first TOP': 'The in-charge midwife was one who was not very supportive and I was just left to try and work through all of the paperwork and care for the family—it was awful. I went home devastated because I felt so unsupported'. (P7AU) Some respondents had feared that reaching out to management for support could lead to professional repercussions: 'We are not supported by upper management at my workplace and I would be worried they would do something or use it against me if I reached out. Have seen this happen and we have lost staff because of it'. (P132AU).

3.2 | Morally Challenged and Emotionally Drained

The second largest category with 530 responses captured quotes illustrating the emotional burden and the moral challenges of TOP care on midwives. This midwife wrote:

'To participate in elective death and birth is very challenging. It is emotionally distressing for everyone involved. The decision to terminate a viable baby is very challenging. It stays with me long after the birth. The distress of the mother (and others) stays

with me. If the mother (and others) is indifferent, that also stays with me. I grieve the loss of the baby. I have a ritual I perform for the baby's soul while it lingers around the time of death and birth'. (P102AU).

3.2.1 | The Emotional Toll

There were 426 responses that highlighted the emotional toll of TOP care with terms like 'emotionally draining' (P26AU), 'emotionally exhausting' (P91AU), 'heartbreaking' (P209NZ), 'heavy sadness' (P38AU), 'saturated in loss' (P56NZ), 'taking the grief home' (P64AU) and 'soaked in grief' (P219AU). Quotes described how dealing with the emotional aspect as well as supporting women emotionally was felt as challenging, in particular when midwives were unsure what to say or how to respond. 'Knowing what to say because nothing you say will take the pain of losing a baby away' (P87AU). The emotional connection with women was making it harder to maintain professional boundaries: 'You form a connection with the woman and her family and take on a portion of their grief'. (P71AU) Despite reflection and time, the emotions sat with some midwives for years, in some cases impacting mental health: 'The stress mounts up, it never goes away, it is now part of me. Just recalling these many years of TOPs is making my heart race'. (P212AU).

Respondents described feelings of grief if they had experienced personal perinatal loss. TOP care also became more challenging when midwives tried to conceive, experienced childlessness, pregnancy loss, or when pregnant themselves: 'Grief. Triggers memories of my own experience of stillbirth'. (P45NZ) This midwife had difficulty bonding with her first pregnancy: 'I had cared for 5 TOPs and miscarriages in my first 20 weeks and so often didn't think I would be taking home a healthy baby or that the morphology scan would be abnormal. [My] child is now 8. As a coping mechanism I say goodbye to all the babies that pass through my care'. (P36AU).

Quotes also illustrated experiences of unfair, uneven workloads in maternity services where conscientious objection to TOP was more commonly expressed. This contributed to the psychological impact: 'We respect the right to be a conscientious objector but that means the same people are looking after these women repeatedly and this can take an emotional toll'. (P96AU) Conscientious objection to TOP by obstetricians made it difficult for midwives to provide timely care for women, increasing midwives' distress. This midwife wrote: 'At our hospital all but one of our staff specialists are unsupportive of TOP for any live pregnancy. Trying to coordinate care to occur on the supportive Dr's workday to ensure the least possibility of delay in care is very difficult'. (P68AU).

Moral and ethical challenges surfaced when personal values or religious beliefs clashed with specific indications for, or TOP in general: 'Cultural and spiritually it goes against my nature that life is precious'. (P194NZ) While there was conscientious objection due to religiosity most midwives held no objection to TOP for lethal fetal abnormalities or life-threatening maternal medical concerns. TOP performed for personal reasons like poor mental health, socio-economic factors or non-lethal

fetal conditions changed this stance. The phrase 'social TOP' was used as an umbrella term for TOP for circumstantial or personal reasons. Frustrations hinted at poor consideration of women's circumstances but were mostly directed at the system. Respondents linked changes in legislative frameworks to an increase in 'social' TOPs and felt the change was one they had no control over: 'When NSW Health decided to add social termination to the workload and late social terminations at that!!! No consultation with staff, then no consultation with staff once again from our hospital in what this service would look like'. (P48AU).

3.2.2 | Caring for a Baby

Care of the baby was referred to as the most distressing aspect of TOP care. This midwife wrote: 'You never forget the little ones, remembering what they look like, how delicate they are'. (P173AU).

A baby born alive was considered the 'worst scenario' (P32AU) as midwives recounted the experience of waiting for the baby to die, counting the minutes until signs of life ceased: 'I held the baby until it passed away. It took 56min'. (P21AU) Where parents declined to hold their baby while it was dying, midwives became the main carer: 'The baby had a heartbeat for approximately 90 min and the parents weren't ready to see her until her heartbeat had stopped. I sat holding this beautiful little girl for 90 min while she passed away on Christmas Day'. (P74AU).

Handling the baby after TOP was equally distressing to midwives. The condition of the human remains may deteriorate quickly, or fetal anomalies may be challenging to see. In both cases midwives found it difficult to take photos and hand- and footprints for memory booklets. This midwife wrote about the difficulty of presenting the baby to the parents when anomalies or the condition of the body were confronting: 'Trying to make a baby look like a baby is sometimes really challenging, taking photos of babies that are not in good condition is really hard. Considering that these are the only photos these women are going to have of their baby, it's really hard'. (P149AU).

A lack of guidance on caring for an alive born baby during TOP increased the confusion and distress midwives experienced: 'My manager would prefer we just put them straight in the cold cot, but how do you not show this tiny little person some compassion and love in their short lives?' (P74AU).

3.2.3 | Complex Situations

Quotes illustrated how difficult situations during TOP care exacerbated emotional distress. Midwives described the strain of obstetric emergencies and long and drawn-out births 'Fatigue when the IOL takes a long time and you're trying to balance workload, caseload, whānau (family) whilst also looking after yourself' Table 4 (P130NZ). Threatening behaviour from women and families and psychosocial complexities added to an already challenging work environment. This midwife wrote about her experience of caring for a Burmese refugee

who was the main bread winner for her family of 7. Her parents and siblings were dependent on her income as a carer at a nursing home. As well as working shifts she supplemented her income as a sex worker but had no health literacy around sexual health, contraception or pregnancy: 'She underwent a feticide at 34 weeks, alone, and arrived for her TOP by bus, alone. She laboured and delivered alone and silently. She held the baby. She was back on night shift at the nursing home at the end of the week. There was so much wrong with the whole situation it was a terrible human rights situation on so many levels, all occurring under the social radar. I made a mandatory report to protect her siblings. I felt like a traitor. A privileged, white traitor'. (P103AU).

3.3 | Midwifery at the Core

This category had 428 responses that captured experiences regarding midwives' professional role and identity in the context of TOP care beyond 12 weeks. Midwives' quotes described a strong identification with their profession and included giving compassionate care, memory making, supporting choice and reproductive autonomy, providing woman-centred care, working across the scope of practice, and reflections on their personal growth. This quote summarised this category:

'All women deserve understanding and empathetic midwifery care, it's one of the most important parts of being a midwife. Not all birth results in a live baby but that process can be part of the healing, acceptance and grief. Done badly it can have catastrophic consequences'. (P207AU).

3.3.1 | Compassionate Care

Midwives described a strong sense of compassion towards the women in their care: 'It is extremely rewarding to be a pillar of strength for women experiencing, sometimes, the worst day of their life. You get to share your kindness, compassion and empathy that will stay with her forever'. (P72AU).

Cultural humility, culturally safe care and supporting cultural practices were important for midwives. This NZ midwife wrote: '(Give) Culturally sensitive care, protect cultural practices and encourage if wanted. Tangi is a natural process for our people and guiding whānau through the health system safely is what matters most. Attending tangi and being able to provide care on a marae or in the home where cultural practices are carried out without judgement, keeping mama safe and navigating through those challenging times'. Table 4 (P128NZ).

Respondents described how they created memorable moments, keepsakes, photos and other treasures as part of their care:

'We often facilitate them to hold their babies and even bathe their babies. We take photos of the baby and the baby with the family to make a keepsake book for them. We also have beautiful, donated handmade toys, blankets and clothes that the parents get to keep. It doesn't feel like some dirty secret, it feels like we honour the life of that little baby, and we honour the woman in that moment'. (P167AU).

Providing TOP care was also an opportunity to mature professionally and personally, and to apply skills learned in a broader sense in their practice:

'It has allowed me to grow emotionally and have a deeper understanding of women's experiences of late TOP. I think it has made me a better midwife. I think it has also helped me to better understand the role of silence in midwifery care and how silence can be therapeutic.' (P210AU).

3.3.2 | Providing Woman-Centred Care Across the Scope of Practice

Quotes illustrated midwives' intrinsic woman-centred philosophy and that TOP care was seen as well aligned with the midwifery scope of practice: 'I feel my midwifery skills are perfectly designed to support labouring women birthing babies after TOP'. (P216AU).

As midwives did not have to complete tasks that are routine during labour and birth of a live baby 'Less distraction by CTG monitoring' (P216AU) they relished the opportunity to truly focus on the woman in their care: "Most of these women have never experienced anything like this in their life and hopefully will never again. It's a really hectic time, I love trying to make it as 'normal' as possible. I feel like I really am 'with woman' when providing this care." (P149AU).

3.3.3 | Supporting Choice and Reproductive Autonomy

Most midwives were strong advocates for women's reproductive rights and autonomous decision-making. Ensuring women received non-judgemental, respectful, high-level care was part of this:

'TOP and pregnancy loss care has always been an interest of mine within the full scope of midwifery, and also as it represents a unique area of women's rights that I feel strongly about protecting and supporting. I feel it is important as a midwife to be competent and compassionate in supporting women through late TOP, as much as I would any woman experiencing labour and birth. I believe strongly that women should have the right to make informed choices about their bodies and their pregnancies, and late TOP is exactly this'. (P210AU).

3.4 | Caring for Myself

3.4.1 | Selfcare

The smallest category with 189 responses captured quotes illustrating what helped midwives cope with their experiences. Respondents described a variety of self-care strategies like physical exercise, 'music and dancing' (P96AU), mindfulness activities including yoga, meditation, spirituality, creativity and gardening, as well as watching TV, shower/bath, a nice meal, a glass of wine and catching up on sleep. 'Spending time with family and friends'. (P45NZ), having a day off, 'a little time to sit down and decompress' (P19AU), 'having a good cry' (P84AU)

or taking a break from TOP care were other examples. Some midwives had rituals, like creating artful mementos or lighting a candle for the babies. Some leaned on their partners to talk through and validate their feelings. Self-care also included drawing on colleagues and the wider team for support. Sense-making happened when midwives were able to talk things through with colleagues, debrief with line managers and reflect on the care given. 'I normally debrief with a colleague to express my sadness/grief'. (P27AU).

3.4.2 | Making sense

Feeling valued and appreciated was a small but important part of processing. This midwife wrote a summarising quote:

'These women are some of the most vulnerable women that we care for. It is important to look after them well. They often say thank you for the support and care that the staff give'.

(P188AU)

'It is also satisfying to be able to follow up with women and have staff explain findings that can sometimes help with the grief and loss... It takes real skill to be able to guide families to think about having an autopsy and ... it is satisfying to help them make the right decisions for their family with all the information delivered in a respectful and kind way. It can be satisfying to know you did a good job in exceptional circumstances.

(P187AU)

4 | Discussion

The lack of insight into the experiences of Australian and NZ midwives when providing TOP care was the reason for our study. We aimed to explore the experiences of midwives when providing TOP care above 14 weeks and the challenges they encounter. Four main themes captured an untold story of midwifery care: 'Failed by the system', 'Morally and emotionally challenged', 'Midwifery at the core' and 'Caring for myself'. Midwives who care for women during a TOP after 14 weeks provide an exceptional service that has the best midwifery has to offer at its core. Our findings show that midwifery care for TOP is strongly aligned with midwives' professional identity. Those who work in this role feel they deliver the best care the profession has to offer: woman-centred, compassionate, and culturally safe care that is trauma-informed. Most midwives recognise women's reproductive autonomy and hold no judgement (Malek et al. 2024). Women's emotional space, often filled with grief and guilt, is safeguarded to improve their experiences of TOP, especially after 14 weeks (Armour et al. 2023; Malek et al. 2024). Our findings show that midwives understand the significance of the event and how important their care is for women's healing with their grief. They strive to give women a positive birth experience despite the circumstances. This is consistent with Downe et al.'s (2013) finding that in bereavement care there is

no second chance and midwives must give the best possible care for the best possible birth experience. Knowing that they have achieved that gives midwives joy, motivation and quiet job satisfaction. Midwives also pride themselves in creating memories and mementos the woman may treasure forever, with some having special rituals to pay their respects. These findings support evidence from international studies (Mauri et al. 2015; Parker et al. 2014; Yang et al. 2016).

Overshadowing the joy this work may bring to midwives are a range of challenges and systemic shortcomings. Rost et al. (2024) described eight clusters of causes of moral distress in midwives that intertwine and reinforce each other (Rost et al. 2024). Our findings echo some of Rost et al. (2024) findings and highlight several institutional, societal and health system issues that play a major role in the impact of TOP care on midwives. These ranged from a deficiency in resources including workforce, a lack of universal access to abortion services, a lack of culturally safe care, an absence of psychosocial support including barriers to accessing counselling, to abortion and mental health stigma. The quotes in this study describing a lack of education, mentoring, and orientation confirm the findings of other studies that have reported a lack of consistent bereavement care training, including TOP (Armour et al. 2021; Burns 2016; Doherty et al. 2018; Ravaldi et al. 2018; Zwerling et al. 2021). Caring for women experiencing perinatal loss is challenging and can be traumatic for students (Leyland and Choucri 2024). Yet, shielding them from the experience of perinatal loss care, as illustrated in our findings, means students are minimally involved and ultimately clinically and emotionally unprepared, especially for TOP care. Lack of education denotes TOP care as an exception rather than a normal reproductive healthcare procedure (Millar 2023). Lack of education on grief and unpreparedness for witnessing death and dying leads to an increase in grief, trauma and burnout (Wallbank and Robertson 2013). Doherty et al. (2018) measured student midwives' confidence following a workshop for perinatal loss care. The authors demonstrated an increased awareness amongst students regarding their educational needs, as well as a significant and sustained increase in knowledge and confidence to deliver bereavement care. Being able to provide perinatal loss care with the support of skilled midwives during their training greatly benefits early career midwives (Sheehy and Baird 2022). It also benefits women and families because emotionally and clinically confident midwifery care fosters a healthy grieving process (Downe et al. 2013; Yenal et al. 2023). Our research shows that some education providers fail to include TOP in their teaching material. One recommendation, based on our findings, is to make the inclusion of TOP care at any gestation mandatory in pre-registration education so midwives can work to their full scope of practice (International Confederation of Midwives 2023). Educational content must cover all aspects of care for women and equip midwives with tools to safeguard their mental-emotional health.

Processing of emotions like grief, moral distress and other difficult experiences in midwives who provide TOP care is, however, not well supported. Unsurprisingly the second main finding is the emotional impact of TOP care on midwives. Grief, sadness, anxiety, physical and emotional exhaustion, and even post-traumatic stress were described and symptoms lasted days, weeks and for some, even years. These findings affirm existing

research regarding long-term implications of perinatal loss care on midwives (Barnes et al. 2020; Ben-Ezra et al. 2013; Malek et al. 2024). Very few studies have explored grief in midwifery, especially in the context of TOP. Grief is also neither commonly discussed nor acknowledged by education providers or workplaces. Yet, the candid descriptions of feeling 'emotionally drained', 'saturated in loss' and 'soaked in grief' in our study add a deeper understanding of how TOP care truly affects midwives. In the context of involuntary perinatal loss midwives may experience sadness, sorrow, helplessness and sometimes traumatic distress (Fernández-Basanta et al. 2022; Yenai et al. 2023). This is similar in our study, although our findings suggest that the complexities and challenges associated with TOP above 14 weeks add an additional layer. Rarely are midwives afforded time and space to decompress and come to terms with their grief before being allocated to another client. Barnes et al. (2020) reported contributing factors that unnecessarily complicated grief in midwives. These included a lack of organisational support and an inability to express the grief they felt at work (Barnes et al. 2020). Midwives are expected to cope and any signs of stress or crying may result in bullying from senior midwives or management due to poor workplace culture (Catling et al. 2017). When midwives are unsupported, undervalued and organisational culture does not care for their emotional wellbeing their risk of burnout, distress, anxiety and depression increases, putting the sustainability of the midwifery profession under further strain (Fernández-Basanta et al. 2021; Hunter et al. 2019; Matthews et al. 2022).

Grief in healthcare professionals is complex and increasingly described as 'disenfranchised' (Lin et al. 2021). Disenfranchised grief is defined as 'grief experienced by those who incur a loss that is not, or cannot be, openly acknowledged, publicly mourned or socially supported' (Doka 1999, 37). This concept includes grief following TOP. Doka explains how societal norms prescribe how humans are supposed to think and feel in most situations, even grief (Doka 2008, 224). The central tenet of Doka's theory is that it is the social context that defines who may grieve, how the person may grieve, when it is appropriate to grieve, and also what social support may be given at the time. Midwives form deep connections with women and it is normal that midwives would grieve with them and for their babies, even following a TOP (Armour et al. 2021; Doherty et al. 2018; Yenai et al. 2023). Midwives who have lived experience of pregnancy loss, including TOP, and care for women through this event may be emotionally triggered and their grief compounded when they provide TOP care (Armour et al. 2021; Musodza 2022). Disenfranchised grief for these midwives means their workplace and social networks do not offer acknowledgment or recognition that they may be grieving or are deserving of compassion and support. Our research shows, that healthcare institutions continue to be in breach of their legal duty to protect midwives' physical and psychological health (Harvey et al. 2014). It is time for institutions to acknowledge that providing TOP care presents an unavoidable psychosocial hazard for midwives that must be managed appropriately. Safe Work Australia's (2022) Code of Practice for managing psychosocial hazards at work offers a practical guide on how to identify, assess and control psychosocial risks and review any measures implemented (Safe Work Australia 2022). Simple, practical first steps maternity service leaders can implement to improve midwives' work environment include the verbal recognition of the

vulnerable space midwives are working in when providing TOP care. Midwives experiencing grief or distress must be supported with compassion, not judgement. Ways to support midwives experiencing grief are listening, being present, validating feelings and avoiding platitudes or judgemental comments. Other strategies include encouraging and covering regular breaks, offering and giving assistance and guidance with clinical tasks, having evidence-based policies and processes for TOP care, rostering extra staff to enable the midwife to provide one-on-one TOP care, offering debriefing and further emotional support through individual reflective supervision.

The judgement towards termination care providers and abortion stigma reported in our study may explain why Doka's notion of disenfranchised grief is in alignment with the findings in our study. Abortion stigma is not just experienced by, or directed at those accessing services. Our findings show midwives experience judgement and stigmatisation in this role. The widespread systemic issues affects service providers through various pathways and is a significant factor in the quality of and how TOP care is delivered (RCOG 2023; Sorhaindo and Lavelanet 2022). A lack of education, insufficient healthcare policies and legal frameworks (Armour et al. 2024; Millar 2023; Valluri 2023), workplace culture (Ennis et al. 2023), a lack of recognition of midwifery care for TOP (Armour et al. 2021), and absent workplace support create an environment where abortion stigma persists. Midwives work in an environment where TOP at later gestation is not that common thus, they are more likely to experience abortion stigma. Discrimination and harassment from conscientious objector colleagues can increase burnout and decrease job satisfaction (Janiak et al. 2018). Our findings confirm that negative attitudes from colleagues and medical teams with off-hand or targeted anti-abortion remarks, or even refusal to attend for obstetric support, can perpetuate midwives' distress. This may further lead to midwives internalising stigma, giving rise to guilt and doubt over their involvement in the process, putting sustaining termination services at risk. Organisations should have a zero-tolerance policy for abortion stigma and must urgently work towards this through targeted interventions. The Royal College of Obstetricians (RCOG) has provided several strategies; however, a lack of evidence regarding the effectiveness of these in the context of TOP care exists (RCOG 2023). Our recommendations, based on our research, echo those made by RCOG, although we suggest additional strategies (Table 5).

With the current workforce shortages and attrition rates, the Australian and NZ health systems cannot afford to lose any more midwives, let alone those willing to provide TOP care. Our findings show that midwives struggle to make sense of their emotions and experiences as they are left to deal with their thoughts and feelings themselves. Midwives must be able to safely debrief and receive emotional support from their workplaces; however, this is most often not the case. Some self-care strategies may work to calm some of the acute emotional strain; however, our study shows that on a long-term basis, these are not sufficient to work through the grief. Several studies have explored strategies to reduce burnout and compassion fatigue to address one of the reasons why nurses and midwives are leaving the profession. An emotional intelligence program for midwives that included relaxation techniques has had promising findings (Tabib et al. 2024). Reflective debriefing has been shown to be

TABLE 5 | Summary of recommendations for all midwives, midwifery leaders, managers, education providers and healthcare organisations.

| Timeframe | Recommendations arising from study |
|--------------------------|--|
| Short-term/ immediate | <p>Recognition of midwives' work within the TOP space</p> <p>Acknowledgement of the psychosocial risk of providing TOP care</p> <p>Mental-health risk assessment of TOP care</p> <p>Provide safe spaces for midwives to have their needs heard</p> <p>Clinical and emotional support of midwives</p> <p>Encouraging and covering regular breaks</p> <p>Enable 1-on-1 care/continuity of care (rostering of additional staff)</p> <p>Reporting of stigmatisation</p> <p>Debriefing following TOP care episode</p> <p>Rotate midwives who provide regular TOP care to avoid burn-out</p> |
| Mid-term | <p>Policy reviews and updates</p> <p>Create a co-designed orientation guide to TOP care for new midwives</p> <p>Ongoing bereavement care education</p> <p>Implement mentoring for midwives new to TOP care</p> <p>Implement reflective supervision</p> <p>Normalising grief and mental health support within the institution</p> <p>Ongoing wellness strategies that are co-designed with midwives and evidence-based</p> |
| Long-term | <p>Regulate pre-registration education to include all aspects of TOP care across The pregnancy continuum and tools for midwives to safeguard own mental health</p> <p>Implement interdisciplinary ongoing values clarification training for all institutions providing TOP to address abortion stigma</p> <p>Organisations to have a zero-tolerance policy towards abortion stigma, normalise TOP within the institution and direct funding to strengthen TOP service provision</p> <p>Gather consumer feedback and invite consumers to review and strengthen services</p> |

supportive for hospice nurses during the COVID-19 pandemic (Knott et al. 2023). A recent scoping review showed that institutional debriefing, resilience training using a range of modalities, mindfulness meditation, and guided imagery showed benefits for reducing post-traumatic stress disorder in hospital nurses

(Liyanage et al. 2022). Despite increasing evidence of the need for and benefit of psychological interventions, any programs are generally short-lived, do not address some of the underlying issues, and are not included in policy changes (Liyanage et al. 2022). There are no known interventions to benefit midwives who provide TOP care.

4.1 | Strengths and Limitations

This study is the first in Australia and New Zealand to explore midwifery care for TOP after 14 weeks. The depth and richness of the data is a strength of the study. The authors reached consensus regarding the findings through regular discussion and refining of categories during the data analysis phase. A limitation of this study may be the small sample size, considering the number of registered midwives in Australia and NZ. However, it is difficult to estimate how many midwives truly provide TOP care. Due to the interpretive nature of this study, the authors acknowledge that repeated analysis may identify different categories or that further insights might be reached by other researchers.

4.2 | Recommendations for Future Research

Following on from our study we recommend

- To measure grief and abortion stigma amongst midwives who provide TOP care at later gestation through the use of current, validated tools.
- The co-design of educational programs for pre- and post-registration midwifery training that is inclusive of values clarification, legal regulation, clinical practice implications, counselling for women and families and grief work for midwives.
- The implementation and evaluation of mentoring for midwives that are new to providing TOP care. Identify if midwives who provide TOP care have different mentoring needs and assess if mentoring decreases the emotional impact.
- The co-design of an interdisciplinary values clarification training framework with consumers, clinicians, allied health and Indigenous health workers and evaluated if this is positively associated with the reduction of abortion stigma experienced by women and clinicians.

5 | Conclusion

Midwives in Australia and NZ play an essential role in ensuring women have ongoing access to the provision of compassionate, holistically safe, high-quality TOP care. With their fundamental woman-centred values and altruistic motives, midwives offer judgement-free spaces for women to birth and lose their babies. Having a positive effect on women's experiences of TOP is rewarding for midwives. Abortion stigma, minimal education, poor workplace culture, a lack of psychosocial support, and a range of other systemic failures present ongoing challenges that have a significant impact on how midwives process their experiences. Midwives who provide TOP care have remained invisible in a

system that continues to stigmatise abortion and dodge the implementation of ongoing psychological support and trauma-informed workplace policies for the benefit of their employees. The result is burnout, empathic distress and disenfranchised grief.

Author Contributions

Susanne Armour: conceptualisation, data curation, formal analysis, investigation, project administration, visualisation, writing (original draft). **Hazel Keedle:** conceptualisation, visualisation, writing (review and editing). **Andrea Gilkison:** conceptualisation, visualisation, writing (review and editing). **Hannah G. Dahlen:** conceptualisation, formal analysis, visualisation, supervision, writing (review and editing).

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Disclosure

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Ethics Statement

The data utilised in this manuscript was lawfully collected. Ethics approval was obtained from Western Sydney University Human Research Ethics Committee, HREC No. 14855.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The dataset generated and analysed during this study are not publicly available to maintain respondents' confidentiality but is available from the corresponding author on reasonable request.

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Supporting Information

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