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Attitudes towards the regulation and provision of abortion among healthcare professionals in Britain: cross-sectional survey data from the SACHA Study

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ABSTRACT

Objectives To gather views of healthcare professionals on the regulation and provision of abortion in Britain.

Methods Cross-sectional, stratified cluster sample survey of healthcare professionals working in a range of healthcare services including abortion services. Measures included knowledge of and attitudes towards the regulation and provision of abortion.

Results A total of 771 healthcare professionals responded. More than nine in ten supported abortion being a woman's choice and a clear majority favoured abortion being treated as a health rather than a legal issue. Some 6.2% saw abortion at any gestational age as contrary to personal beliefs and a similarly small minority (6.7%) opposed abortion after 12 weeks' gestation. One in five of all healthcare professionals and a third of those aged under 30 years were unaware that the law in Britain requires two doctors to authorise an abortion. Free-text comments revealed opposition to the need for this legal requirement. Support for an extended role for nurses in abortion care was high; 65.3% agreed that nurses should be able to prescribe abortion medication. Little more than a third of all healthcare professionals (37.0%) agreed that abortion should be standard practice in their service; the proportion was highest among those in sexual and reproductive health services (58.4%) and lowest among those in general practice (18.7%).

Conclusions Healthcare professionals in Britain were generally supportive of abortion being treated in the same way as other health issues and would be likely to support any moves to decriminalise abortion.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ The 21st century has seen major changes in the landscape of abortion. Therapeutic and technological advances have led to an increase in the prevalence of medication abortion, which can be safely managed by women at home, and have provided the innovative telemedical interventions enabling them to do so.

⇒ The trends have prompted reflection on the appropriate regulation of abortion in Britain, on the role of different cadres of healthcare professionals, and on the appropriate healthcare settings in which abortion can be provided. Little is known about the views of healthcare professionals on these issues.

INTRODUCTION

Recent years have seen marked changes in the landscape of abortion. Therapeutic advances have led to the increasing adoption of medication as opposed to surgical abortion, once the mainstay of abortion provision.[1] Broader trends within 21st century health systems have contributed to new directions in abortion provision: the increasing use of digital approaches in healthcare, task-sharing by healthcare professionals, and greater patient-centred

WHAT THIS STUDY ADDS

⇒ The study shows that the law on abortion is not widely known. One in five of all healthcare professionals and one in three of those aged under 30 years were not aware that for abortion to be legal in Britain two doctors must certify that certain grounds have been met.

⇒ There was near universal support among healthcare professionals for abortion being a woman's choice and a widely held view that abortion should be treated no differently from any other health condition.

⇒ Enthusiasm for incorporating abortion into existing practice was high among healthcare professionals employed in sexual and reproductive health services but most of those in general practice saw abortion provision as beyond the scope of their service.

⇒ An extended role in abortion for nurses commanded considerable support among healthcare professionals, including prescribing abortion medication and, while the legal requirement to do so remains, to authorise abortions.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Should there be political will in Britain for a legal reform that removes specific criminal prohibitions against abortion, our data suggest that it would encounter strong support among healthcare professionals.

STRENGTHS AND LIMITATIONS OF THE STUDY

⇒ The study describes the views of a range of healthcare professionals in different specialities and settings on the current and future regulation and provision of abortion.

⇒ The use of a stratified cluster sampling strategy increases the generalisability of the study's findings.

⇒ Additional qualitative data from free-text comments helps in understanding the survey responses.

⇒ The main limitation stems from the timing of the study. Scheduling fieldwork at the height of the COVID-19 pandemic and its immediate aftermath may have introduced both participation and reporting bias.

⇒ Healthcare professionals most actively involved in coping with the pandemic may have declined to participate because of time pressures and/or provided responses influenced by awareness of the current constraints of their workload.

care and supported self-management. Changes in the cultural climate have formed the backdrop to these trends, including increasing secularisation and heightened attention to reproductive rights and gender equality.

These developments have prompted re-examination of issues such as the appropriate location for procedures and the roles of healthcare cadres in abortion provision. They have also provided the impetus to changes in the regulation of abortion. Abortion in Britain continues to be regulated by the 1967 Abortion Act which required that, for an abortion to be lawful, two doctors must sign certifying that one of a number of grounds have been met, the abortion should be performed by a medical practitioner and should be carried out in an National Health Service (NHS) hospital or approved premises.[2] There have been significant changes in how the Act is implemented. The requirement for authorisation by two doctors remains, but in practice is liberally interpreted and may be based on information conveyed to clinicians by other healthcare staff.[2] The requirement that abortions must be performed by a doctor is interpreted to permit other appropriately trained healthcare professionals to carry out certain tasks in abortion under the doctor's supervision[2.] During the COVID-19 pandemic, the governments in England, Wales and Scotland extended the premises in which an early medical abortion was permitted to take place to include a woman's home, with remote support from approved abortion services. The measure was made permanent in April 2022 and the 1967 Abortion Act was amended accordingly in August 2022.[3]

In the recent past, several high-income countries have made liberalising changes to the legislative framework governing abortion[4 5] including the Republic of Ireland in 2018 and Northern Ireland and the Isle of Man in 2019,[4] leading to speculation that Britain might follow.[6] Pressure for the 1967 Abortion Act to be repealed in Britain has mounted, as evidenced in statements from the Royal Colleges and professional associations, in political party manifestos and in Private Member's Bills in Britain.[7–10] This echoes views expressed by international organisations such as the WHO and the Committee on the Elimination of Discrimination against Women (CEDAW) that abortion should not be criminalised.[11 12]

Amending the legal framework for abortion is likely to create opportunities for a wider range of healthcare professionals to provide abortion care and support.[13] Even within the existing law, healthcare professionals from a range of specialities may encounter patients seeking abortion referral or support in routine healthcare. Nearly one in three women in Britain can now expect to experience abortion before age 45 years[14] and demand is increasing.[15] Understanding the views of healthcare professionals is important to optimising service provision yet little is known on the subject in Britain. Studies in the past have examined attitudes among selected groups such as medical students,[16] general practitioners (GPs)[17] and obstetricians and gynaecologists.[18] There are no up-to-date, comprehensive data on the views of the wider range of healthcare professionals such as nurses, midwives and pharmacists.

In this article we draw on data gathered as part of a larger National Institute for Health and Care Research (NIHR)-funded study: SACHA (Shaping Abortion for Change; https://www.lshtm.ac.uk/research/centres-projects-groups/sacha), aimed at guiding the optimal configuration of health services in Britain in response to changes in models of abortion care. We report on the survey component of the larger study that explored attitudes towards the regulation and provision of abortion among a range of healthcare professionals.

METHODS

Participants and procedures

We carried out a survey of attitudes towards abortion provision between November 2021 and August 2022 in England, Scotland and Wales.[19] Healthcare professionals including nurses, midwives, doctors and pharmacists in a range of settings were eligible for inclusion. We used a stratified cluster sampling strategy, selecting a random sample of services as 'clusters'. Service types were drawn from separate sampling frames. A list of general practices was compiled from data from the Care Quality Commission (CQC) in England, Health Inspectorate Wales and NHS Inform Scotland. A list of NHS and independent sector abortion services was compiled from abortion statistics in England and Wales reported to the Chief Medical Officer in 2020 and clinic lists available from the independent sector providers, and from those involved in abortion provision in Scotland. Registered pharmacies in England, Scotland and Wales were identified via the General Pharmaceutical Council. For sexual and reproductive health (SRH) and midwifery services, our sampling frame consisted of a complete list of all six-digit postcodes in England, Wales and Scotland. Randomly selected postcodes were entered into the 'Find a Service' function on the NHS website to identify the nearest service for selection. All eligible staff within each selected service were invited to take part. Information on the total number of potentially eligible participants working at that service was sought, to calculate the denominator for our response rate.

We used prevalence estimates of pro-choice attitudes among healthcare professionals from earlier research in Britain[17] to inform sample size calculations. Questionnaires, together with information sheets, consent forms, unconditional tokens of gratitude (vouchers) and free-post return envelopes, were mailed to individual practitioners within each service. We provided the option of completing the survey online. Space in the standardised questionnaire was provided for free-text comments to be added. Non-responders were followed up with two reminder telephone calls or emails. Provision of unique ID numbers enabled response rates to be calculated.

Measures

Knowledge of the law was measured by probing awareness of the legal requirement for abortion to be authorised by registered medical practitioners. We measured views on regulatory aspects of abortion by seeking agreement with statements relating to abortion as a woman's choice, abortion as a health rather than a legal issue, gestational age limits, and the probity of abortion. We measured attitudes towards abortion provision by seeking respondents' views on whether abortion care should be standard practice in their specialty and on the ability of different practitioners to provide aspects of abortion care. Verbatim wording of the attitudinal statements is provided in tables 1 and 2. Response options were three-point Likert scales (True, False and Don't Know; and Agree, Neither Agree nor Disagree, Disagree). Respondent characteristics included in the analysis were gender, age, time since qualification, current involvement in abortion provision, service type, profession, constituent country of Britain, and importance of religion and political persuasion.

Analysis

Survey data were analysed in Stata 17,[20] taking account of clustering within health service sites. We present descriptive analyses (estimated percentages and 95% confidence intervals) of the knowledge and attitude measures by respondent characteristics. Analysis of data on views on the regulation of abortion included the total sample of healthcare professionals. Analysis of data on views on whether it should be provided in respondents' own healthcare services excluded providers in dedicated abortion services.

Free-text comments relevant to the survey responses were selected for thematic analysis with the aim of better understanding survey responses. Textual data were independently analysed thematically by KW and RF using the Framework method.[21]

Patient and public involvement

We established a Patient and Public Involvement panel for the study to help inform study design and recommendations.

RESULTS

Of 1370 questionnaires distributed to eligible healthcare professionals, 771 (56.3%) were returned from 147 health service sites. The respondents' characteristics are shown in online supplemental table x.

Knowledge

Of all healthcare professionals surveyed, 78.6% selected 'True' to the statement 'An abortion is a criminal offence unless it has been signed off by two doctors' and 9.4% selected 'False'. The proportion providing the correct answer was higher among women (80.3%) than men (65.2%) and increased with years since qualification and with age (table 1). One-third of healthcare professionals aged under 30 years were unaware of this aspect of the law. Correct understanding of the law was more common among those

Table 1 Knowledge of and attitudes towards the regulation of abortion among healthcare professionals

	Knowledge of abortion law			Attitude towards the regulation of abortion														
	An abortion is a criminal offence unless it has been signed off by two doctors			The choice to have an abortion should be completely that of the woman			Abortion should not be carried out after 12 weeks' gestation			Abortion is a health and not a legal issue and should be treated as such			Abortion at any gestational age is against my personal beliefs			Abortion should be standard practice in my specialty		
Parameter	n	%	95% CI	n	%	95% CI	n	%	95% CI	n	%	95% CI	n	%	95% CI	n	%	95% CI
Total	768			764			762			763			765			517		
Attitude towards/knowledge of statements																		
Agree/True	604	78.6	(73.94 to 82.66)	693	90.7	(87.92 to 92.88)	51	6.7	(4.86 to 9.17)	521	68.2	(63.91 to 72.28)	47	6.15	(4.53 to 8.30)	191	37	(30.38 to 44.18)
Neither agree nor disagree/Don't know	92	12	(9.01 to 15.80)	53	6.95	(5.24 to 9.16)	125	16.4	(13.31 to 20.11)	174	22.8	(19.38 to 26.70)	82	10.7	(8.57 to 13.36)	178	34.5	(30.32 to 38.93)
Disagree/False	72	9.39	(7.23 to 12.10)	18	2.36	(1.45 to 3.82)	586	76.9	(71.86 to 81.23)	68	8.92	(6.97 to 11.36)	636	83.1	(79.87 to 85.93)	148	28.5	(22.76 to 35.00)
Agreement with statements																		
Age group (years)	762			762			760			761			763			516		
<30	55	65.5	(54.37 to 75.12)	78	92.9	(83.80 to 97.03)	*	*	(*)	64	76.2	(65.26 to 84.50)	5	5.95	(2.71 to 12.59)	27	46.6	(33.42 to 60.18)
30–39	162	78.3	(71.24 to 83.96)	194	93.7	(89.39 to 96.35)	14	6.76	(3.91 to 11.45)	156	75.4	(69.12 to 80.69)	15	7.21	(4.41 to 11.59)	53	40.2	(31.56 to 49.39)
40–49	163	77.9	(70.51 to 83.84)	191	90.9	(86.02 to 94.20)	20	9.57	(6.45 to 13.98)	127	60.6	(52.94 to 67.73)	17	8.13	(5.06 to 12.83)	52	36.1	(25.50 to 48.27)
50+	220	84	(77.92 to 88.60)	228	87.4	(82.28 to 91.13)	14	5.41	(2.92 to 9.78)	173	66.3	(60.05 to 72.00)	10	3.83	(1.97 to 7.32)	59	32.6	(24.58 to 41.78)
Gender	761			761			759			760			762			516		
Female	536	80.3	(75.29 to 84.55)	616	92.3	(89.48 to 94.47)	41	6.17	(4.41 to 8.58)	460	69	(64.58 to 73.14)	37	5.56	(4.01 to 7.65)	169	38.2	(30.94 to 45.92)
Male	60	65.2	(54.97 to 74.23)	73	79.4	(70.88 to 85.84)	10	10.9	(5.97 to 18.99)	59	64.1	(53.60 to 73.46)	10	10.8	(5.93 to 18.71)	22	31	(22.27 to 41.30)
Non-binary or prefer not to say	*	*	(*)	*	*	(*)	*	*	(*)	*	*	(*)	*	*	(*)	**	**	(**)
When qualified	760			760			758			759			761			515		
<5 years ago	71	73.2	(62.47 to 81.75)	91	93.8	(86.07 to 97.38)	5	5.15	(2.02 to 12.56)	75	77.3	(69.06 to 83.89)	8	8.25	(4.34 to 15.12)	28	45.9	(32.18 to 60.27)
5–10 years ago	119	72.1	(63.45 to 79.41)	154	92.8	(87.61 to 95.88)	6	3.64	(1.61 to 7.99)	123	74.6	(66.89 to 80.93)	13	7.83	(4.49 to 13.32)	42	37.8	(27.89 to 48.93)
11–20 years ago	173	80.4	(72.74 to 86.27)	195	91.1	(86.09 to 94.40)	19	8.88	(5.81 to 13.34)	142	66.2	(58.34 to 73.25)	10	4.67	(2.60 to 8.27)	51	38.1	(29.90 to 46.96)
>20 years ago	234	82.7	(77.62 to 86.80)	250	88.3	(83.58 to 91.85)	20	7.12	(4.43 to 11.24)	179	63.3	(56.70 to 69.35)	16	5.65	(3.30 to 9.52)	70	33.7	(25.67 to 42.70)
Nation	767			763			761			762			764			516		
England	436	78.1	(72.86 to 82.63)	502	90.3	(86.96 to 92.84)	38	6.86	(4.68 to 9.95)	363	65.3	(60.48 to 69.80)	41	7.37	(5.32 to 10.14)	151	36.9	(30.92 to 43.35)
Wales	58	73.4	(53.67 to 86.82)	70	89.7	(81.24 to 94.65)	7	8.97	(4.45 to 17.28)	56	72.7	(62.81 to 80.81)	*	*	(*)	30	42.9	(16.67 to 73.76)
Scotland	109	83.9	(72.31 to 91.16)	120	93	(84.23 to 97.08)	6	4.65	(1.99 to 10.47)	101	78.3	(65.89 to 87.07)	5	3.85	(1.51 to 9.48)	10	27	(14.98 to 43.78)
Currently provides abortion care	761			756			754			755			757			511		
Yes	405	86.9	(81.86 to 90.71)	445	95.9	(93.78 to 97.33)	14	3.03	(1.80 to 5.07)	336	72.6	(67.71 to 76.95)	22	4.74	(3.12 to 7.14)	113	50	(40.49 to 59.51)
No	193	65.3	(59.77 to 70.46)	240	82.1	(76.71 to 86.51)	36	12.4	(8.69 to 17.31)	182	62.2	(55.61 to 68.37)	24	8.22	(5.26 to 12.63)	77	27.1	(21.73 to 33.26)
Type of service	767			763			761			762			764			516		
SRH clinic	91	79.1	(65.50 to 88.33)	102	89.5	(83.39 to 93.50)	9	7.96	(4.78 to 12.99)	77	67.5	(60.31 to 74.02)	*	*	(*)	66	58.4	(41.20 to 73.78)

Continued

Table 1 Continued

	Knowledge of abortion law			Attitude towards the regulation of abortion														
	An abortion is a criminal offence unless it has been signed off by two doctors			The choice to have an abortion should be completely that of the woman			Abortion should not be carried out after 12 weeks' gestation			Abortion is a health and not a legal issue and should be treated as such			Abortion at any gestational age is against my personal beliefs			Abortion should be standard practice in my specialty		
Parameter	n	%	95% CI	n	%	95% CI	n	%	95% CI	n	%	95% CI	n	%	95% CI	n	%	95% CI
Maternity service	141	71.2	(65.70 to 76.16)	188	95.4	(91.74 to 97.52)	6	3.05	(1.50 to 6.08)	141	71.9	(65.56 to 77.54)	10	5.08	(2.98 to 8.52)	83	42.4	(34.25 to 50.87)
GP practice	104	67.5	(58.20 to 75.65)	120	77.4	(70.71 to 82.96)	22	14.3	(9.55 to 20.82)	72	46.5	(37.56 to 55.58)	16	10.3	(6.02 to 17.13)	29	18.7	(13.03 to 26.12)
Pharmacy	30	55.6	(42.80 to 67.62)	42	80.8	(67.67 to 89.39)	10	18.9	(9.93 to 32.90)	37	71.2	(56.42 to 82.45)	7	13.2	(6.44 to 25.16)	13	25	(15.53 to 37.67)
Dedicated abortion service	237	96.3	(93.46 to 97.98)	240	98	(95.71 to 99.04)	*	*	(*)	193	78.8	(71.30 to 84.72)	11	4.49	(2.46 to 8.04)	**	**	(**)
Professional role	762			758			756			757			759			513		
Doctor	137	77.8	(69.86 to 84.19)	150	86.2	(80.39 to 90.50)	13	7.51	(4.43 to 12.47)	108	62.1	(52.71 to 70.61)	12	6.9	(3.62 to 12.74)	27	24.6	(17.80 to 32.83)
Nurse	217	84.1	(76.58 to 89.55)	237	90.8	(85.59 to 94.26)	19	7.34	(4.52 to 11.68)	179	68.6	(62.15 to 74.37)	15	5.75	(3.25 to 9.97)	66	44.6	(30.43 to 59.70)
Midwife	209	78.5	(69.97 to 85.11)	251	95.4	(92.09 to 97.39)	8	3.05	(1.69 to 5.47)	189	72	(66.95 to 76.61)	13	4.96	(3.12 to 7.79)	79	40.3	(32.56 to 48.56)
Pharmacist	37	59.7	(47.25 to 70.98)	50	83.3	(71.55 to 90.86)	11	18	(9.89 to 30.60)	42	70	(56.86 to 80.51)	7	11.5	(5.57 to 22.17)	16	27.6	(17.92 to 39.93)
Importance of religion in life	760			761			759			760			762			515		
Very important	41	68.3	(55.63 to 78.78)	44	73.3	(61.25 to 82.71)	14	23.7	(13.69 to 37.90)	27	45	(33.55 to 57.01)	17	28.3	(16.80 to 43.64)	6	13	(5.87 to 26.51)
Quite important	117	80.7	(73.38 to 86.36)	128	87.7	(81.15 to 92.16)	16	11	(6.20 to 18.65)	94	64.4	(55.76 to 72.16)	8	5.48	(2.56 to 11.34)	36	31.9	(22.76 to 42.59)
Not important	410	79	(73.09 to 83.83)	486	93.6	(90.65 to 95.70)	18	3.47	(2.12 to 5.64)	378	72.9	(67.95 to 77.37)	21	4.05	(2.63 to 6.18)	140	42.2	(34.27 to 50.49)
Prefer not to say	30	83.3	(67.53 to 92.32)	32	88.9	(74.00 to 95.74)	*	*	(*)	20	55.6	(39.10 to 70.88)	*	*	(*)	9	39.1	(22.19 to 59.17)
Political beliefs	757			758			756			757			759			514		
Right/right of centre	24	82.8	(64.39 to 92.72)	23	76.7	(58.81 to 88.32)	*	*	(*)	19	63.3	(41.05 to 81.08)	*	*	(*)	8	33.3	(16.24 to 56.33)
Centre	90	78.8	(69.72 to 85.66)	104	92	(83.42 to 96.30)	9	7.96	(3.85 to 15.77)	67	58.9	(49.42 to 67.82)	*	*	(*)	24	28.9	(19.94 to 39.91)
Left/left of centre	188	82.8	(76.21 to 87.89)	213	93.8	(89.69 to 96.38)	8	3.52	(1.74 to 7.00)	184	81.1	(74.49 to 86.25)	15	6.61	(3.98 to 10.78)	64	43	(33.35 to 53.12)
None	229	76.1	(69.73 to 81.45)	269	89.1	(84.87 to 92.21)	22	7.31	(4.76 to 11.06)	201	66.8	(61.58 to 71.59)	20	6.62	(4.11 to 10.50)	81	39.1	(29.87 to 49.25)
Prefer not to say	65	75.6	(64.39 to 84.12)	78	90.7	(81.56 to 95.55)	8	9.41	(4.73 to 17.87)	49	57	(45.95 to 67.35)	*	*	(*)	13	26	(14.83 to 41.49)

Total number (n) for each column is the number of respondents who addressed the item; *suppressed as cell count ≤5; **not applicable.
Denominator for statement 'Abortion should be standard practice in my specialty' excludes healthcare professionals in dedicated abortion services.
CI, confidence interval; GP, general practitioner; SRH, sexual and reproductive health.

Table 2 Views of healthcare professionals on which practitioners should be able to deliver abortion care

	With training, which practitioners do you feel should be able to deliver the following aspects of care?											
	Doctors			Nurses			Midwives			Pharmacists		
Proportion ticking to endorse	n	%	95% CI	n	%	95% CI	n	%	95% CI	n	%	95% CI
Prescribing abortion medication	743	96.49	94.97 to 97.56	502	65.28	59.74 to 70.43	243	31.60	27.77 to 35.00	286	34.72	31.30 to 38.30
Dispensing abortion medication	661	85.83	82.88 to 88.34	661	85.83	82.61 to 88.53	431	56.05	50.32 to 61.00	491	63.72	60.31 to 67.00
Carrying out surgical abortion <14 weeks	730	94.80	93.08 to 96.11	314	40.70	36.78 to 44.74	104	13.52	11.07 to 16.00	18	2.34	1.51 to 3.61
Carrying out surgical abortion ≥14 weeks	715	92.85	90.86 to 94.43	247	31.99	28.59 to 35.59	86	11.18	8.75 to 14.10	16	2.08	1.26 to 3.42

Note: For doctors and nurses the proportions represent views on working in any one setting.
CI, confidence interval.

currently providing abortion in any service (86.9%) compared with those not doing so (65.3%) and was near universal among those working in a specialist abortion service (96.3%). It was less common among those in other service types; almost half of those in pharmacies were unaware of this legal requirement.

Attitudes towards the regulation of abortion

Almost all respondents (90.7%) agreed with the view that abortion was a woman's choice and 2.4% disagreed (table 2). Agreement was higher among women (92.3%) than men (79.4%) and among those seeing religion as not important in their lives (93.6%) compared with those for whom it was very important (73.3%). Agreement was also higher among healthcare professionals in maternity services (95.4%) and specialist abortion services (98.0%) compared with those in general practice (77.4%) and pharmacies (80.8%).

Support for the view that abortion was a health, and not a legal, issue was less widespread, but was nevertheless a majority opinion with 68.2% overall agreeing and 8.9% disagreeing. Agreement was lower among those considering religion to be very important in their lives (45.0%) compared with others and decreased with time lapsed since qualification. Important differences by service type were seen only for healthcare professionals working in general practice, fewer than half of whom (46.5%) endorsed this view.

A minority of the respondents (6.2%) agreed that abortion at any gestational age was against their personal beliefs and 83.1% disagreed. Levels of agreement were marginally higher among men, respondents with right of centre political views, and those employed in general practice and pharmacies (rising slightly above 10.0% in each case). Among those for whom religion was very important in their lives, it was considerably higher at 28.3%.

Again very few respondents (6.7%) agreed with the statement that abortion should not be carried out after 12 weeks' gestation and 76.9% disagreed. Endorsement of the statement was more common among respondents aged 40 years and over and among those for whom religion was very important. Again, marked differences were seen by service type. The proportion of healthcare professionals who held this view was higher among staff in general practice and reached one in five in pharmacies (18.9%).

Attitudes towards provision of abortion in different service settings

Of the 517 respondents employed outside of dedicated abortion services, 37.0% agreed that abortion care should be standard practice in their specialty and 28.5% disagreed (table 1). Fewer than one in five healthcare professionals in general practice (18.7%) and one in four of those in pharmacies (25.0%) supported the idea, compared with the majority of those in SRH

services (58.4%) and a sizeable minority (42.9%) of those in maternity services. Receptivity to the idea of abortion provision in their service was higher among nurses and midwives than among doctors, across all services.

Views on provision of abortion care by different practitioners

All respondents were asked for their views on which practitioners, other than designated abortion providers, should be able with training to provide aspects of abortion care. Support for prescription and provision of abortion medication by such practitioners was generally higher than for surgical methods (table 2). Endorsement of the notion that doctors should be able to prescribe and dispense was near unanimous; 96.5% and 85.8%, respectively, signified approval. For nurses it was lower but still a majority view; nearly two-thirds of respondents (65.3%) felt nurses should

Table 3 Illustrative examples of free-text comments

Category	Theme	Illustrative comment
Regulating abortion	► Abortion as a woman's choice	*"Regardless of my own beliefs I think every woman should make their decision based on circumstances around them."* [Pharmacist in community pharmacy] *"Abortion is a personal choice for the woman/girl. No one else should have a say over someone else's body/health."* [Midwife in maternity service] *"Abortion should be available to all women, it's their body, their choice."* [Nurse in abortion service] *"Abortion should be decriminalised and left solely as a healthcare choice for women – no matter the gestation."* [Midwife in abortion service]
	► Need for two doctors' signatures	*"The Abortion Act should be updated and the two medical signatures scrapped."* [Nurse in SRH clinic] *"Continuing to make it illegal without a doctor's approval is unfair in the 21st century."* [Nurse in abortion service] *"[I] don't feel there need to be two signatures on a Cert A, or at least one signature could be a nurse/midwife. Could there not be nurse-led clinics, so nurses/midwives can consent and prescribe medication. The majority of counselling … is undertaken by nurses."* [Nurse in abortion service] *"Abortion care has largely been 'devolved' and provision is made predominantly by nursing colleagues. It should therefore be possible for them to sign the HSA1 forms. It is archaic to think it must be two doctors."* [Doctor in abortion service]
	► Role of non-medical nurses/ midwives	*"… trained and experienced nurses and midwives should be able to prescribe mifepristone and misoprostol. They should also be able to sign certificates as they are the practitioners assessing the requirement for completing the document remains in place."* [Nurse in abortion service] *"I am a prescribing midwife and would like to be able to prescribe the first dose of medication."* [Midwife in maternity service] *"If more RN/RM did the prescribers' course that would improve the service."* [Midwife in abortion service]
Abortion provision	Extending the approved premises ► Perceived advantages	*"Abortion care is an essential part of women's healthcare and should be an integral part of training of all … those working in women's healthcare."* [Doctor in abortion service] *"Expanding existing abortion provision in under-serviced areas would be helpful."* [Midwife in abortion service] *"… wider healthcare practitioner involvement improves access to abortion and will lead to earlier procedures. I also think, however, that women would be less likely to receive non-judgmental, empathetic and skilled care."* [Nurse in SRH clinic] *"I would not be opposed to abortion care falling into the remit of sexual health, it would improve health outcomes and accessibility for women as well as allowing women to discuss and access ongoing contraception post abortion … attending a single service that can meet all needs encourages rapport and as such a holistic approach to women's reproductive healthcare."* [Nurse in SRH clinic] *"Opening abortion up to more community based setting (such as pharmacies and GP surgeries) can reduce the stigma and make it feel more like a normal medical procedure."* [Pharmacist in community pharmacy]
	► Perceived barriers	*"Time constraints are a major obstacle in involving many professionals."* [Nurse in SRH clinic] *"It is not GPs don't want to do it but cannot with so many different competing targets."* [Doctor in general practice] *"I strongly agree with holistic practice and care, but without increased resources and staff it will be difficult to manage effectively and safely."* [Doctor in general practice] *"GPs are not the ones to be burdened additionally with abortion care, even though they could provide the care."* [Nurse in SRH clinic] *"The suggestion that GPs have the opportunity to inspect for completion of aborted products is unrealistic if there is any understanding of a GP's working day."* [Doctor in general practice] *"I can see general practice taking on more abortion care may well benefit patients… but primary care is swamped as it is!"* [Doctor in general practice] *"Staff- huge shortage of nurses in SRH."* [Nurse in SRH clinic] *"I would be comfortable and willing to provide abortion services IF they were a separate entity from maternity wards … women should not be around expectant people while obtaining an abortion, not appropriate and not fair."* [Midwife in maternity service] *"Anyone providing abortion care should be doing it on a regular basis. It would be hard for GP practices/ pharmacists etc.as they wouldn't be exposed to the numbers."* [Doctor in abortion service] *"I'm in favour of wider provision, but feel that as a practising midwife I would not see enough women wanting abortion to keep my skills up to date … I would want women to be treated …by HCPs skilled in this area, not just offering this service every now and then."* [Midwife in maternity service] *"Primary care should be allowed to do this if they wish, not forced or expected to do it."* [Doctor in abortion service]

GP, general practitioner; HCP, healthcare professional; RM, registered midwife; RN, registered nurse; SRH, sexual and reproductive health.

be able to prescribe and 85.8% that they should be able to dispense. Support for midwives and pharmacists prescribing abortion medication was indicated by roughly a third (31.6% and 34.7%, respectively) but more than half felt they should be able to dispense abortion medication.

Almost all respondnets (94.8%) indicated that doctors should be able to perform surgery before 14 weeks' gestation and 92.9% after this time. A sizeable minority (41.0%) felt that nurses should be able to carry out surgical abortion before 14 weeks' gestation. Support for surgical methods being carried out by midwives was lower, and by pharmacists was negligible.

Free-text comments

Twenty-six free-text comments added to the questionnaire related to the regulation of abortion and 56 to the appropriateness of abortion provision in different healthcare settings.

Comments relating to the regulation of abortion were universally in favour of relaxing the law (table 3). None stated a preference for retaining the current legal restrictions, which were described as outdated and as having adverse consequences for the quality of abortion care. Where this view was qualified, it was with reference to the need for a prior medical consultation. Strong opposition was expressed to the continued need for two doctors to authorise an abortion. It was held that should the legal requirements remain in place, since abortion was increasingly led by nurses, their role should include responsibility for certifying that the grounds for abortion were met.

There was a consensus that abortion should be nurse-led with the proviso that this should be a provider's individual choice. Comments suggested that the lower levels of endorsement for incorporating abortion into standard heath care seen in the survey data may be attributable to recognition of the challenges rather than to disinclination to provide abortion. While benefits of integration were identified, notably reducing stigma surrounding abortion, increasing access and availability of provision, and providing more holistic care, so too were potential costs. These included a possibly detrimental effect on other services, a poorer-quality abortion service where skill sets were not adequate, and possibly less sensitive treatment of patients. Greater involvement of primary care in abortion provision was seen as currently unfeasible given perceptions that the service was already understaffed and overburdened. Similar, though more muted, reservations were expressed in relation to midwifery, with the additional concern that midwives were unlikely to see enough abortion patients to maintain essential skills. Pharmacists were considered useful sources of information but reservations focused on provision of adequate privacy. By contrast, and amplifying survey responses, clear benefits were identified for abortion provision in community SRH services in terms of continuity of care, provision of a more holistic service and attention from knowledgeable and responsive staff. Integrating abortion into SRH services was seen as conditional on a change to commissioning patterns and addressing resource limitations.

DISCUSSION

Our data show generally liberal attitudes towards the regulation of abortion among healthcare professionals in Britain. The view that abortion should be completely a woman's choice is near universal and a clear majority support the idea of abortion being treated as a health as opposed to a legal issue. Fewer than one in ten saw abortion at any gestational age as contrary to their personal beliefs. Perhaps surprising was the relatively low levels of awareness, especially higher among younger practitioners, of the legal requirement for two registered medical practitioners to authorise an abortion. Free-text comments suggested that many practitioners consider the current law to be outdated.

We found strong support in the survey data for nurses being able to prescribe abortion medication and, in free-text comments, for them to authorise abortions. Support for incorporating abortion within their existing service was higher among nurses than doctors, and among practitioners in SRH services compared with those in general practice. Free-text comments shed light on perceived benefits of integrating abortion into standard healthcare, including continuity of care, more holistic healthcare and destigmatising abortion, but also the challenges, including constraints of time, staffing levels and resources, especially in general practice.

Strengths and limitations

Our study provides much-needed data on the views of healthcare professionals on abortion regulation. Its strengths lie in the range of healthcare professionals surveyed – unique in British studies to date – providing opportunities for comparisons between specialities and settings, and in the use of a stratified cluster sampling strategy, increasing the generalisability of the findings. The addition of qualitative data from free-text comments provides insights into survey responses. The main limitation stems from the timing of the study. Scheduling fieldwork at the height of the COVID-19 pandemic in Britain and its immediate aftermath may have introduced both participation and reporting bias. Healthcare professionals most actively involved in coping with the pandemic may have declined to participate because of time pressures. The responses of those who did may reflect heightened awareness of the constraints of their workload, which may have negatively influenced their propensity to be involved in abortion care and support. In formulating survey questions to capture the range of issues on which the views of healthcare professionals seemed to us to be

relevant, we will inevitably have missed some that others consider important. Regrettably, questions about very late abortions, for example, were not asked.

Interpretation and contextualisation

Comparisons of the findings of this study and those of others are difficult because of differences in questions asked, populations under study, and recency of investigation. We found no other studies exploring knowledge of regulations governing abortion provision. Other studies in Britain have found similarly liberal attitudes towards the regulation of abortion among specific groups of healthcare professionals.[16 17 22–24] We found no other research which compared attitudes towards abortion by service type or profession. The views of healthcare professionals on appear to be generally in line with those of the general public. The most recent British Social Attitudes Survey[25] shows 76% support for allowing abortions if the woman does not want the child.

Regarding provision of abortion, the strong support among healthcare professionals in community SRH clinics for abortion provision being standard practice in their service is consistent with evidence that such settings would be sensitive to the needs of abortion patients and better able to meet other SRH needs including ongoing contraception.[26 27] However, the markedly lower level of enthusiasm for routinely incorporating abortion care and support into general practice sits in tension with recent international evidence suggesting the merits of doing so.[28–32] Contextual differences in Britain – notably, the pressures under which the NHS is operating and the consequent burden on primary care and other health services – may adjust the cost–benefit ratio and limit the extent to which insights from other countries might translate to the British setting.[28]

Implications for policy and practice

We anticipate that our findings will be of interest to commissioners and policymakers.

The recognition among healthcare professionals that aspects of the current law are out of step with best practice echoes earlier findings of the Royal College of Obstetricians & Gynaecologists (RCOG)[7] and the House of Commons Science and Technology Committee[33] that the requirement for two doctors' signatures no longer serves a useful purpose. The support shown in our study for nurses and midwives to be permitted to authorise abortions and to prescribe abortion medication is consistent with the WHO guideline endorsing the wider range of cadres who can safely perform medical and surgical abortion.[34] Our findings suggest that consideration might also be given to routinely licensing SRH services to offer abortion care. They suggest the need to proceed with sensitivity in considering any wholesale extension of abortion care into general practice. High-quality services are unlikely to result where practitioners currently have neither the capacity nor the resources to offer them.

Finally, should there be political will for a legal reform that removes specific criminal prohibitions against abortion, our study suggests that it would encounter strong support among healthcare professionals. Our respondents expressed a clear preference for regulating abortion as a matter of health and the individual's choice, rather than as an issue addressed through criminal law.

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Contributors KW and RSF conceptualised the study. RSF, MJP, JS, STC and KW designed the survey with input from all authors. RSF, JS, MJP, RM, ML and NS managed ethics/R&D approvals and fieldwork. RS, OM and MJP contributed to the analysis. KW drafted the article with input from SS, RSF, RHS, MJP, RM, ML, STC and JR. All authors approved the final manuscript. The corresponding author KW, guarantor for the work, attests that all listed authors meet authorship criteria and that no others meeting the criteria have been omitted. KW is the guarantor.

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