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Research

Australian nursing and midwifery curriculum design blind spots: a qualitative study through the prism of unplanned pregnancy

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ABSTRACT

Background: There is rising concern about the work readiness of nursing and midwifery graduates. Using the prism of unplanned pregnancy to understand Australian academics' perspectives of teaching this topic may highlight challenges associated with the current national education accreditation model and contribute to the dearth of international research on nursing and midwifery education accreditation.
Aim: This study aimed to explore Australian academics' perspectives on teaching unplanned pregnancy prevention and care to undergraduate nursing and midwifery students.
Methods: A constructivist qualitative study of undergraduate nursing and midwifery academics in Australia.
Findings: We constructed three major themes from the thematic analysis: *accreditation barriers and conflicting agendas*, *important but not important enough* and *protecting against the "unmentionable"*.
Conclusions: These findings highlight participants' misunderstanding of curriculum development and the lack of safeguards to protect against curriculum blind spots allows important healthcare topics to slip through the cracks. The official curriculum appears to be at the discretion of individuals and groups who, rightly or wrongly, have their own opinions of what knowledge and skills are essential. We also found prevailing abortion stigma remains a barrier to education.

Background

The idiom “looking through a prism” means changing the way you see something. In this paper we use the findings of a study on Australian academics' perspectives of teaching unplanned pregnancy to undergraduate nursing and midwifery students as a prism to view curriculum design and accreditation. For context, we first briefly explain how nursing and midwifery courses are designed in Australia and our study topic—unplanned pregnancy. Next, we present the study findings, followed by a scholarly discussion of the issues that emerged from the data. While set in Australia, this article has international significance, especially for countries where degrees are approved by a regulatory or professional body. The article also addresses the dearth of healthcare accreditation literature.

Under Australia's National Registration and Accreditation Scheme (NRAS), the Nursing and Midwifery Board of Australia (NMBA) approves entry-to-practice nursing and midwifery programs following an accreditation process that is overseen by the Australian Nursing and Midwifery Accreditation Council (ANMAC) (ANMAC, 2022b; COAG Health Council & Australian Health Ministers' Advisory Council, 2018). Through this accreditation process, academics and stakeholders design a curriculum that is then assessed against ANMAC's accreditation standards, designed to ensure that graduates are competent to practize safely (ANMAC, 2022a). The standards are underpinned by the nursing and midwifery practice standards (ANMAC, 2019, 2021), which are benchmarking criteria for professional practice (NMBA, 2016, 2018). Similar arrangements exist in the United Kingdom, New Zealand, Canada and Ireland (Health Professions Accreditation Councils Forum & Ahpra, 2016). There is a rising concern, internationally, among clinicians, academics and graduates as to the fitness of curricula and their ability to prepare “work-ready”

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graduates with consistent knowledge and competence (Järvinen et al., 2018; Schwartz, 2019).

The Australian Senate report on universal access to reproductive healthcare recently identified fundamental knowledge and skills gaps of frontline healthcare staff as contributing factors to significant adverse outcomes for people experiencing unplanned pregnancies (Community Affairs Reference Committee, 2023). The report recommended (i) a review of the availability, timing and quality of sexual and reproductive healthcare training and (ii) the inclusion of sexual and reproductive healthcare training in undergraduate and postgraduate health professional courses (2023, p.79). Unplanned pregnancy, a reproductive health issue, directly impacts around 40% of Australia's population (women/pregnant people and their partners) (Rowe et al., 2016). Half of the people in Australia who find themselves pregnant unexpectantly or at the wrong time continue with their pregnancy, a third have abortions and the remainder experience miscarriages (Taft et al., 2018); all require nuanced care which occurs across the healthcare system (Mainey et al., 2020).

Between 2019 and 2020, we undertook a three-phased mixed-method study, based on the Hewitt and Capiello's (2015) 27 essential nursing education competencies for unintended pregnancy to learn to what extent unplanned pregnancy prevention and care (UPPC) is taught in Australian undergraduate nursing and midwifery degrees. Phase 1 was a content analysis of UPPC in prescribed textbooks, we found variable information across resources, stigmatizing language and attitudes and a lack of instruction regarding vulnerable populations, patient education and service access (Downing et al., 2019). Phase 2 was cross-sectional surveys of nursing and midwifery academics and students. Ninety-five percent of academics agreed that students should be taught UPPC but reported it was inconsistently covered in the curriculum. Furthermore, they felt that only 3 of the essential competencies should be taught as core curriculum. Academics also thought UPPC was important but inconsistently covered, and students felt ill-prepared to provide UPPC (Downing et al., 2023). Ninety-two percent of students agreed that they should be taught UPPC, however over 50% of students reported that five of the competencies were included in the curriculum; over half of the participants indicated they were well or somewhat prepared to deliver care in pregnancy testing (76%), pregnancy prevention (66%) and sexual history taking (57%), however, the majority felt unprepared or not very prepared in abortion care (85%) and options counseling and/or referral (76%) (Cappiello et al., unpublished manuscript).

Methods

Aims

This study aimed to explore Australian academics' perspectives on teaching UPPC to undergraduate nursing and midwifery students.

Design

This paper reports on the final phase of a three-phased mixed-methods study exploring UPPC content in undergraduate nursing and midwifery curricula in Australia. We used a constructivist rendering of thematic analysis (Braun & Clarke, 2006) to analyse semi-structured interviews with nursing and midwifery academics.

Constructivism accepts that reality is an interpretation and research findings are the researchers' interpretation of the situation (Creswell, 2013; Morse et al., 2016). That is, the knowledge generated from the research cannot exist independently from the researchers (Guba & Lincoln, 1989, as cited in Howell, 2013). We are a team of nursing and midwifery academics who come to the research project with varying levels of experience in undergraduate nursing and midwifery curriculum design and UPPC. We understand the context of providing undergraduate nursing and midwifery education; we acknowledge the subjectivity that this brings. Constructivism provided the team with tools (such as debate and discussion) to engage with this subjectivity reflexively.

Participants

Academic staff who taught in Australia's undergraduate nursing and midwifery programs was eligible to participate in this study. We used convenience sampling to recruit participants. In 2020, when the study commenced, 38 Australian higher education providers offered undergraduate registered nurses and midwifery degrees. The chief investigator emailed the head of department for each of these programs, inviting their staff to participate in the study, and also promoted the study through nursing and midwifery peak bodies such as the Maternal, Child and Family Health Nurses Australia, Australian Nurse Teachers' Society and the Australian College of Midwives.

Thirteen people from 11 organizations registered for an interview. All identified as women—eight taught undergraduate nursing courses, and five taught undergraduate midwifery courses. We did not ask participants how long they had been teaching. Participants verbally consented to the interview and being recorded. They were not remunerated for their time.

Data collection

The team developed a six-question semi-structured interview guide (Table 1), guided by the broader literature of UPPC in clinical and educational (for example Cappiello, et al.,2107) contexts, which allowed us to address the study aim and enabled participants to present new ideas.

Three team members conducted the one-on-one semi-structured interviews online due to COVID-19 restrictions. Interviews lasted up to 1 hour and were recorded and transcribed verbatim; the chief investigator checked audio against transcriptions and de-identified the transcripts.

Ethical considerations

James Cook University Research Ethics Committee approved this project (HREC: H8237).

Data analysis

All authors were involved in the analysis. First, the authors split into two groups and commenced data immersion and the construction of tentative initial line-by-line codes and tentative higher-order codes. The groups then met to compare, contrast

Table 1
Time for reformation.

1. Can you broadly describe the content related to unintended pregnancy prevention and care that's currently included in the curriculum that you are involved with?
2. What do you think should be the expected sexual and reproductive health skills and knowledge a new graduate should have?
3. What do you think the professional attitudes to unintended pregnancy prevention and cares are?
4. What are the specific barriers to teaching unintended pregnancy prevention and care to undergraduate nursing or midwifery students?
5. What kind of preparation does faculty need to incorporate unintended pregnancy prevention and care into their teaching?
6. Is anything else that you can think of that you would like to share?

Table 1: Interview questions.

and reconstruct their codes. This continued until the authors were satisfied the codes had sufficient conceptual depth (Nelson, 2016) to construct themes that told a significant story about the data.

Rigor

We used various strategies to preserve trustworthiness and credibility. For example, we followed the rigorous process of thematic analysis: The chief investigator checked transcripts against the original recording, individual members independently reviewed open coding of the transcripts, and then came together to discuss and debate coding, which assisted with reflexivity.

Findings

We constructed three major themes from the thematic analysis. Each theme will be explored individually using participants' quotes to illustrate concepts.

Theme 1. Accreditation barriers and conflicting agendas.

Subtheme 1.1 Accreditation barriers.

This subtheme describes the perceived barriers participants felt ANMAC accreditation standards presented in preparing an emerging nursing and midwifery workforce to provide UPPC. Their narratives indicate confusion about curriculum design and accreditation, which we address in the discussion.

Academics believed that the accreditation standards significantly influenced the entry to practice nursing and midwifery curricula and drove learning outcomes (and therefore the curriculum). They explained that learning outcomes *have to be linked to the ANMAC standards* (P3), which connect to the NMBA standards for practice - a set of behavioral expectations, not measures of clinical competence. Consequently, they questioned the usefulness of the accreditation standards in driving clinical content.

We've talked about building capacity and capability, we've talked about raising awareness, but maybe the other thing is ANMAC need to put (UPPC) *in as a clear learning outcome. Their new standards don't mention it at all. But their new standards are very generic. (P3)*

Academics felt this was a missed opportunity for ANMAC to protect comprehensive and quality nursing and midwifery education across the board and left the curriculum at the mercy of political influences.

The undergraduate program is an accredited program, so I think that is a big driver of curriculum design and content…if ANMAC doesn't tell us it should be in there, then we won't put it in there. I think even the government is pushing us to concentrate on the aged care population... and young people be damned. It's a real problem…So yeah, I think the barriers are government bodies and the higher-ups calling the shots. (10)

ANMAC accreditation standards also require curriculum input from external and internal stakeholders. Academics revealed stakeholders' preferences for behavioral attributes rather than clinical competence.

*We talk to our industry partners, we talk to the future employers of our graduates, and they all have a really influential voice in that conversation. And for them it's about – those graduate attributes they want are the critical thinkers, the self-directed learners, the good communicators, the innovators, the team players; the confident graduate – that's who they want. But they don't talk about content knowledge… It's those other qualities – their characteristics as opposed to content information. (*P1)

Subtheme 1.2: Agenda-driven curriculum.

Participants discussed professional interest groups control over the curriculum. The inference was that academics with the strongest voices or most power set the curriculum.

We're developing a new curriculum. We've got a very strong mental healthcare team, so they're always in my ear about mental health...If you had academics who had a particular interest in women's health, they would make sure it was in the curriculum. (P3)

Other participants thought that the *Catholic's in the corridor* (P8) (i.e., faculty culture) and religious health facilities, which universities relied on for clinical placements, were highly influential in teaching UPPC:

A lot of our undergrads within the (capital city) environment, work within the (religion-based facility). And that's obviously an area of contention in the way they treat certain issues…So, that will always be a bit of a barrier to curriculum development in that space, particularly if we were to continue to send students to those environments. (P11)

To fill assumed curriculum gaps, some participants indicated there was scope for them to "*go in and add and include some things*". (P6) However, the issue this presented was that content was created based on the academics' background and what they believe is important.

I'm an acute care nurse, so I automatically think everybody needs to be able to care for medical-surgical patients, but I know that that's a bit of a siloed way of nursing. (P3)

Some faculty used creative ways to *incorporate it (UPPC) into what you're already doing* (P4). Participants included UPPC into many different topics such as law and ethics, safety and quality, global health, communication and recognition of biases, to mention a few.

We've got a new unit coming about global health… the World Health Organization that put out that information about the worldwide cost of unintended pregnancy care to women. It was related to the International Day of the Midwife… I think it's a good way to view this globally because I think it demonstrates to our students the inequities in care, and availability to resources, and what the reality is like for a lot of women across the world. I think that's one way to look at it or approach it. (P5)

Other faculty disguised UPPC content in discussions about biases and found it a comfortable and practical approach to hiding it from judgmental colleagues and students.

I wrapped it up into a few different things, so it wasn't just focusing on (UPPC) because I thought if I even put that in the syllabus, no one would turn up. (P2)

Theme 2. Important but not important enough.

Subtheme 2.1: Overcrowded and misdirected curriculum.

There was a resounding acknowledgement among academics regarding *the lack of room in the curriculum (P7),* which left content jockeying for position. This left some academics, like Participant 1, struggling to prioritize UPPC.

I do think it is important, but I just don't think it's as important as some other things. Like stroke maybe or pain management, or palliation. All of those things, they're all important. And you can do a semester on each of them. But you can't, you've only got them for six semesters, so you need to prioritize it. (P1)

Academics explained that they rationalized what they taught by focusing on the national health priority areas (an accreditation requirement), meaning that UPPC *may always get trumped by something else like mental health. (P1)* Another way was by following the money, as Participant 10 describes:

So, you've got these competing issues where, depending on the flavor of the day, the head of school and the professors, and the vice chancellor – depending on where the funding is coming from or the topic of the day is coming from, really does determine what gets put in the curriculum. (P10)

Indeed, concerning women's health needs, political will and funding were considered critical influencers of what was prioritized in curricula.

I think politically there needs to probably be more awareness of the issue and the care needs of this particular group of women, so I think its political drivers. If suddenly we open the paper and it says, "$5 million's been given to unintended pregnancy or unplanned pregnancy, and all this grant money, and you'd soon see people getting interested in it. (P3)

A compounding factor was nursing curricula mirroring societal values. Some academics reflected that women's needs are not valued in society. Therefore, UPPC is *probably not seen as a priority, because it's women's health, and women's health isn't a priority.* (P3) Consequently, curricula are developed from the perspective that women's health is a specialty (i.e. non-compulsory). This was considered a barrier to adequate teaching.

Our nursing curriculum very much follows medicine, and medicine is very much focused on the male anatomy, hormones, pathophysiology – everything – there's no reason, push, or desire to include the female anatomy, pathophysiology, and things specific to women, because, "If they need – it's women's bits are speciality bits." So, that goes to OBs and gynae because that covers the big, broad umbrella of all fallopian tubes and uteri. (P6)

However, others reflected that the traditional focus, or culture within nursing schools, was to prepare undergraduate nursing students for the acute care setting, creating an implicit bias against primary care and women's health-related content.

A lot of the focus is on acute patient care rather than a topic that could be there relating to women's health, primary healthcare, and so on. I think the main reason is just because of the lack of room in the curriculum, and perhaps the lack of awareness of the need for the topic. (P7)

Subtheme 2.2: Leaving it to others.

Participants did not explicitly agree on whose role it was to provide UPPC - nurses, midwives, or both. Participants shared that they assumed the content was taught in other programs, courses, or by other academics. Curriculum mapping within nursing programs was challenging or not visible to faculty. Curriculum mapping between undergraduate nursing and midwifery courses also appeared to be absent with nursing assuming midwifery should prepare students in UPPC and vice versa.

*The other thing around this – that topic area – is it's a bit of a grey area because is it covered in midwifery? Or is it covered in general nursing? Whose scope of practice does it capture? Is it in general nursing? Is it in community nursing? Is it in health promotion? Is it in midwifery? I think it probably falls through the net. (*P3)

Some participants felt *anything that relates to pregnancy – intended or unintended, or otherwise – gets, "Here you go, midwives."* (P6) However, nursing academics who deferred UPPC-related content to midwives potentially misunderstood that for some midwifery courses *the focus is more on an intended pregnancy that has had a poor outcome rather the unintended, unwanted pregnancy. (P9)*

Next, some participants felt that faculty lacked the skill to teach what they felt was a highly specialized skill. They believed the topic needed to be taught by faculty with expertise in sexual health.

I think there's probably a skill deficit in nursing education. I think – because I think it encompasses not only the sort of psychological needs of that woman, but also the physical needs, but also it would encompass health promotion, perhaps preventing future unplanned pregnancies? I think it needs to be taught by a sexual health expert. (P3)

The complexity of a woman's psychosocial needs and physical needs were often alluded to or referred to regarding abortion care specifically. The fact that unintended pregnancy and prevention care includes, but is not limited to, involving abortion care was a crucial driver in the pressure for an expert to lead the content.

You need capacity and capability within academic teams so that they can teach evidence-based practice graduates around what these women need. And I would imagine they have quite specific needs – I'm not an expert, but I imagine if I was having an unintended pregnancy and had to go through a termination, as I said, I'd be battling all sorts of psychological as well physical issues. I think they would be quite complex in terms of their care needs. (P3)

Theme 2.3: Protecting against the "unmentionable."

Without clear curriculum guidance on teaching UPPC, several participants highlighted the importance of protecting students (and themselves) from distress or judgment from colleagues caused by *an unmentionable* (P1) topic. Some used examples of their previous experiences teaching divisive issues and student fragility as reasons why they would not want to teach unplanned pregnancy topics.

I would also be concerned with students' wellbeing around this topic. Just like whenever you talk about something that's a bit emotive – I've been in tutorials where we've covered breast cancer and a student ends up crying because her mum's currently undergoing treatment for breast cancer. . .. and anxiety and depression are so rife in these undergraduates at the moment. I'd be concerned about students that maybe have undergone a termination being distressed by the content being discussed in the classroom. (P1)

Culture was also raised as a reason why some participants could not address unplanned pregnancies. In the following quote, an academic explains both the taboo nature of unplanned pregnancy among international student groups and the lack of a basic understanding of reproduction and contraception.

(A) lot of our international students, with the topic being so taboo, it can be quite difficult to navigate the classroom situation when there's males and females in the class because it can be too sensitive, too taboo to talk about it in front of them, or each other. . ..many of our (international) students have not had any education themselves in contraception and preventing pregnancy. And their lessons are quickly turning into basically teaching these students about this topic. They were finding it more interesting and relating it to their own lives, and what they needed to know. (P7)

Teaching staff on casualized contracts (i.e. short-term and insecure employment) were considered a compounding risk for multicultural student groups.

You've got this bunch of different casual teachers and you're telling them to teach something that is so sensitive to a multicultural group of students who are going to have such a variety of views. (P2)

Others explained that students could become hostile when exposed to topics challenging their worldview. One academic used her experience of student backlash when she taught inclusive practice as a reason to be cautious of addressing issues like unplanned pregnancy.

They were uncomfortable and they were expressing that they didn't see why they had to sit there in this class and listen to these things because they're a Christian, it was against their belief and that sort of thing. (P13)

Still, others felt it was essential to protect academics from teaching content contrary to their beliefs.

I think there has to be that safe space, and for staff to be able to say, "That makes me feel uncomfortable. I don't know whether I can deliver that content." (P12)

Finally, some academics were concerned that covering the topic of unplanned pregnancy and abortion care would alienate them from other faculty members or repel students. For example, in the following quote, a staff member explains how she 'hid' the abortion care content to avoid judgment from other faculty and to ensure students attended class:

I thought if I even put that in the syllabus, no one would turn up. And these were first-years, so I actually did it on a film. I was even more

worried about what my colleagues would think if I made something that blatant in there, so instead I did it about biases. (P2)

Discussion

In this paper we have set out explore the design and accreditation of nursing curriculum through the prism of UPPC. Our exploration of Australian academics' perspectives on teaching UPPC to undergraduate nursing and midwifery students found that they considered it difficult to teach in the context of ANMAC's accreditation standards and the overcrowded curriculum. In this context they did not feel UPPC was important enough to include in their teaching and believed it was not in their professional remit. Some participants felt they had to protect themselves and students from the sensitive topic of UPPC.

In using the UPPC prism, we have exposed some potential vulnerability in Australia's nursing and midwifery curriculum design and accreditation process. Participants spoke of curricula bursting at the seams, where some academics shoehorned UPPC into their regular lessons. Others thought it was too topical, and many felt there were more important topics to cover. Some could reflect that their beliefs about what was important to teach depended on their clinical experience. These findings are not new and correspond with Ralph et al.'s (2017) study on the design of Australian undergraduate nursing curricula in the context of national accreditation. Ralph found that time pressures, lack of resourcing and coercion by other people's agendas led to haphazard curriculum design and a substandard curriculum that valued quantity over quality. That this is an ongoing problem suggests that crucial processes, that lie somewhere between accreditation and content delivery, are missing and leave the teachers plugging perceived curriculum gaps, potentially contributing to the overload they are concerned about. Further work is needed to address what appears to be an entrenched issue.

For us, the two most important revelations seen through the prism of UPPC were participant's misunderstanding of curriculum development and the potential lack of safeguards to protect against curriculum blind spots. It is not a revelation that nursing programs did not have learning outcomes related to a topic as specific as UPPC. And it may not surprise readers that abortion care was mostly referred to in the context of foetal demise in the midwifery curriculum. However, it was startling that participants believed women's health was overlooked in nursing. Participants partially implicated this oversight on the ambiguity of the nursing and midwifery practice standards as well as ANMAC's accreditation standards which they believed caused confusion over what could or should be taught to undergraduate nurses and midwives. This rhetoric is present in the wider literature (see Ralph et al., 2015; Schwartz, 2019), however it demonstrates a misunderstanding of the curriculum development process.

The NMBA nursing and midwifery practice standards are a key component of ANMAC accreditation and therefore the curriculum (ANMAC, 2021; ANMAC, 2019). As their name suggests, these practice standards were designed *primarily* for practice, and not to communicate specific skills or competencies to education providers (Cashin et al., 2017). Consequently, the NMBA standards are purposefully broad so as not to reduce or lock nurses and midwives into a set of predetermined skills, and to be translated across a range of contexts (Cashin et al., 2017). Participants' belief that the NMBA practice standards dictated content is a misunderstanding; they are behavioral cues that should be applied to all healthcare topics. This may not be an issue for Australian academics alone with the Nursing and Midwifery Council (UK) releasing a range of supportive resources to help guide curriculum developers put the standards into practice (NMC, 2023). This strategy requires evaluation and could be useful to Australia.

Like the practice standards, the ANMAC accreditation standards are also broad. This is to provide curriculum designers the scope to adapt to the dynamic healthcare environment (Ralph et al., 2015), though ANMAC expects curriculum designers to use the standards alongside multi-stakeholder engagement to identify content that is relevant both to contemporary nursing and midwifery practice and their geographical context (ANMAC, 2021; ANMAC, 2019). In other words, if stakeholders do not identify the need for the content, it will not be included in the curriculum. ANMAC and the NMBA may need to consider safeguards such as outreach to Schools of Nursing and Midwifery to increase their visibility and demystify accreditation to junior academics.

Our findings hint at stakeholder groups that preference acute care curriculum. This is consistent with other Australian nursing curriculum research which found a predominance of acute care in the curricula and clinical experiences (Murray-Parahi et al., 2020). We also found evidence of implicit androcentrism. Much is written about the androcentrism of healthcare and what it has meant for the care of women/pregnant people (Merone et al., 2022; Mirin, 2021) and participants demonstrate how this plays out in the nursing curriculum; women's health is not prioritized, and in our study, participants viewed UPPC as a specialized knowledge or the property of midwives. However, this belief is misguided and suggests that relevant stakeholders are not being engaged. UPPC is routine care and the purview of nurses working in perioperative, gynecological, medical, primary care, sexual health and telemedicine contexts (Mainey et al., 2020). Perpetuating the belief that UPPC is irrelevant is a considerable challenge for abortion care, which is continuously undermined by misinformation and stigmatization (Makleff et al., 2023), which we also witnessed in some participants' narratives. This directly impacts patients, resulting in later-than-necessary abortions or the forced continuation of the pregnancy (Community Affairs Reference Committee, 2023, p.78).

Many stakeholder groups are affected by nursing and midwifery curriculum – e.g., students, educators, researchers, patients/consumers, clinicians and health services. While there is emerging literature on stakeholder engagement in nursing and midwifery curriculum design, such as Belita et al.'s (2020) review which identifies the facilitators of positive stakeholder engagement, to our knowledge there is no research or guidance on facilitating equitable contributions of relevant stakeholder groups across the curriculum development process. The MuSE project (Petkovic et al., 2020), which is compiling evidence for multistakeholder engagement in healthcare guideline development, may provide guidance that can be translated to curriculum development context, safeguarding against unintentional biases or misunderstanding.

Within Australia's curriculum design and accreditation model, there are obviously variations in knowledge and skills between universities. Clinicians and academics have raised concerns about these inconsistencies and have called for standardized core knowledge and skills (Kerr et al., 2022; Schwartz, 2019). Facing similar challenges in the UK, the Nursing and Midwifery Council (NMC) has created annexes to its professional standards, outlining the skills that nurses must have upon graduation (NMC, 2018). While introducing a standardized curriculum is complicated and poses its own set of issues, for some core topics, particularly those that have the potential to be stigmatized by academics or stakeholders, it may be safer to have some level of national oversight and safeguarding.

Limitations

Like all research, this study has limitations. Due to its limited sample size, further research is needed to confirm the experiences of

academics teaching undergraduate nursing and midwifery courses. Unfortunately, due to the time and resources allocated to this research we did not perform member-checking of our study themes. However, participant validation of the analysis may have strengthened its credibility and trustworthiness. The participants came from both midwifery and nursing backgrounds, but we did not explore comparisons between these two groups due to the small sample sizes.

Conclusion

Our study contributes to the absence of research on nursing and midwifery curriculum design and accreditation through the prism of UPPC. Our main contribution was highlighting participant's misunderstanding of curriculum development and the lack of safeguards to protect against curriculum blind spots such as women's health. What constitutes the official curriculum appears to be at the discretion of individuals and groups who, rightly or wrongly, have their own opinions of what knowledge and skills are essential. Abortion care was misunderstood and stigmatized by some academics and, consequently, not seen as important. Understanding these issues can help direct further research and inform resources that assist educational facilities in curriculum development. In turn, it may also assist in reducing the reproductive health knowledge and skills gap that detrimentally affects Australia.

Conflicts of Interest

Nil to declare.

CRediT authorship contribution statement

Lydia Mainey: Conceptualization, Methodology, Formal analysis, Writing – review & editing. **Sandra Downing:** Conceptualization, Methodology, Investigation, Formal analysis, Writing – review & editing. **Mary-Clare Balnaves:** Methodology, Formal analysis, Writing – review & editing. **Joyce Cappiello:** Methodology, Writing – review & editing. **Jemma King:** Project administration, Methodology, Formal analysis, Writing – review & editing. **Ann Peacock:** Methodology, Formal analysis. **Lisa Peberdy:** Methodology, Investigation, Formal analysis. **Judith Dean:** Conceptualization, Methodology, Formal analysis.

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