Exploring womxn's experiences obtaining an abortion after the gestational age limit in the Maritimes: A multi-methods qualitative study

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Abstract

The availability of abortion services in Canada is dependent on a multitude of factors, including gestational age. Although there are no legal restrictions on when in a pregnancy an abortion can occur, women, transmen, gender non-binary folks and Two-Spirit people (womxn) are only able to obtain abortion services up to 24 weeks' gestation. Those seeking a later gestational age (LGA) abortion must obtain services outside of the country. For those living in New Brunswick, Nova Scotia, or Prince Edward Island (the Maritimes), the availability of abortion services is limited to 15 weeks' 6 days. This multi-methods study aimed to understand what is currently known about LGA abortion in Canada and examine womxn's experiences seeking and obtaining an LGA abortion in the Maritimes. We also interviewed abortion providers and support staff, sexual and reproductive health (SRH) rights and justice advocates, and SRH researchers to further understand the gaps in LGA abortion services. The results of this study show that further provision, support and awareness for LGA abortion is warranted, both in the Maritimes and Canada more broadly.

La disponibilité des services d'avortement au Canada dépend d'une multitude de facteurs, dont l'âge gestationnel. Bien qu'il n'y ait aucune restriction légale sur le moment où un avortement peut avoir lieu au cours d'une grossesse, les femmes, les hommes trans, les personnes de genre non binaire et les personnes bispirituelles (femmes) ne peuvent obtenir des services d'avortement que jusqu'à 24 semaines de gestation. Ceux qui cherchent un avortement à un âge gestationnel plus tardif (AGT) doivent obtenir des services à l'extérieur du pays. Pour les personnes vivant au Nouveau-Brunswick, en Nouvelle-Écosse ou à l'Île-du-Prince-Édouard (les Maritimes), la disponibilité des services d'avortement est limitée à 15 semaines et 6 jours. Cette étude multi-méthodes visait à comprendre ce que l'on sait actuellement sur l'avortement AGT au Canada et à examiner les expériences des femmes cherchant et obtenant un avortement AGT dans les Maritimes. Nous avons également interrogé des prestataires d'avortement et du personnel de soutien, des défenseurs des droits et de la justice en matière de santé sexuelle et reproductive (SSR) et des chercheurs en SSR afin de mieux comprendre les lacunes dans les soins de santé liés à l'avortement AGT. Les résultats de cette étude montrent qu'une offre, un soutien et une sensibilisation supplémentaires à l'avortement AGT sont justifiés, à la fois dans les Maritimes et au Canada en général.

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List of acronyms and abbreviations

CAS	Canada Abortion Study
CIHI	Canadian Institute for Health Information
GA	Gestational Age
GRA	Graduate Research Assistant
IDI	In-depth interview
KI	Key informant
LGA	Later gestational age
LMP	Last menstrual period
NAF	National Abortion Federation
NB	New Brunswick
NFL	Newfoundland and Labrador
NS	Nova Scotia
PEI	Prince Edward Island
SRH	Sexual and reproductive health
SSHRC	Social Sciences and Humanities Research Council
TAC	Therapeutic abortion committee

Chapter 1: Introduction

1.1 Background

1.1.1 Overview of abortion in Canada

Canada is one of a very small number of countries in the world to have fully decriminalized abortion. Pressure from medical and legal associations as well as women's groups to liberalize Canada's abortion law began in the 1960s (Arthur, 1999). During this time, researchers estimate that anywhere from 35,000 to 120,000 illegal abortions were performed in Canada each year (Arthur, 1999). The first step toward decriminalization occurred in 1967 when the General Council of the Canadian Medical Association called for the legalization of abortion under certain circumstances (Burnett, 2019). The Justice Minister of Canada presented a bill to liberalize Canada's abortion law and, with Prime Minister Pierre Trudeau's support, the bill became law in 1969, exactly 100 years after abortion was first inserted into the criminal code (Arthur, 1999). The 1969 reform allowed Canadian women to apply to a hospital-based therapeutic abortion committee (TAC); if the three-member panel determined that the pregnancy threatened the life or health of the woman, she could obtain a legal abortion (Arthur, 1999). However, this did not come without complications. Each TAC interpreted the word "health" differently – and mostly conservatively (Arthur, 1999). As a result of the vague term, some TACs approved very few abortions (Arthur, 1999). Additional problems included that it often took six to eight weeks to process an application, there was no requirement that hospitals have a TAC in place so most did not, and the committees were overwhelmingly comprised of white men (Arthur, 1999). These TACs wielded tremendous power and control.

Dr. Henry Morgentaler – a pioneer in the sexual and reproductive health field and a self-proclaimed rebel – continuously defied section 251 of the Criminal Code and performed abortions in Quebec outside of the hospital and without going through a TAC (Abortion Rights Coalition of Canada, 2017). Between 1970 and 1975, Dr. Morgentaler was charged with conspiracy to perform an abortion – a criminal offence that carries a prison sentence. Although he was acquitted initially, that decision was overturned and ultimately the Supreme Court of Canada voted 6-3 to uphold the Quebec Court's conviction (Abortion Rights Coalition of Canada, 2017). In 1976, the Federal Minister of Justice set aside Morgentaler's conviction and ordered a new trial (Marshall & Mclaren, 2013). Juries acquitted Dr. Morgentaler in both his first and second retrial and he subsequently expanded his abortion practice to Toronto and Winnipeg (Abortion Rights Coalition of Canada, 2017).

Dr. Morgentaler's defiance of the law led to one of the biggest victories for women, transmen, gender non-binary folks and Two-Spirit people (womxn) in Canadian history; in 1988, the Supreme Court of Canada struck down the existing abortion law (Kaposy, 2008). The ruling in *R. v. Morgentaler* held that inclusion of abortion in the criminal code violated the Canadian Charter of Rights and Freedoms (Kaposy, 2008). The abortion law violated Section 7 of the Charter, which protects life, liberty, and security of the person, because it made access to an abortion contingent upon the inconsistent decision making of a committee (Kaposy, 2008). In 1990, the federal government, led by Progressive Conservative Brian Mulroney, introduced Bill C-43, which would have sentenced doctors to two years in jail for providing abortions if a woman's health was not at risk (National Abortion Federation (NAF) Canada, 2020). The House of Commons passed the bill, but it died in the Senate after a tie vote (NAF Canada, 2020).

Between 2006-2015 there were several private members' bills introduced to the House of Commons that aimed to establish independent fetal rights (NAF Canada, 2020). None of these bills have passed and critics have argued that these were back-door attempts to re-open the abortion debate (NAF Canada, 2020).

The decriminalization of abortion in Canada is an integral component of ensuring that pregnant people across Canada can exercise their right to personal bodily autonomy. However, decriminalization has not ensured equitable access to abortion services (Shaw & Norman, 2020). Health care funding contributes to these inequities. Although health care is under provincial/territorial jurisdiction, the federal government contributes funding to the provincial/territorial health care systems and exerts its influence over policy decisions by distributing or withholding resources (Kaposy, 2008). Adopted in 1984, the Canada Health Act is Canada's federal legislation that governs publicly funded health services and is grounded in the principles of universality, comprehensiveness, accessibility, portability, and public administration (Government of Canada, 2020). Although the Canada Health Act has long deemed abortion a "medically necessary" service, all provinces and territories determine health policy and services for their jurisdiction, within the principles of this Act (Shaw & Norman, 2020). This has resulted in variation in abortion coverage; for example, New Brunswick health insurance does not cover the costs of abortion care provided through clinics (Foster et al., 2017). Critics argue that the federal government should be more willing to penalize provinces financially when they violate principles such as accessibility and portability (Johnstone & Macfarlane, 2015). Eggerston has described the abortion landscape in Canada as a "patchwork quilt with many holes" (2001, page 847).

Abortion care in Canada is extremely safe. In most Global North countries, death from unsafe abortion has been virtually eliminated (Arthur, 2010), including later gestational age (LGA) abortion (Ibis Reproductive Health, 2015). The available data confirms that serious complications have been rare in Canada since decriminalization (Sabourin & Burnett, 2012). Abortion procedures in Canada are also relatively common. Canada has had a stable abortion rate of approximately 14.5 per 1,000 women aged 15-44 years old for many years (Shaw & Norman, 2020). It is experienced by nearly a third of Canadian women during their reproductive years (Norman, 2012).

1.1.2 Abortions beyond the first trimester

Although close to 95% of all abortions performed in Canada occur in the first trimester (in the first 12 weeks) after the first day of the last menstrual period (LMP), some Canadian womxn need access to services beyond this gestational age (Action Canada for Sexual Health & Rights, 2019). Nationally, there are no gestational age restrictions and abortion is legal at any stage of pregnancy (Long, 2020; NAF Canada, 2020). Yet, there are only three service locations in Canada that offer abortion up to 23 weeks and 6 days (one in British Columbia, one in Southern Ontario, and one in Quebec) (Action Canada for Sexual Health & Rights, 2019). Currently, no providers in Canada offer abortion care at or beyond 24 weeks; patients needing abortion care at this gestational age generally travel to the United States.

Methods for abortion depend on gestational age and provider training. The gold standard of medication abortion, mifepristone and misoprostol, became available in Canada as the combination pack Mifegymiso® in 2017 (LaRoche & Foster, 2020). This regimen of medication

abortion is approved for use through 63 days from the first day of the last menstrual period (LMP) and is used off-label through 77 days (LaRoche & Foster, 2020). If mifepristone is not available, methotrexate combined with misoprostol or misoprostol alone remain important alternatives for use through 49 days LMP and 84 days LMP, respectively (Jones et al., 2017). In the first trimester, instrumentation abortions are usually performed through a variety of vacuum aspiration techniques while second trimester terminations are generally performed through dilatation and evacuation (Davis, 2006). Later gestational age abortions can also be performed with the in-patient use of medications (misoprostol with or without mifepristone) to induce labor after administration of a feticidal agent (Davis, 2006). In Canada, all induced abortions over 20 weeks of gestational age take place in hospitals; LGA terminations are predominantly related to maternal-fetal indications (Shaw & Norman, 2020). Although termination of pregnancy after 24 weeks may occur in the context of pregnancy complications or emergencies (in the wake of a car accident, for example), these are generally performed by maternal-fetal medicine specialists and are not captured as induced abortions. In 2018, the Canadian Institute for Health Information (CIHI) reported that of the 30,799 total hospital abortions that took place in Canada during 2016, 10.12% of them happened after 12 weeks' gestation. In 2016, approximately 68% of Canadian abortions were performed in abortion clinics and the rest were performed in hospitals (CIHI, 2018).

In Canada there are several hotlines that help those seeking abortion care navigate the system at any gestational age. There are three national hotlines as well as six hotlines that serve Alberta, British Columbia, and Quebec respectively (Abortion Rights Coalition of Canada, 2022). Two of the three national hotlines are provided by NAF Canada and Action Canada for

Sexual Health and Rights and are the most frequented (Abortion Rights Coalition of Canada, 2022). Working independently but for same purpose, these hotlines operate seven days a week, and provide callers with accurate information, confidential consultation, case management, referrals to providers of quality abortion care, and often times financial assistance (Action Canada, 2022; NAF Canada, 2022). The hotlines are free and offers services to everyone, regardless of the individual's situation (Action Canada, 2022; NAF Canada, 2022). Abortion hotlines have the potential to facilitate access to safe abortion care through evidence-based information and to decrease maternal mortality and morbidity from unsafe abortions for women and girls globally (Gill, Cleeve & Lavelanet, 2021). These hotlines are especially important for pregnant womxn at an advanced gestational age seeking an abortion. Norman and colleagues (2014) found that even though women with unintended pregnancy of advanced gestation represent a small proportion of those seeking abortion services in Canada, they represent a significant proportion of those seeking service with the hotlines. These toll-free hotlines play a large role in service delivery and knowledge translation for womxn seeking abortion care.

There has been little discussion in the literature of LGA abortions and the womxn that have them in Canada. Previous research indicates that womxn face economic, social, and facility-type barriers when seeking first trimester abortion care (Boland, 2010); it is likely that these barriers are heightened at later gestational ages. Some research shows that the most common reason womxn give for seeking an abortion past the first trimester is that they did not know they were pregnant or were in denial about their pregnancy (Boland, 2010). Other women face pressure from family members or partners, which delays the decision-making process, or are undecided about what course to take (Boland, 2010). Further, geographic barriers and wait-times

delay abortion care. Finally, some decide not to continue a wanted pregnancy after facing difficult altered personal circumstances, a newly discovered or unexpectedly exasperated health risk, or a diagnosis of a serious fetal anomaly (Boland, 2010). Threats to health and life often do not arise until the second or third trimester of pregnancy, and many tests to detect fetal abnormalities cannot be carried out until well into the second trimester (Abortion Rights Coalition of Canada, 2017; Boland, 2010). However, we know relatively little about Canadian womxn's decision-making, reasons, or experiences seeking and obtaining abortion during this period.

1.1.3 Setting the context: The Maritimes

Even though abortion has been a legal medical procedure in Canada for more than 30 years, access throughout the country remains unequal. This is largely attributed to geographic location, with significant disparities between rural and urban areas. Labeled as some of the worst places to obtain an abortion by researchers, New Brunswick (NB), Nova Scotia (NS), and Prince Edward Island (PEI) comprise Canada's Maritime region and make up most of the land mass on the east coast. These three provinces comprise 1.3% of Canada's total land mass and have a combined population of just under 2 million people (Statistics Canada, 2016, Statistics Canada, 2022). Women of reproductive age (15-49) make up approximately 20% of the population of the Maritimes (Statistics Canada, 2021; World Health Organization, 2022). The Maritime provinces are experiencing their fastest population growth in decades; more than 16,000 people moved to the Maritimes in 2019, almost doubling the number of arrivals in 2010 (Mercer, 2020).

According to the 2016 Census provided by Statistics Canada, PEI had the second largest overall growth by province in the country at 11.7%.

Women in the Atlantic provinces (the three Maritime provinces as well as Newfoundland and Labrador (NFL)) have the lowest access to abortion services in the country (Arthur, 1999; Sethna & Doull, 2013), a dynamic shaped by rurality. A study done by Norman and colleagues (2016) revealed that 70% of women aged 15-44 residing in rural parts in the Atlantic region did not have proximate access to an abortion providing facility. In addition, the study showed that there was only one abortion provider for the rural areas of all four provinces combined. The social, medical and political realities of the Maritime provinces are all very different, but all three provinces share common barriers for people trying to access abortion care and services (Pittman, 2016).

Presently, there are three hospitals (one of which is regional to city locals only) and one clinic (that is currently closed) in NB, four hospitals in NS, and one hospital in PEI that provide abortion services. In 2019, there were 1,933 reported abortions that took place in hospitals and 98 reported abortions that took place in clinics in the Maritimes (Abortion Rights Coalition of Canada, 2021; CIHI, 2019). The figure given for abortions in clinic settings is likely inaccurate as clinics are not bound by mandatory reporting requirements – reporting is voluntary (CIHI, 2019). Further, primary care or other providers of medication abortion care do not report to CIHI. Both NB and NS have gestational age limits of 16 weeks while PEI's is 12 weeks (Action Canada for Sexual Health & Rights, 2019). The gestational age at which abortions are available in each province is not limited by law but by physician/provider discretion. This dynamic is often influenced by the extent of training, funding regulations, and the availability of facilities

(Johnstone & Macfarlane, 2015). Thus, womxn seeking abortion care after 16 weeks' gestation must travel outside of the region for care.

1.1.4 Limited options for womxn

To date, there are no estimates for how many Canadian womxn travel outside of their region for abortion care and services each year. These womxn essentially become medical tourists in their own country (Sethna & Doull, 2012). The lack of attention paid to these abortion journeys not only highlights the vulnerability of this population but also provides confirmation that abortions does not need to be illegal in order to be inaccessible (Sethna, 2012).

Studies suggest that abortion tourism is a widespread, transnational phenomenon based on extra-legal impediments to abortion access (Sethna & Doull, 2012; Shaw, 2013). Abortion tourism skews abortion data, making it difficult to establish the need for abortion services in different areas (Sethna & Doull, 2012). Marginalized populations of women – including those who live in the NB, NS, and PEI – tend to travel the furthest to access abortion services (Arthur, 1999; Sethna & Doull, 2012). For example, Foster and colleagues (2017) explored women's experiences obtaining an abortion care before and after the two-physician policy reform in New Brunswick. They found that even after amending *Regulation 84-20*, women were still travelling outside of the province to seek abortion care (Foster et al. 2017).

Despite this, we know very little about Maritime womxn's experiences with LGA abortions or perspectives on how services could be improved (Sethna & Doull, 2012). We also know little about womxn's experiences obtaining LGA abortion care in the context of the COVID-19 pandemic. Despite many reports on the COVID-19 pandemic being a catalyst for

more accessible ways to deliver abortion care in Canada (Ennis et al., 2021; Hukku et al., 2022), none of these reports have been on LGA abortion. Evidence from the United States suggests that because of quarantine measures, reduced travelling capacity and the increased financial burden, the population of LGA abortion seekers who already face challenges in accessing health care now face even more barriers. (Ruggiero et al., 2020). The closure of the US-Canada border during the early part of the pandemic and the vaccination and other requirements related to international travel once the border reopened likely impacted Canadian womxn who needed post-24 week abortion care in the US. However, no published studies have explored these dynamics.

1.1.5 Use of gender inclusive language

Although the overwhelming majority of people obtaining abortion care identify as women, this study recognizes that any person who has the capacity to become pregnant and sustain a pregnancy can also have an abortion. Throughout this thesis, I use the term "womxn" to signify (cis)women, transmen, gender non-binary individuals, and Two Spirit folks. However, most of the research that has been done on abortion in Canada and around the world has focused on women and when referring to the work of others, I will use the terms used in the original source.

1.2 Study rationale

By exploring womxn's experiences obtaining an abortion after the gestational age limit of 16 weeks in the Maritimes, we will be addressing a considerable gap in the abortion literature in Canada. Currently, no such research exists. Further, provincial regulations in the Maritimes, and

in New Brunswick in particular, create barriers for womxn to obtain timely and affordable abortion care. The information generated from this study could help reproductive health, rights, and justice organizations that are currently fighting for equitable reform. Finally, efforts are currently underway by the NAF Canada and others to ensure that there are more LGA abortion providers in various areas around the country. Documenting womxn's experiences could aid these advocacy efforts.

1.3 Specific objectives and questions

Using qualitative methods, this study aims to explore womxn's experiences seeking and obtaining (or not obtaining) an abortion after the gestational age limit in the Maritime provinces of New Brunswick, Nova Scotia, and Prince Edward Island.

The objectives of this study are to:

1. Document womxn's experiences with seeking abortion care after the gestational age limit in the Maritimes;
2. Identify the ways that being denied an abortion within the region and/or having to travel outside of the region impacts womxn financially, emotionally, and personally; and
3. Offer recommendations for how later gestational age abortion care could be improved for womxn residing in the Maritimes

The research questions are:

1. What are Maritime womxn's experiences seeking and obtaining abortion care after 16 weeks' gestation?

2. What are the financial and personal costs associated with seeking and obtaining abortion care outside of the region?
3. From the perspective of Maritime womxn who have sought or obtained abortion care after the gestational age limit and the perspective of providers and reproductive health, rights, and justice advocates, how could information and services be improved?

1.4 Thesis structure

This multi-methods study resulted in a "thesis by articles" and is divided into six chapters. This first chapter provides background information on the history of abortion in Canada, the current abortion landscape in Canada and the Maritimes, LGA abortion and its accessibility, and gaps in literature. I also provide information on gender inclusive language. Chapter 1 then offers the rationale behind this project, outlines the project's objectives and research questions and concludes with the outline of the thesis.

Chapter 2 describes the methodology I used to accomplish my objectives and research questions. This includes my recruitment strategy, the interview process, and a detailed summary of my analytic approach. Lastly, I include a section on research ethics.

Chapters 3 through 5 consist of the three articles: chapter 3 is a scoping review done on LGA abortion in Canada, chapter 4 is an analysis of NAF Canada and Action Canada's abortion hotline data pre-and during-COVID-19 pandemic, and chapter 5 is a study exploring womxn's experiences obtaining a LGA abortion in the Maritimes and across Canada. These articles are

formatted for submission to the *Canadian Journal of Human Sexuality, Contraception* and *Perspectives on Sexual and Reproductive Health*, respectively.

The final chapter, begins with a discussion of the three articles and how they related to each other, followed by some suggestions on future directions for research on LGA abortion in Canada and the Maritimes. I continue this chapter with a description of my positionalities, values, and self-reflections as a researcher and how these dynamics may have impacted the research. I end this chapter with an overview of the limitations of the project, a statement of contribution, and a conclusion. The bibliography and appendices are at the end of the thesis.

Chapter 2: Methods

Based on the research questions and objectives of this study, and in consultation with my supervisor, I determined that a multi-methods qualitative study would be the most appropriate approach. Qualitative data collection methods are important for gaining a deep understanding of complex problems and poorly researched areas (Rust et al., 2017). I used a variety of methodology techniques throughout this thesis. To begin, I explain the methodology employed for Article 1, a scoping review on later gestational age abortion in Canada. Following this, I describe the approach and framework used for Article 2, which centered on analyzing data from NAF Canada and Action Canada's toll-free hotlines between April 1, 2019 and March 31, 2021. I continue with a description of the interviews that are the focus of Article 3. I conclude this chapter by discussing my overarching analytical approach and ethical considerations.

2.1 Component I: Scoping review

To gain perspective on the LGA abortion landscape in Canada and as a frame for the overall project, we conducted a scoping review on what is currently known about later abortion care in Canada. Scoping reviews do not aim to produce a critically appraised and synthesized result/answer to a particular question, but rather aim to provide an overview or map of evidence (Munn et al., 2018). This was our goal as a preliminary review of the literature suggested that LGA abortion in Canada is severely understudied. We designed and conducted our scoping review using the framework published by Arksey and O'Malley (2005) and revised by Levac, Colquhoun, and O'Brien (2010). We followed the six-step framework described by Levac and colleagues by: 1) identifying the research question; 2) identifying relevant studies; 3) selecting

studies based on defined criteria; 4) charting the data; 5) collating, summarizing and reporting the results; and 6) consulting with topic experts. We used the PRISMA extension for scoping reviews (PRISMA-ScR) checklist for guidance in the reporting process (PRISMA, 2021).

2.2.1 Data collection

To identify relevant publications, we searched Ovid, Medline/Embase, CINHAL, Scopus, and Sociological Abstracts via ProQuest databases for published studies and abstracts. We chose these databases for relevance on abortion literature and level of interdisciplinarity. We employed a structured inclusion and exclusion criteria process when searching for relevant articles, grey literature, documents and media accounts. We included the resource if it specifically discussed abortion at or beyond 16 weeks' gestation, womxn's experiences seeking or obtaining an abortion, geographical disparities accessing services, and/or any general information providing insight into LGA abortions in Canada. We also included studies that reported on abortion provider training, particularly in the second and third trimesters. Lastly, in order to incorporate additional relevant information, knowledge, and perspectives into our scoping review we engaged topic experts in informal conversations, as described as the optional sixth phase by Levac and colleagues (2010). We spoke with experts in abortion provision, advocacy and education from across Canada to help fill in the remaining gaps left by the review of published source material.

2.2.2 Data analysis

Nineteen published journal articles, 10 grey literature articles (Google Scholar and sexual and reproductive health (SRH) resources), and three newspaper articles published between 1990-2020 (inclusive) met our eligibility criteria. We used Covidence, a web-based tool to help

identify and organize studies relevant to the review. I sequentially screened titles, abstracts and then full-texts for all journal articles in Covidence independently; a post-doctoral fellow in my supervisor's research group reviewed the titles and abstracts as well. For grey literature and articles from the media audit, we extracted information on study objective(s), study population, gestational age studied, reported barriers and experiences, distance travelled by patients, and key findings of the articles, as applicable. We charted all relevant information and conducted thematic analyses for an accurate account of the literature. Lastly, we identified common themes in the informal conversations and incorporated those accordingly.

We reached out over 20 SRH advocacy and justice groups, pro-choice organizations and networks, womxn's SRH academics and LGA abortion providers across Canada. These efforts resulted in informal conversations with six people over the phone and one via email; these seven individuals represented all of the aforementioned sectors. All conversations began with an introduction of the research team, followed by some background on our scoping review, and then individually tailored questions based on the topic expert's background. I then incorporated the salient content from these conversations into the overarching scoping review.

2.2 Component II: Analyzing Canadian hotline data

Two of the national hotlines in Canada – run by NAF Canada and Action Canada, respectively – help callers seeking abortion care navigate the system to obtain needed care. These patient navigation services disproportionately work with those seeking LGA abortion care, as these patients often need assistance and support obtaining care outside of their province of residence or in the United States. My supervisor, Dr. Angel M. Foster, received a Partnership

Engage Grant from the Social Sciences and Humanities Research Council (SSHRC) to work with NAF Canada to understand the impact of the COVID-19 pandemic on abortion care; one part of this project included exploring changes in the use of these national hotlines before and after the onset of the pandemic (SSHRC, 2020). Given that these hotlines serve those seeking LGA abortion care, I coordinated this component of the larger project.

Consistent with both the aims of my thesis and the larger SSHRC-funded project, this study focused on calls to both the NAF Canada and the Action Canada hotlines in the year before (April 1, 2019-March 31, 2020) and the year after the onset of the COVID-19 pandemic (April 1, 2020-March 31, 2021). I was especially interested in calls about LGA abortion care and whether or not there were changes in the types of callers and requests for help navigating later abortion services after the onset of the pandemic

2.1.1 Data collection

Personnel of the NAF Canada and Action Canada hotlines record information about each call in a paper logbook. During the call, the NAF Canada or Action Canada hotline staffers manually recorded data on caller demographics, patient location, facility for procedure, gestational age at the time of the call, pledge amount from either NAF Canada or Action Canada, use of Hope Air[1], a column for special circumstances or additional notes, and follow-up as applicable. We received date from both organizations for the two-year study period. We transferred these data to a Microsoft Excel® spreadsheet.

2.1.2 Data analysis

[1] Hope air is a national charity that provides Canadians in need of medical care "far from home" with travel and accommodations.

We analyzed these data using descriptive statistics (frequencies, cross-tabulations) to characterize callers and outcomes. We also reviewed written comments and analyzed these for content and themes. We reached out to those responsible for the two hotlines when we had questions about specific cases or needed clarification or more information.

To identify the changes during the COVID-19 pandemic, we separated data into two time periods: prior to the onset of COVID-19 (April 1, 2019-March 31, 2020) and after the onset of the COVID-19 pandemic (April 1, 2020-March 31, 2021). We looked for differences between these two time periods in the total number of calls, number of people who travelled from Canada to the US for abortion care, average distance travelled for abortion services before, and average wait time for the first appointment. We explored these data, and changes in these data, for each hotline as well as for both hotlines.

2.3 Component III: Interviews

For this thesis, I worked with three types of interview data. First, I conducted in-depth interviews (IDIs) with participants from the Maritimes who sought or obtained an abortion at or beyond 16 weeks' gestation. Second, I engaged with interviews from a large-scale, national qualitative study conducted by Dr. Foster and her research group, the Canada Abortion Study (CAS), in order to more fully explore womxn's experiences seeking and obtaining later abortion care. Lastly, I conducted key informant (KI) interviews to incorporate the perspectives of clinicians and advocates working the LGA abortion space.

2.3.1 De novo in-depth interviews

In order to understand better womxn's experiences seeking or obtaining an abortion at or beyond 16 weeks' gestation in the Maritimes, we aimed to recruit 30 womxn from the Maritimes; 10 from NB, 10 from NS and 10 from PEI to interview. To cast the widest array of participants, I used a multi-modal recruitment strategy that included posting on classified sites such as Kijiji and Reddit, posting on various social media websites such as Facebook, Instagram and Twitter, asking clinics and community organizations in NB, NS, and PEI to share the study materials, circulating a study announcement on relevant listservs, and using word of mouth throughout communities. These recruitments efforts were both in English and French and included non-gendered language. As a result of this strategy, in the fall of 2021, I ultimately conducted three English in-depth interviews (IDIs) with women from the Maritimes (all from NB) who obtained abortion care.

I conducted these interviews using a semi-structured interview guide via Zoom-audio, Skype, and telephone. Domains of inquiry included: participant demographics, reproductive health and pregnancy history, information about the index pregnancy and the abortion decision-making process, experiences seeking and/or obtaining an abortion past 16 weeks, the abortion experience, and perspectives on how services could be improved in the Maritimes. I audio recorded all interviews with permission and transcribed verbatim with the help of volunteer; I memoed after each interview and took notes during the encounter. The interviews averaged 40 minutes in length. Each participant received a CAD40 gift card to Amazon.ca as an expression of gratitude for participating. Although my aim had been to reach thematic saturation with the desired 30 participants, recruitment proved to be extremely challenging as the targeted pool of

potential participants is incredibly small. Thus, I was not able to reach thematic saturation and was not able to make claims based on this small sample.

2.3.2 Canada Abortion Study interviews

The Canada Abortion Study (CAS) is a multi-methods qualitative study conducted by Dr. Angel M. Foster and her research team from 2012 to 2016 that documented women's abortion experiences in Canada prior to the introduction of mifepristone (Cano & Foster, 2016; Foster et al., 2017; Foster et al., 2020; LaRoche & Foster, 2017; LaRoche & Foster, 2018; LaRoche & Foster, 2018; Vogel et al., 2016). The CAS included 305 in-depth, semi-structured interviews with Anglophone and Francophone women who resided in all provinces and territories at the time of the procedure. They followed the same procedure as I did by using a multi-modal recruitment strategy, having an interview guide with similar domains of inquiry, recoding the interviews with permission, and transcribing them verbatim. The research team also compensated their participants with a CAD40 gift card to Amazon.ca.

I reviewed the CAS dataset and identified 12 interviews with participants who obtained an abortion at or beyond 16 weeks gestation. This sample of the CAS dataset included 11 English and 1 French with women residing in Alberta, British Columbia, Newfoundland and Labrador, and Quebec in addition to all three of the Maritime provinces. I added these interviews to the three interviews I conducted specifically for this study; the combined data set yielded 15 interviews with women from seven provinces who had a total of 16 abortions at or beyond 16 weeks gestation.

2.3.3 Key informant interviews

I also conducted key informant (KI) interviews to collect information from a wide range of professionals who have first-hand knowledge of abortion care in Canada. I aimed to interview a diverse array of individuals working in the SRH and abortion provision fields, both in the Maritimes and nationally. Using publicly available information, the professional network and personal connections of my supervisor, and early participant referral, I contacted dozens of individuals and agencies in the spring of 2022. Between April and May 2022, I conducted 12 English interviews with experts including LGA abortion providers, pro-choice activists and consultants, representatives from advocacy groups, abortion doulas, and abortion providing nurses and staff centers. This allowed me to obtain a range of perspectives.

After obtaining consent from the participant, I audio-recorded the phone/Zoom interviews for later transcription. I also took notes during the interview and wrote analytic memos after the encounter. The interview followed a semi-structured interview guide which was tailored to each key informant depending on their position and geographical location. I asked KIs about demographics, professional background, motivations for entering the field, experiences as abortion providers or activists (as applicable), opinions and recommendations on the gestational age limit restrictions in the Maritimes and later abortion care in Canada, and ways that later abortion care can be improved. The interviews averaged 35-40 minutes in length.

2.3.3 Data analysis

I analyzed both the IDI (combined de novo interviews and CAS interviews) and the KI interviews for content and themes. Based on my knowledge of the field, the interview guides,

and the other components of this project (the scoping review and hotline analysis) I developed an initial codebook. I then used an iterative process to add more codes and categories as I familiarized myself with the data (Elo & Kyngäs, 2008; Nowell & Norris, 2017). I then used a multi-phase analysis approach to code and categorize content, explore relationships between ideas and concepts, and identify themes. Analysis was an iterative process and I used both deductive and inductive techniques throughout and drew from transcripts, notes, and memos. Because both datasets were relatively small, I did not use qualitative data management software to organize my data and instead relied on my judgment to make claims and recommendations (Nowell & Norris, 2017). In the final analytic phase, I compared the themes from the two datasets for concordance and discordance. I was also able to then examine my interpretation of the findings in light of the other components of the thesis.

2.4 Ethical considerations

This project received approval from the Social Sciences and Humanities Research Ethics Board (REB) at the University of Ottawa. We have provided copies of the relevant certificates in Appendix A.

Chapter 3: Later gestational age abortion in Canada: A scoping review

We submitted this article to the *Canadian Journal of Human Sexuality*. The article conforms to the structural, word count, and formatting requirements of this peer-reviewed journal.

Later gestational age abortion in Canada: A scoping review

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Running title: Later gestational age abortion in Canada

Later gestational age abortion in Canada: A scoping review

Abstract:
Since the decriminalization of abortion in Canada in 1988, there have been no legal restrictions on when in pregnancy an abortion can take place. However, abortion care is only available in Canada up to 23 weeks and 6 days; women, transgender men, and gender non-binary individuals who need post-viability abortion care typically obtain services in the United States. Further, abortion care beyond 16 weeks is unavailable in some regions of the country. We undertook this scoping review to explore what is currently known about later gestational age (LGA) abortion in Canada. We followed the six-stage scoping review framework developed by Arksey and O'Malley (2005) and revised by Levac, Colquhoun, and O'Brien (2010). We identified 32 relevant sources that were published in the last 30 years and we consulted with seven topic experts to validate the findings from our document synthesis. The body of literature on LGA abortion in Canada shed light on the safety of both medical and instrumentation procedures, the type and training of abortion-providing clinicians, the characteristics of those obtaining abortion care after the first trimester, and geographic disparities in service availability. Our topic experts emphasized the need for future research on patient experiences and developing and implementing strategies to help provinces and territories expand abortion care to later in pregnancy and improve comprehensive reproductive health services.

Keywords: Abortion, Canada, late-term abortion, sexual and reproductive health, scoping review

Introduction

Canada is one of a very small number of countries that has fully decriminalized abortion and there are no gestational age limits on when women, transgender men, gender non-binary individuals, and Two-Spirit people (womxn)[2] with the capacity for pregnancy can obtain an abortion (Long, 2020; Sabourin & Burnett, 2012). The abortion rate in Canada has been relatively steady at approximately 14.5 abortions per 1,000 women aged 15-44 and 90% of abortions in Canada occur in the first trimester (Shaw & Norman, 2020; Action Canada, 2019; Norman et al., 2016). However, some womxn need services after 12 weeks gestation (Action Canada, 2019; Abortion Rights Coalition of Canada, 2019). Indeed, the Canadian Institute for Health Information (CIHI) reported that of the 30,799 abortions that took place in Canadian hospitals during 2016, approximately 10% of them occurred after 12 weeks gestation (CIHI, 2018).

The federal government has long defined abortion as a medically necessary service and thus provincial and territorial health insurance schemes must cover this care (Norman et al., 2016; Government of Canada, 2017). However, inequities in access to abortion services persist and there is considerable geographic variability in cost coverage and the location of providers (Shaw & Norman, 2020; Government of Canada 2017). For example, provincial health insurance does not cover procedural abortions provided by clinics in New Brunswick (Foster et al., 2017) and most abortion providers are located near the Canada-United States border (Sabourin & Burnett, 2012).

[2] We use the term womxn to both acknowledge that the vast majority of those who need, seek, and obtain abortion care identify as women and girls and recognize that anyone who is pregnancy capable may need, seek, or obtain an abortion. When referring to published studies and government statistics we preserve the language used in the original source.

There is also tremendous geographic variability in the availability of abortion services at different gestational ages. As of 2021, there were only four service locations in Canada that provide abortion care and services up to 23 weeks and 6 days gestation, all of which were located in urban centers (Abortion Rights Coalition of Canada, 2021). In the Maritimes, there are no abortion provides who offer services after 16 weeks (Action Canada, 2019). This variability in later gestational age (LGA) abortion availability is not limited by law but is instead influenced by institutional regulations, provider training, and funding (Johnstone & Macfarlane, 2015; Sethna & Doull, 2012; Shaw, 2010).

As a result, Canadian womxn needing LGA abortion care, especially those living in the Maritimes and in northern and rural areas, often have to travel considerable distances to obtain needed services (Sethna & Doull, 2013). Canadians who need post-viability abortion care often travel to the United States for services (Action Canada, 2019). Inter-provincial and international travel for abortion care can result in delayed care and increased costs and can influence the need for and timing of disclosure (Sethna & Doull, 2012; Cano & Foster, 2016; Foster et al., 2017).

However, few studies in Canada have focused specifically on LGA abortion care. A body of research indicates that Canadian womxn face economic, social, and facility-type barriers when seeking first trimester procedural and medication abortion care (Norman et al., Cano & Foster, 2016; Foster et al., 2017; LaRoche & Foster, 2020; LaRoche et al., 2020; Hukku et al., 2022). These barriers are likely even more pronounced for those seeking care at later gestational ages. Further, those seeking LGA abortion care include a larger proportion of womxn with wanted pregnancies who make the decision to have an abortion because of maternal or fetal health conditions (Boland, 2010; Abortion Rights Coalition of Canada, 2020). But few published studies explore Canadian womxn's decision-making or experiences seeking and obtaining LGA

abortion care. We undertook this scoping review to understand better what is known about abortion care after 16 weeks gestation in Canada, document gaps the existent literature, and identify priority areas for future research.

Methods

We used the framework published by Arksey and O'Malley (2005) and revised by Levac and colleagues (2010) to develop our scoping review protocol. This six-step process began with identifying our research question. We then identified relevant studies, selected studies based on specified criteria, charted the data, and collated, summarized, and reported the results. The sixth and final step involved consulting topic experts to solicit feedback on our findings from the document synthesis and obtain a range of perspectives on future research priorities. The PRISMA extension for scoping reviews (PRISMA-ScR) checklist guided the way we reported our findings (PRISMA, 2021).

Eligibility criteria and data sources

Our primary research question was: What do we know about later gestational age abortion in Canada? Our secondary research questions centered on understanding the role of geographically bounded policies in shaping access to LGA abortion care, facilitators and barriers to seeking and obtaining LGA abortion care in Canada, and Canadian womxn's experiences with LGA abortion care. To identify the relevant studies, we searched for published sources in Ovid, Medline/Embase, CINHAL, Scopus, and Sociological Abstracts via ProQuest databases. We chose these databases for their relevance to the abortion literature and level of interdisciplinarity. We developed broad inclusion and exclusion criteria related to general topic (later gestational

age abortion care), geography (Canada), language (English or French), and year of publication (1990-2020, inclusive). We present these criteria on Table 1. We intentionally included all article types (original research articles, commentaries, editorials, letters, etc.), study types (qualitative, quantitative, experimental, observational, etc.), and publication types (peer-reviewed, refereed, non-peer reviewed, commissioned, etc.) included in these databases. We did not critically appraise source material and we did not exclude publications based on quality.

[Table 1 about here]

We also conducted a media audit to include journalistic accounts of LGA abortion care in Canada in the scoping review. We used two media databases, Factiva and Canadian Major Dailies, to search for relevant newspaper and magazine articles using the same inclusion and exclusion criteria on Table 1. We also used Google Scholar to identify additional source material, including reports and other grey literature. For each search we captured the first 100 unique sources (typically 10 pages of search results) that the platform determined as most relevant. We then reviewed these listings and applied our inclusion and exclusion criteria. Finally, based on our knowledge of the field and the Google Scholar search results, we reviewed the content of multiple Canadian sexual and reproductive health (SRH) organizations' websites for additional source material.

Our scoping review centers on later gestational age abortion care. However, "later gestational age" is variably defined (Guttmacher Institute, 2019). Common terms include second trimester, third trimester, post-viability, late, later, and later gestational age; other publications list specific gestational ages, in weeks from the first day of the last menstrual period. For the

purpose of this scoping review we defined LGA as at or beyond 16 weeks gestation, as this is the gestational age limit of care available in the Maritimes (Action Canada, 2019) and thus has policy relevance in the Canadian context. However, we included source material that used other terms (such as late or later) even if the gestational age was not specified.

Search strategy

In order to identify relevant studies and media articles, we used a series of key words and terms when searching in the databases. Although we adapted our search terms to each database, our general strategy included use of 10 primary terms and their variations: abortion, induced abortion, termination of pregnanc*, second/third pregnancy trimester, late/second/third/last trimester/term/stage, medical method*, dilation and evacuation, abortion delay, Canada (as well as all individual provinces and territories). We provide an example search string in Table 2. To increase search sensitivity, we did not apply date and language restrictions during database searches. Instead, we applied our inclusion/exclusion criteria after executing the search. For our search for source material in Google Scholar we streamlined our strategy and used various terms for "later gestational age" combined with "abortion" and "Canada." We set the date range manually. Finally, we conducted a "hand-search" of the reference lists on sources we identified from the databases, Google Scholar, and organizational websites to find relevant references that we had missed.

[Table 2 about here]

Study selection

CD and AD reviewed all titles and abstracts that we identified through our database searches. When abstracts were not available, we reviewed the opening paragraph of the source. We included for full text review all source materials that centered on LGA abortion care in Canada and met the other inclusion criteria. At this stage we eliminated duplicate sources. CD and AD then independently reviewed the full texts of all source material that passed the initial screen. We selected those sources that after the full text review met all inclusion criteria; we resolved disagreements through discussion. AMF was available to adjudicate cases that could not be resolved but this was not necessary. We used Covidence, a web-based tool, to manage our data.

Data extraction and synthesis of results

We used Microsoft Excel® to chart information about the included articles and conducted a descriptive numerical summary of course material characteristics. We extracted information on publication type, article type, and year, venue, and language of publication. We also charted information about the population, gestational age, and geographic focus of the source material. We reviewed each source and summarized its content, making specific note of key points or issues raised. We then reviewed the corpus of sources for categories of content, themes, and missing or absent content. This process allowed us to synthesize the results and characterize the body of relevant literature.

Consultation phase

We consulted topic experts to gain additional insight into what is known about LGA abortion in Canada, the gaps in existing research, and priorities for policy reform, service

delivery, and research. We reached out to over 20 SRH advocacy and justice groups, pro-choice organizations and networks, SRH-focused researchers and academics, and LGA abortion providers across Canada; we identified these topic experts based on publicly available information, information generated during the document review, our knowledge the abortion landscape in Canada, and AMF's professional network. Over a three-week period in 2021, CD had phone conversations with six topic experts and a series of email exchanges with a seventh. These individuals included researchers, providers, advocates, and organizers.

We used the preliminary findings from the first five stages of the scoping review as the foundation of the conversation. After explaining the purpose of the project and summarizing the preliminary scoping review findings, CD asked for initial reactions to the findings and then a series of open-ended questions related to LGA abortion care tailored to the specific expert. The conversations lasted 15-20 minutes and CD audio-recorded and transcribed them verbatim. We then analyzed these transcripts and the email exchange for content and themes. We have incorporated salient findings into the scoping review.

Results

PRISMA outline

Our search strategy yielded a total of 281 articles from the scientific databases and 132 articles from the media audit, Google Scholar, and hand searches of reference lists. For the identification of articles in scientific databases, after removing 45 duplicates we screened 236 entries via title and abstract. We then reviewed the full texts of 46 studies; 19 of these met our inclusion criteria. We identified a total of 132 records through our media audit, Google Scholar and hand searches; 13 of these sources met our inclusion criteria. We obtained these sources

from the media audit (n=3), Google Scholar (n=4), and SRH organization websites (n=6). In total, we included 32 sources in our scoping review (see Fig. 1).

[Figure 1 about here]

Article and document characteristics

We provide information about the characteristics of our source material on Table 3. Of the 23 peer-reviewed journal articles, the majority (n=12) reported on the findings from quantitative studies, followed by literature reviews (n=6), and qualitative studies (n=2). Most of the sources focused on the national later gestational age abortion landscape in Canada (n=17) or on one of three provinces (British Columbia, Ontario, or Quebec). About half of the sample (n=15) focused on abortion in Canada at all gestational ages, including later gestational age abortion. Notably, none of peer-reviewed journal articles included direct quotes from or narratives about Canadian abortion seekers whereas this was a prominent feature of media accounts (data not shown).

[Table 3 about here]

Findings from the synthesis

A synthesis of the source material provides insight into the safety of abortion care after the first trimester, the providers of LGA abortion care, the characteristics of those who seek and obtain LGA abortion care in Canada, and geographic disparities in service availability. We provide a brief summary of the research published on LGA abortion care in Canada in Table 4.

[Table 4 about here]

Safety of abortion care after the first trimester in Canada: Both dilation and evacuation (D&E) procedures and induction with misoprostol (with or without mifepristone) are used for abortion care in the second trimester of pregnancy in Canada (Lalitkumar et al. 2007; Grossman, et al. 2008; Guan, 2017; Mitchell, 2014). Which option is offered depends on gestational age, provider training, patient condition, and patient preference; the latter is particularly important with regard to seeing and engaging with fetal remains (Mitchell, 2014). However, no information is available about the specific techniques used in post-viability or third trimester abortion care in Canada.

The available literature confirms that abortion after the first trimester is extremely safe in Canada and serious complications are relatively rare (Grossman, et al. 2008). A study by Jacot and colleagues (1993) conducted at a single facility found that the risk of complications was similar for abortions performed before and after the first trimester. However, a province-wide study by Ferris and colleagues (1996) found that the risk of complications increased with increased gestational age; this finding is consistent with the broader literature (Grossman et al. 2008). In order to reduce the risk of complications associated with medical abortion after the first trimester, Canadian physicians will often administer a feticidal agent prior to induction (Abortion Rights Coalition of Canada, 2018). This has been flagged by anti-abortion advocates as an indication that fetuses are capable of feeling pain in utero (Abortion Rights Coalition of Canada, 2020). Thus, some of the sources included in this scoping review also explore issues related to fetal pain.

Providers of LGA abortion care in Canada: In Canada, all induced abortions over 20 weeks gestational age take place in hospitals (Shaw & Norman, 2020; Abortion Rights Coalition of Canada, 2019). A survey conducted in 2012 identified 37 facilities in the country that provide second trimester instrumentation and medical abortion care (Guan et al. 2017). In 2021, there were four facilities in Canada providing abortion care and services up to 23 weeks and 6 days gestation and no providers offering services after 24 weeks gestation (Abortion Rights Coalition of Canada, 2021).

About 300 clinicians provide abortion care in Canada (Shaw & Norman, 2020) and more than half these clinicians in Canada are family physicians or general practitioners (Norman et al. 2016). The lack of routine training of medical students and residents may account for the relatively small number of abortion-providing clinicians (Liauw et al. 2016; Myran et al. 2015; Roy et al. 2006; Ferris et al. 1998;). A study published in 2006 found that half of the obstetrics and gynecology residency programs did not routinely integrate abortion into the curriculum (Roy et al. 2006). More recent evidence suggests that abortion training opportunities have decreased (Liauw et al. 2016; Myran et al. 2015) and that the overall decrease in medical students entering family medicine in Canada also has an impact on the future pool of abortion-providing clinicians (Myran et al. 2015; O'Connell et al. 2008).

Most Canadian physicians hold positive attitudes towards the legality and availability of abortion in Canada (Myran et al. 2015; Shaw & Norman, 2020). However, medical students' intentions to provide abortion services are considerably weaker than their support for the availability of abortion (Myran et al. 2015). This is especially true with abortion beyond the first-trimester (Myran et al. 2015; Liauw et al. 2016). Studies indicate that hesitancy to provide abortion care after the first trimester is due to anticipated harassment, concern about protesters,

concern about social opposition, and conscientious objection (Bundale, 2017; Levesque, 2020; Myran et al. 2015; Shaw & Norman, 2020).

Characteristics of those seeking LGA abortion care in Canada: About 10% of abortions in Canada take place after the first trimester of pregnancy (CIHI, 2018). However, there is little published information about the number of abortions that occur at more specific gestational ages (Auger et al. 2012). Several studies indicate that young and single women with lower educational attainment and those who already have children at more likely to have LGA abortions than their older, married, nulliparous counterparts (Wadhera & Millar, 1994; Guilbert, 1994; Boland, 2010). Patients seeking abortion care for a later abortion are often subjected to enhanced externalized stigma, regardless of their reason for the abortion (Boland, 2010). Those seeking LGA abortion care in Canada may also be more likely to experience multiple unintended pregnancies, a dynamic that further exacerbates social and economic disadvantages (Norman et al. 2011). Researchers have suggested that expanding access to intrauterine devices (IUDs) after a second-trimester abortion could be highly effective at preventing future unintended pregnancies (Norman et al. 2011).

Geographic disparities in service availability: Significant urban-rural disparities exist with respect to the availability of abortion services in Canada, as most facilities are concentrated in large urban centers (Shaw & Norman, 2020; Liauw et al. 2016). A 2013 examination of geographical disparities in abortion access in Canada found that 18.1% of women travelled more than 100 km to access abortion services (Sethna et al. 2013; Shummers et al. 2019). This was especially the case for those seeking abortion care beyond the first trimester (Sethna et al. 2013; Guan et al. 2017; Abortion Rights Coalition of Canada, 2020). The majority of facilities providing second trimester abortion care are in Quebec (Guan et al. 2017; Action Canada for

Sexual Health & Rights, 2019) and those outside of Quebec are concentrated along the Canada-United States border (Shaw & Norman, 2020).

Consultation phase findings

We spoke with three LGA abortion providers, three directors/executives of pro-choice networks and advocacy groups, and one womxn's sexual and reproductive health research in Canada. All topic experts currently or previously held senior positions within their organizations/institutions and resided in British Columbia, Nova Scotia, or Ontario. All had experience helping abortion seekers who were past the gestational limit in their region access needed abortion care.

Our topic experts all recognized that LGA abortion care has received scant attention and thus the central finding of our scoping review – that very few studies exist that focus on abortion after 16 weeks gestation – was not a surprise. Indeed, most noted that they were not familiar with any studies specifically focused on LGA abortion in Canada. After describing our preliminary findings from the document synthesis, all seven topic experts agreed that there are major gaps in what we know about LGA abortion in Canada. Topic experts felt there was a need for both quantitative information, broken down by gestational age and province, on the number of LGA abortions provided in Canada, the number of abortion seekers who travel out-of-province and out-of-region for care, and the number of abortion seekers who travel to the United States for care. As one expert explained: "If we can't quantify the problem, how can we fix it?" Topic experts felt there was also a significant need to document womxn's experiences obtaining LGA abortion care. Several topic experts felt that it was important to specifically focus on the issue of stigma, both internalized and externalized, among those obtaining LGA abortion care.

Our topic experts also discussed priorities for addressing service delivery gaps. All agreed that the geographic disparities in the availability of LGA abortion providing facilities, particularly beyond 16 weeks gestation and in rural areas, required federal and provincial attention and well as concerted efforts within medical schools and residency programs. Several specifically focused on the lack of abortion services after 24 weeks gestation as being an increasing problem. As one expert explained, "Until progress is made towards post-24-week care being available within Canada, provinces and territories should have robust 'out-of-country' travel processes that support individuals to make a plan to get the care they need." Finally, our topic experts also referenced a number of non-abortion related policies and services that should be prioritized This included providing universal cost coverage for a full range of contraceptive methods and expanding and improving sexual education in schools.

Discussion

Taken together the articles and reports in our scoping review begin to paint a picture of the LGA abortion care landscape in Canada. Abortion care beyond the first trimester in Canada includes both instrumentation and induction procedures and is extremely safe. However, the availability of services is concentrated in urban areas and a small number of provinces. Clinicians and clinicians-in training are generally supportive of decriminalized abortion but training, especially at more advanced gestational ages, is not routine and intention to provide wanes as gestation increases.

But the literature on LGA abortion care is minimal. Notably, there is almost no research that focuses on Canadian womxn's lived experiences seeking and obtaining later abortion care. Given the decriminalized status of abortion in Canada, this is a missed opportunity to understand

better decision-making, care seeking, and health system navigation. Although several studies speculated on barriers to accessing LGA abortion care, the absence of womxn's voices is striking. Engagement with those who seek and obtain LGA abortion care, as well as those who provide that care, offers an opportunity to explore both internalized and externalized stigma. Researchers in the United States have developed validated abortion stigma measures to more fully explore the complex issue of stigma (Cockrill et al. 2013; Cockrill & Nack, 2013; Wollum et al. 2021). However, these tools have not been used among Canadian womxn and have not specifically focused on LGA abortion care. Applying and adapting these tools could be an important first step.

The biggest barrier that Canadian womxn face when seeking an LGA abortion is finding a qualified provider. Because of the lack of post-viability providers in-country, womxn needing abortion care after 24 weeks typically travel to the United States. Because abortion is defined as a "medically necessary" health services most Canadian womxn receive cost coverage for the out-of-country abortion procedure (Connolley & Browne, 2019). However, womxn are often required to cover the travel and accommodations costs out-of-pocket; some seek assistance from Canadian charities (Connolley & Browne, 2019; Action Canada for Sexual Health & Rights, 2019; National Abortion Federation, 2022). Recent reports indicate that the financial, travel, and logistical challenges with seeking cross-border care have been exacerbated by the pandemic (Connolley, 2021; Abortion Rights Coalition of Canada, 2021). And for womxn residing outside of Canada's urban centers, these expenses are often even greater. However, little information is included in the literature about this sub-population of abortion seekers, including information about the supports that they need to obtain care. Our topic experts identified this as a significant

gap in current knowledge of LGA abortion care in Canada and a priority area for future research and service delivery reform.

One of the more challenging aspects of undertaking this review involve the lack of consensus as to what constitutes a "later gestational age" abortion. In the Canadian context, 13 weeks, 16 weeks, and 24 weeks all have specific relevance, as these represent specific provincial/territorial, regional, and national gestational age limits. However, these terms do not map cleanly to the trimester framework. In order to engage with the literature, we used a variety of terms and use the phrase "later gestation age" in this paper. However, as a number of researchers have previously noted, terminology surrounding abortion care is problematic and confusing (Grimes & Stuart, 2010; Cha, 2019; LaRoche & Foster 2018; Rinkunas, 2020; Weitz et al., 2004). Moving toward a consensus on language, and terms that really focus on weeks of gestation rather than other classification systems, could be beneficial for future research.

Limitations

We attempted to use clear and consistent search terms to identify relevant literature. However, we may have missed sources that used more general key words to define their geographic scope or topical focus. We also intentionally did not critically appraise studies and thus we are unable to comment on the quality of the studies we identified. We made the decision to use Google Scholar rather than Google for our Internet search; we may have missed lay accounts and other non-peer-reviewed reports using this strategy.

Conclusion

Our scoping review highlighted what is known about LGA abortion in Canada and some of the barriers Canadian womxn face when seeking care. However, there is little research on this topic and the picture is incomplete. Further research, especially on the number of procedures (with details on gestation age, province of residence, and location of provider) and on womxn's and providers' experiences, is warranted. There is a missed opportunity to study womxn's experiences to help improve existing services and understand better the intersection between LGA abortion care and stigma. Focusing on the sub-population of abortion seekers who obtain abortion care in the United States could be an important first step in both research and service delivery reform. Finally, working to develop better terminology to describe later gestational age abortion care appears warranted.

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Figure 1. PRISMA-ScR flow diagram of study selection for this scoping review of later gestational age abortion in Canada

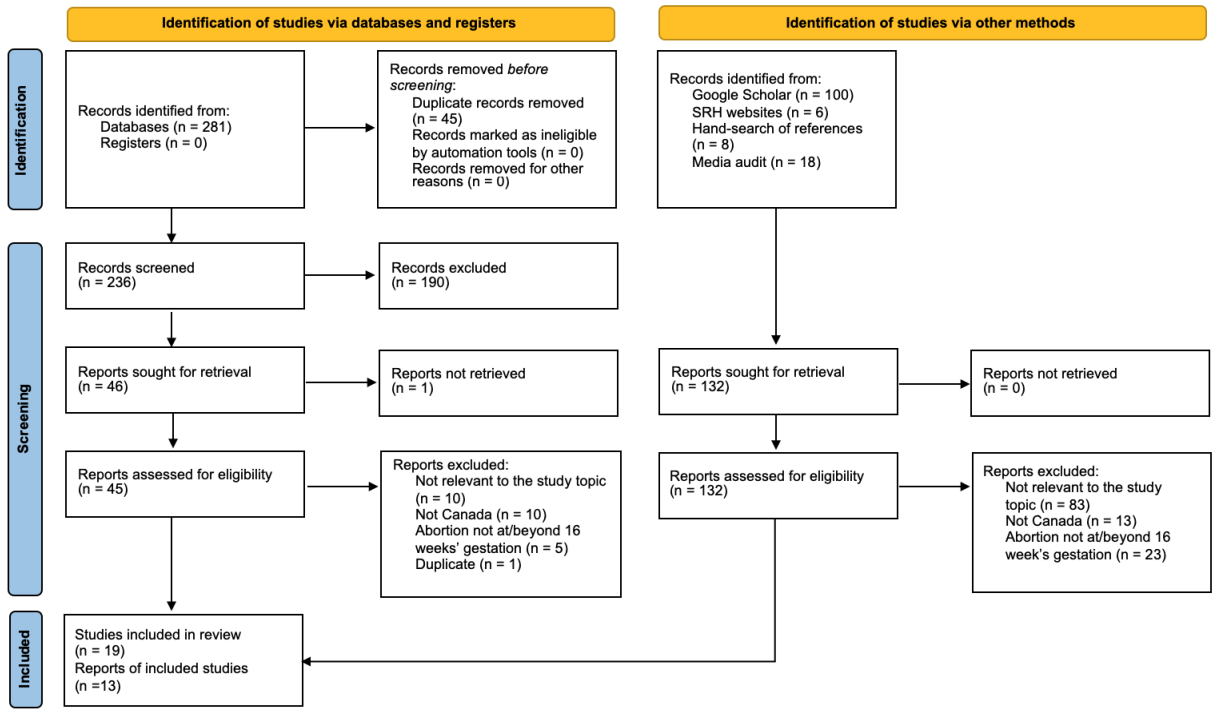

Table 1. Inclusion and exclusion criteria for published source material included in this scoping review

Inclusion criteria	Exclusion criteria
Focused on later gestational age abortion (at 16 weeks gestation or beyond)	Focused on abortion before 16 weeks gestation
Published between 1990-2020 (inclusive)	Published before 1990
Focused on Canada or includes Canada	Focused on a country other than Canada
Published in English or French	Published in a language other than English or French

Table 2: Example search strategy for databases included in our scoping review

Step	Term used in Ovid (Medline)
1	exp abortion, Induced/
2	abortion.ti,ab.
3	(termination adj3 pregnanc*).ti,ab.
4	or/1-3
5	pregnancy trimester, second/ or pregnancy trimester, third/
6	((late or second or third or last) adj3 (trimester? or term? or stage)).ti,ab.
7	(medical adj1 method*).ti,ab.
8	(dilation and evacuation).ti,ab.
9	(abortion adj1 delay).ti,ab.
10	or/5-9
11	4 and 10
12	exp Canada/
13	(Alberta or Ontario or Manitoba or Saskatchewan or Quebec or British Columbia or Nova Scotia or Prince Edward Island or New Brunswick or Northwest Territories or Nunavut or (Newfoundland and Labrador) or Yukon).ti,ab.
14	12 or 13
15	11 and 14
Results	**38**

Table 3: Characteristics of the documents included in our scoping review on later gestational age abortion in Canada (N=32)

Characteristic	Frequency
Type of source material	
Article in peer reviewed journal	23
News article	4
Other documents/websites	5
Research method	
Literature review	6
Qualitative study	2
Quantitative study	11
Other/not applicable	12
Geographic focus	
Canada (national)	17
Ontario	2
Quebec	6
British Columbia	2
International focus that includes Canada	5
Gestational age focus	
All gestational ages	15
Up to 16 weeks	2
First and second trimester (up to 27 weeks)	4
Second trimester (13 weeks to 27 weeks)	4
Second and third trimester (13 weeks to 40 weeks)	6
Other	1

Table 4. Summary of studies published in peer-reviewed journals on later gestational age abortion care in Canada (N=19)

Author & year	Aim/objective	Study design	Geographic area	Gestational age	Key findings
Auger et al. (2012)	To document later abortions from 1981 to 2006.	Quantitative	Quebec	16 weeks to 37 weeks	Later abortions do occur in Quebec, but are not very common. The increased amount of later abortions needs further investigation.
Boland (2010)	To review the laws of 191 countries and categorize them by legal indications.	Literature review	International (Canada mentioned)	Through 28 weeks	Most countries do not decriminalize all abortions. The wording of laws is not always clear and many laws are silent on second trimester abortion.
Flanagan (1997)	Explores the attempted legislative response to the R v. Morgentaler decision and how this reflects principles of rational choice theory.	Literature review	Canada	All gestational ages	The Morgentaler decision fragmented the major blocs (pro-choice, compromise and pro-life) and exposed weakness in the House of Commons and the Senate.
Grossman et al. (2008)	To review literature comparing dilation and evacuation and medical induction using misoprostol alone or a combination of mifepristone and misoprostol.	Literature review	International (Canada mentioned)	13 weeks to 26 weeks 6 days	Second trimester abortion is associated with higher rates of complications compared to first trimester terminations. The absolute risk is low when the termination is reported during the second trimester, irrespective of method. In the one dilation and evacuation study reported in Canada with 547 cases between 15-20 weeks gestation <2% of women had complications.
Guan et al. (2017)	To describe second-trimester surgical and medical abortion practices in Canada.	Quantitative	Canada	13 weeks to 26 weeks 6 days	47% of respondent facilities provided second-trimester abortions. Of the 167 physicians, 87 (52%) performed second-trimester abortions. Among those 87, 22 (25%) provided both surgical and medical options. Second trimester abortion facilities were unevenly distributed.
Guilbert et al. (1994)	To investigate decision-making factors associated with obtaining a second trimester abortion.	Quantitative	Quebec	Up to 16 weeks	The major determinant of second-trimester abortion is patient age. Women whose abortions were delayed were either due to personal request or the clinic schedule.
Jacot et al. (1993)	To compare the complication rate between first-trimester aspiration/curettage procedures and second trimester dilation and	Quantitative	Quebec	Between 5 weeks and 20 weeks	The overall surgical complication rate was extremely low: 5.1% in the <15 week group compared to 2.9% in the >15 week group. Infection was the most frequent complication, occurring very rarely. In most cases infection was mild.

	evacuation procedures in the same clinic setting.				
Lalitkumar et al. (2007)	To provide a review of the current literature of mid-trimester abortion methods with respect to efficacy, side-effects, and acceptability.	Literature review	International (Canada mentioned)	Through 24 weeks	Treatment with mifepristone-misoprostol is a safe and effective method for mid-trimester medical abortion. Abdominal pain is one of the most side effects of abortion. Pain ranges from mild to severe, depending on which type of abortion procedure the patient receives.
Liauw et al. (2016)	To evaluate the current state of abortion training in Canadian obstetrics and gynecology residency programs.	Quantitative	Canada	First and second trimester (up to 26 weeks 6 days)	By the end of residency, most residents expected to be competent in providing first-trimester surgical abortion care and some expected to be competent in second-trimester surgical abortion care. 69% desired more abortion training during residency.
Kornegay (2011)	To explicate and evaluate the roles that fetal metaphysics and moral status play in Rosalind Hursthouse's abortion ethics.	Literature review	International (Canada is mentioned)	All gestational ages	This essay argues that Hurthouse's classification of the late-term abortion fetus as a human being is incorrect.
Mitchell (2014)	To explore the social, material, and interpretive strategies mobilized to create fetal visibility after second trimester abortion for fetal anomaly.	Qualitative	Canada	Between 18 weeks and 24 weeks	Prior to the termination, about half of the 19 women had not wanted to see the fetus, 6 were certain they wanted to see, and 3 were undecided. In the end, about two thirds of the women saw the fetal remains. Seeing the remains, and in particular the impairment, relieved several women's concerns. Some women reported that hospital practices made it hard to decline viewing. Some women preferred the pain as a reminder of what happened.
Myran et al. (2015)	To assess the attitudes and intentions of medical students toward abortion training and future provision.	Quantitative	Ontario	All gestational ages	Students surveyed held significantly more positive attitudes toward first trimester medical abortions than toward second trimester surgical abortions.
Norman et al. (2011)	To examine whether intra-uterine device placement immediately post second trimester abortion or 4 weeks later resulted in fewer pregnancies at 1 year follow up.	Quantitative	British Columbia	Up to 16 weeks	Immediate intra-uterine device insertion after second trimester abortion reduced pregnancy at one year follow-up more than insertion 4 weeks after the abortion.
Norman (2012)	To assess abortion services among rural and urban abortion providers in British Columbia	Qualitative (abstract)	British Columbia	All gestational ages	98% of second-trimester abortions were performed in 3 urban areas. 41% of rural facilities offered second trimester abortion care and 4% of rural providers offered abortion care after 16 weeks only for fetal indications.

Norman et al. (2016)	To determine the location of Canadian abortion services relative to where reproductive-age women reside, and the characteristics of abortion facilities and providers.	Quantitative	Across Canada	All gestational ages	Abortion facilities are primarily located in large urban centers except British Columbia and Quebec where they were more equitably distributed. No facilities provided abortion care on Prince Edward Island. Nearly half of all identified facilities were in Quebec.
O'Connell et al. (2008)	To assess the second-trimester surgical abortion practices of National Abortion Federation members in North America and Australia.	Quantitative	Canada, United States and Australia	All gestational ages	13 of 16 Canadian clinics reported performing an estimated of 1,850 dilation and evacuation procedures.
Shaw et al. (2020)	To study implications of decriminalization of abortion for clinical care, health service and systems decisions, health policy, and the epidemiology of abortion.	Commentary	Canada	All gestational ages	There has been a declining proportion of abortions that occur late in the second trimester. There is concern that this will have implications for training and maintaining skills and that the distribution of services for second trimester abortion is becoming increasingly uneven.
Roy (2006)	To assess quality of training, participation in training, and intention to become abortion providers of residents in Canadian obstetrics and gynecology programs.	Quantitative	Canada	Up to 24 weeks	Most Canadian obstetrics and gynecology departments provide abortion services to their patients in the first and second trimesters of pregnancy and offer abortion training to residents. However, in approximately half of programs, it is not integrated routinely into the curriculum and in these programs competence relies on residents' interest in training.
Wadhera et al. (1994)	To evaluate the trends in second trimester abortions performed in hospitals from 1974 to 1991.	Quantitative	Canada	Between 13 weeks and 24 weeks	There has been an increase in second trimester abortions in Canada following decriminalization.

Chapter 4: Seeking support for abortion care from national hotlines in Canada: Caller characteristics and call outcomes, 2019-2021

We submitted this article to *Contraception*. The article conforms to the structural, word count, and formatting requirements of this peer-reviewed journal.

Seeking support for abortion care from national hotlines in Canada: Caller characteristics and call outcomes, 2019-2021

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Seeking support for abortion care from national hotlines in Canada:

Caller characteristics and call outcomes, 2019-2021

Abstract

Objectives: Both the National Abortion Federation Canada and Action Canada for Sexual Health and Rights operate national toll-free hotlines that provide information, financial support, and travel assistance to people seeking abortion care. We aimed to characterize callers to both hotlines before and after the onset of the COVID-19 pandemic.

Methods: Hotline personnel routinely document information about callers and type(s) of assistance needed and received. We received call logs from both organizations for a two-year period (April 1, 2019 through March 31, 2021). We exported these data to Microsoft Excel® and analyzed them using descriptive statistics. We analyzed case notes for content and themes.

Results: Over the study period the two hotlines worked with 270 callers seeking support to obtain abortion care. Nearly two-thirds of the callers (n=174) were seeking support after 14 weeks gestation, including 69 callers (26%) who were at or beyond 24 weeks gestation. Most callers were seeking support to obtain abortion care outside of their province of residence because services at their gestational age were not available. Caller needs were similar before and after the onset of the pandemic, but fewer travelled to the United States for later abortion care in the COVID-19 era.

Discussion: Patient assistance hotlines play an important role in helping some Canadians navigate the health system to obtain needed abortion care. The needs of those seeking care at later gestational ages points to gaps in current service availability. Identifying ways to expand later abortion care, and particularly post-viability services, in Canada appears warranted.

Implications: Although abortion is decriminalized in Canada, some abortion seekers need to travel considerable distances or to the United States to obtain later care. National hotlines play an important role in helping abortion seekers navigate the system and provide critical financial support. Identifying ways to fully cover costs associated with abortion-related travel and accommodations, expand in-country later gestational age abortion care, and make permanent federal support for these hotlines and patient navigation services appears warranted.

Keywords: Abortion, Canada, COVID-19 pandemic, hotlines, sexual and reproductive health

1. Introduction

Canada is one of only a few countries in the world to have fully decriminalized abortion [1]. Although the Canadian federal government has long considered abortion care a medically necessary service [2], disparities in access persist. Indeed, Eggerston has described the abortion landscape in Canada as a "patchwork quilt with many holes" [3, p.847]. These disparities are tied to geography. With the exception of Quebec, all abortion providing clinics and many abortion providing hospitals in Canada are located in urban areas and the vast majority of abortion providing facilities are within 150 km of the Canada-United States (US) border [4-5]. Provincial and territorial regulations also shape the availability, accessibility, and affordability of abortion care. For example, the provincial health insurance scheme in New Brunswick does not cover the costs of procedural abortion care provided through clinics [6]. As a result, many Canadians must travel significant distances to obtain care both within and between provinces and territories [6-8].

The introduction of medication abortion with the mifepristone/misoprostol regimen in 2017 has expanded access to abortion services and an increasing number of primary care providers, located in a variety of practice settings are offering this care [9-11]. However, those needing abortion services after the first trimester of pregnancy often face additional hurdles to accessing timely and affordable care. There are no legal restrictions on the gestational age at which abortions can be provided in Canada. However, in both Prince Edward Island and Nunavut abortion care is only offered through the first 13 weeks of pregnancy and there are no abortion services beyond 16 weeks gestation east of Quebec [12-14]. There are four facilities that provide services up to 23 weeks and 6 days: two in British Columbia, one in southern Ontario, and one in Quebec [14]. There are no abortion providers that consistently offer services beyond

24 weeks gestation [12,14]. Patient volume, funding regulations, and the availability of trained clinical teams all influence the location and distribution of facility-based services [12,15-16].

In Canada, about 100,000 abortions take place each year, the vast majority of which occur in the first trimester of pregnancy [17-18]. In 2020, Canadian hospitals outside of Quebec reported performing 2,679 abortions after 13 weeks gestation, including 652 after 21 weeks gestation [18]. Canadian abortion seekers requiring care after 24 weeks gestation generally obtain that service in the US [12,19]. Most Canadians that have to travel across provincial or international borders are eligible for cost coverage for the procedure, although that coverage may vary by province [12]. However, the costs associated with travel and accommodations may not be covered. Further, those living in Canada that are not eligible for provincial, territorial, or federal insurance may also have to pay the procedure costs out-of-pocket.

For Canadian abortion seekers, identifying a provider, navigating the health system to obtain a funded abortion out of province, and making the travel and other logistical arrangements can be complicated and overwhelming [6-7]. Some abortion seekers also need financial support to cover the costs associated with the procedure or associated travel [12,20]. The COVID-19 pandemic has also complicated abortion care in Canada and created additional challenges for some abortion seekers to navigate [21]. Although the federal government reaffirmed in March 2020 that abortion care is an essential medical service [22] temporary clinic closures and local, inter-provincial, and international travel restrictions impacted access to facility-based abortion services, particularly at later gestational ages [23-24].

Both the National Abortion Federation (NAF) Canada and Action Canada for Sexual Health and Rights (Action Canada) operate national toll-free hotlines that provide information, financial support, and travel assistance to people seeking abortion care. To date, no research has

been published about those calling the hotline or the outcomes of the interactions between callers and hotline personnel. Through this study we aimed to characterize callers to both hotlines before and after the onset of the COVID-19 pandemic.

2. Methods

2.1 Data sources

NAF Canada is a registered charity dedicated to promoting reproductive health among Canadians by ensuring that high quality abortion care is accessible [25]. In addition to supporting provider training and education, NAF Canada operates the Dr. Henry Morgentaler Patient Assistance Fund. This fund provides financial support to pregnant women, transgender men, gender non-binary individuals, and Two-Spirit people in Canada whose abortion care is not covered by provincial or territorial insurance schemes and/or who need to travel to obtain abortion care. NAF Canada operates a national, toll-free hotline that provides abortion seekers with information about services, logistical support for inter-provincial or international travel for abortion care, and funding through the Dr. Henry Morgentaler Patient Assistance Fund.

Action Canada is a charitable organization dedicated to advancing sexual and reproductive health and rights in Canada and globally [26]. Among their many activities, Action Canada runs a national, toll-free hotline that provides information about and referrals for sexual and reproductive health services. This hotline also works with callers seeking abortion care to navigate the health system and obtain any necessary financial support.

2.2 Data collection

Personnel at both organizations routinely collect information about calls to their respective hotlines. Both organizations keep logbooks with basic demographic information about callers (including caller age, province/territory of residence, and gestational age), requested services, and received support. These logbooks also contain written notes about and/or narrative summaries of each case, including additional details relevant to addressing caller needs. However, recorded information for each unique caller varies depending on the content and duration of the interaction.

We received redacted logbooks from both organizations; personnel from each organization removed all personally identifiable information about individual callers from these datasets. NAF Canada provided the study team with their entire call log from April 1, 2019 through March 31, 2021. Action Canada provided the study team with information about all calls to their hotline from abortion seekers during this same period. CD, a graduate student in interdisciplinary health sciences at the University of Ottawa, cleaned and manually combined these datasets using Microsoft Excel®; she followed up with relevant personnel at both organizations if information about a specific case was confusing or unclear. We included all calls that were initiated during this two-year window in the final dataset, and we identified a sub-set of callers who worked with both hotlines during the study period.

2.3. Data analysis

We first analyzed these data using descriptive statistics to characterize the callers, the primary reason they contacted the hotline, and the interaction (including number of contacts). Next, for those who obtained an abortion after contacting one of the hotlines we calculated distance travelled for care. We calculated this distance by inputting the caller's city of residence

and city of the abortion providing facility into Google Maps®. We then compared the characteristics of callers, reasons, interactions, and outcomes (including distance travelled) in the year before the pandemic (April 1, 2019-March 31, 2020) to the year after the onset of the pandemic (April 1, 2020-March 31, 2021). We compared the characteristics of callers, reasons, interactions, and outcomes between the two hotlines, and we performed Chi-square tests to assess the statistical significance of any differences between these two periods. Finally, we analyzed the notes and narrative summaries for content and themes.

2.4 Ethical consideration

This study is a part of a larger body of work dedicated to exploring abortion care in Canada in the COVID-19 era [21]. We obtained permission from both organizations to work with these redacted datasets and received approval from the University of Ottawa's Social Sciences and Humanities Research Ethics Board to conduct the analysis.

3. Results

3.1. Caller characteristics

Between April 1, 2019 and March 31, 2021, the two hotlines worked with 270 unique callers seeking abortion care. NAF Canada recorded information about 155 unique callers and Action Canada recorded information about 68 unique callers; an additional 47 callers worked with both hotlines and had entries in both logbooks. We provide basic demographic information about the callers in Table 1. The two hotlines received calls from residents of nine provinces; 43% of callers (n=116) were from Ontario and no residents of Newfoundland and Labrador or Canada's three territories contacted the hotlines during this period (see Fig. 1). About two-thirds

of the callers (n=174) were seeking support after 14 weeks gestation, including 69 (26%) who were at or after 24 weeks gestation. Overall, the characteristics of callers to each hotline and the characteristics of callers to both hotlines were similar. Although 85% of callers to both hotlines were seeking support after 14 weeks gestation, including 42% who were seeking support at or after 24 weeks gestation, compared to all callers this was not statistically significant.

3.2 Callers' reasons for contacting a hotline

Almost half of all callers (n=133, 49%) were seeking financial assistance to travel for abortion care. In the majority of these cases, the caller lived in a province that did not offer abortion care at their gestational age. A smaller subset of all callers (n=77, 29%) were seeking financial support to cover the abortion procedure itself. These individuals did not have provincial insurance and/or were not eligible for coverage largely due to their immigration or residency status. Callers also needed logistical support to obtain care out-of-province or in the United States. Finally, some callers contacted the hotline with requests for basic information on the process of obtaining abortion care in Canada, either for themselves or on behalf of a loved one. Most callers inquiring about abortion care at earlier gestational ages fell into this category.

3.3 Outcomes of callers' interactions with the hotlines

We provide information about the outcomes of the caller-hotline interactions on Table 2. Of the 270 unique callers to the two hotlines, all of those seeking financial support for travel and accommodations to obtain abortion care (n=133, 49%) received financial that support; these callers were split between those who received support for travel and accommodations within their province of residence (n=46, 17%), outside of their province of residence but within Canada

(n=49, 18%), and in the US (n=38, 14%). Callers also received support to cover the costs of an abortion procedure in Canada (n=73, 27%) or in the US (n=4, 1%). About 20% of callers (n=56) received other types of support from one or both hotlines. These supports included providing basic information about abortion care in Canada and how to access services, assisting with appointment scheduling, and serving as a liaison between the patient and the abortion providing facility (data not shown). Personnel at the NAF Canada hotline were unable to support four callers. Two of these callers were beyond 35 weeks gestation and one caller was beyond 24 weeks gestation and because of immigration issues could not travel to the United States; NAF Canada hotline personnel were unable to find facilities that could accommodate these callers. Finally, one caller requested reimbursement for an abortion procedure that had taken place two months earlier and NAF Canada hotline personnel were unable to secure retroactive cost coverage or financial support.

Of the 270 unique callers who contacted one or both hotlines over the two-year study period, 197 (73%) were required to travel to receive abortion care. Callers travelled distances from less than 100 km (62.5 miles) to over 800 km (500 miles) from their place of residence. We detail these results in Table 3. Almost a quarter of all callers (n=61, 23%) travelled over 800 km to receive care in Canada or the United States. Most callers who travelled for abortion care obtained care at one of five facilities in either Ontario or the US: Cabbagetown Clinic (Toronto, ON), Morgentaler Clinic (Toronto, ON), Morgentaler Clinic (Ottawa, ON), London Health Sciences Center (London, ON), and Boulder Abortion Clinic (Boulder, CO, US). The determination of the specific facility was largely determined by the caller's gestational age.

3.4. Differences in calls and outcomes before and after the onset of COVID-19

In order to explore any changes in the calls to the hotline or outcomes of the interactions after the onset of the pandemic we divided the dataset into two years: April 1, 2019 to March 31, 2020 (Year 1, prior to the onset of COVID-19) and April 1, 2020 to March 31, 2021 (Year 2, after the onset of COVID-19). We present these data on Table 4. The overall volume of unique callers increased by 37%, from 114 in Year 1 to 156 in Year 2. During this time the NAF Canada hotline experienced an increase in call volume and the Action Canada hotline experienced a decrease in call volume (data not shown). Caller needs and outcomes were similar before and after the onset of the pandemic. However, fewer callers travelled more than 800 km for their abortion care after the onset of the pandemic ($p < 0.02$) and fewer callers travelled to the US after the onset of the pandemic (25 in Year 1 vs. 13 in Year 2, $p < 0.006$), irrespective of distance travelled (data not shown).

4. Discussion

Although the Canadian government classifies abortion as a medically necessary and essential health service, some abortion seekers need support navigating the health system and obtaining care. Our analysis of two years of data shows that compared to all of those who obtain abortion care in Canada, callers to two national hotlines disproportionately needed support to obtain abortion care after the first trimester in pregnancy. That these callers were largely seeking financial support for travel or to cover procedure costs reflects gaps in the current abortion care landscape. Our results support the chorus of voices in Canada that advocate for ensuring that provincial health insurance schemes cover abortion care irrespective of facility type, enforcing the portability requirement of the Canada Health Act, and expanding the provincial, territorial,

and federal definitions of cost coverage to include costs associated with travel and accommodations [12,16,27-28].

Our results also indicate that there is a need to fortify later abortion services in Canada. Gestational age limits in Canada are not a function of criminal law or federal regulation. However, in large swaths of the country abortion care after 16 weeks is not available. That 23% of callers to these two national hotlines travelled more than 800 km for care reflects these geographic disparities. Supporting more facilities to expand their gestational age limit, especially in the Maritimes region, appears warranted.

Consistent with media accounts [29], our study found that fewer hotline callers travelled to the US in the year after the onset of the pandemic, likely due to restrictions on cross-border travel. Although the Canada-US border reopened in 2021, in June 2022 Supreme Court held in *Dobbs versus Jackson Women's Health Organization* that abortion is not a protected constitutional right overturning nearly 50 years of precedent. In the wake of the decision a number of states banned abortion in many or most circumstances resulting in surges in non-ban states and increased wait times for care. This dynamic complicates the ability of Canadians to obtain timely abortion care in the US [19]. Given these complex dynamics there is an evidence need to establish in-country services for those seeking abortion care at or after 24 weeks gestation.

Finally, even if service availability after the first trimester expands in Canada, there will continue to be abortion seekers that need support to navigate the system, travel between provinces, and obtain care. The 2021 federal budget included CAD45 million (USD30 million) over three years to increase the accessibility of sexual and reproductive health information and services, including those related to abortion care [30]. In May 2022, the federal government

announced the first recipients of funding from this new envelope; both NAF Canada and Action Canada received support to expand the reach of their hotlines and patient navigation services [31]. This is an important step but to ensure that the needs of abortion seekers in Canada are met, it will be critical for the federal government to make this funding permanent.

5.1 Limitations

We worked with data collected for programmatic rather than research purposes. As a result, we have limited demographic information about callers. As these hotlines continue to expand it would be valuable to obtain additional information about callers in order to understand better intersectional systemic oppressions shaping access to care. Future research would also benefit from including the voices and perspectives of those who used these hotlines, both to understand better abortion seekers' experiences navigating the Canadian health system and inform improvements to hotline services.

5.2 Conclusion

Although abortion is decriminalized in Canada, some abortion seekers are unable to obtained needed care within their province of residence. The geographic disparities in later abortion care mean that some abortion seekers need to travel considerable distances or to the United States for services. Our study shows that national hotlines play an important role in supporting abortion seekers to navigate the system and cover out-of-pocket both travel and procedure costs. Identifying ways to fully cover abortion-related travel and accommodations costs through existing public health insurance schemes, expand in-country later gestational age

abortion services, and make permanent federal support for these hotlines and patient navigation services is critical.

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Table 1. Characteristics of callers to the NAF Canada and Action Canada hotlines, April 1, 2019-March 31, 2021 (N=270)

Characteristic	NAF Canada callers only (n=155) n (%)	Action Canada callers only (n=68) n (%)	Callers to both hotlines (n=47) n (%)	All callers (N=270) n (%)
Age of caller (in years)				
≤ 18	3 (2%)	3 (4%)	4 (9%)	10 (4%)
19-25	25 (16%)	2 (3%)	6 (13%)	33 (12%)
26-30	8 (5%)	0 (0%)	0 (0%)	8 (3%)
≥ 30	4 (3%)	0 (0%)	2 (4%)	6 (2%)
Not recorded	115 (74%)	63 (9%)	35 (7%)	213 (79%)
Gestational age				
≤ 6 weeks 6 days	32 (21%)	0 (0%)	2 (4%)	34 (13%)
7 weeks-13 weeks 6 days	40 (26%)	4 (6%)	5 (11%)	49 (18%)
14 weeks-23 weeks 6 days	36 (23%)	49 (72%)	20 (43%)	105 (39%)
24 weeks-29 weeks 6 days	30 (19%)	14 (21%)	18 (38%)	62 (23%)
≥ 30 weeks	4 (3%)	1 (1%)	2 (4%)	7 (3%)
Not recorded	13 (8%)	0 (0%)	0 (0%)	13 (5%)
Province/territory of residence				
Alberta	8 (5%)	12 (18%)	7 (15%)	27 (10%)
British Columbia	28 (18%)	4 (6%)	3 (6%)	35 (13%)
Manitoba	2 (1%)	1 (1%)	0 (0%)	3 (1%)
New Brunswick	16 (10%)	5 (7%)	3 (6%)	24 (9%)
Nova Scotia	14 (9%)	3 (4%)	4 (9%)	21 (8%)
Ontario	59 (38%)	37 (54%)	20 (43%)	116 (43%)
Prince Edward Island	3 (2%)	0 (0%)	3 (6%)	6 (2%)
Quebec	5 (3%)	5 (7%)	0 (0%)	10 (4%)
Saskatchewan	6 (4%)	1 (1%)	4 (9%)	11 (4%)
Newfoundland and Labrador, Northwest Territories, Nunavut, Yukon	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Not recorded	14 (9%)	0 (0%)	3 (6%)	17 (6%)

NAF: National Abortion Federation

Action Canada: Action Canada for Sexual Health and Rights

Note: Columns may not sum to 100% due to rounding

Table 2. Outcome of the interactions between callers and hotlines (N=270)

Outcome	NAF Canada only callers (n=155) n (%)	Action Canada only callers (n=68) n (%)	Callers to both hotlines (n=47) n (%)	All callers (N=270) n (%)
Received financial support for travel and accommodations				
Within province of residence	16 (10%)	26 (40%)	4 (9%)	46 (17%)
Within another Canadian province	18 (12%)	18 (26%)	13 (28%)	49 (18%)
In the US	15 (10%)	7 (10%)	16 (34%)	38 (14%)
Received financial support for the abortion itself				
Within Canada	53 (34%)	11 (16%)	9 (19%)	73 (27%)
In the US	2 (1%)	0 (0%)	2 (4%)	4 (1%)
Received other forms of support				
Within province of residence	18 (12%)	5 (7%)	1 (2%)	24 (9%)
Within another Canadian province	21 (14%)	0 (0%)	0 (0%)	21 (8%)
In the US	8 (5%)	1 (1%)	2 (4%)	11 (4%)
Did not receive support	4 (3%)	0 (0%)	0 (0%)	4 (1%)

NAF: National Abortion Federation

Action Canada: Action Canada for Sexual Health and Rights

US: United States

Note: Columns may not sum to 100% due to rounding

Table 3. Distance travelled by callers to obtain abortion care (N=270)

Distance travelled for abortion care	NAF Canada only callers (n=155) n (%)	Action Canada only callers (n=68) n (%)	Callers to both hotlines (n=47) n (%)	All callers (N=270) n (%)
<300 kilometers	54 (35%)	37 (54%)	13 (28%)	104 (39%)
300-800 kilometers	12 (8%)	13 (19%)	7 (15%)	32 (12%)
>800 kilometers	21 (14%)	18 (26%)	22 (47%)	61 (23%)
Not recorded/not applicable	68 (44%)	0 (0%)	5 (11%)	73 (27%)

NAF: National Abortion Federation

Action Canada: Action Canada for Sexual Health and Rights

Note: Columns may not sum to 100% due to rounding

Table 4. Calls and outcomes to the hotline before and after the onset of COVID-19 (N=270)

Calls and outcomes	All callers in Year 1 (n=114)	All callers in Year 2 (n=156)	p-value (Year 1 vs. Year 2)
Travelled <300 kilometers	41	63	<0.62
Travelled 300-800 kilometers	17	18	<0.46
Travelled >800 kilometers	37	26	<0.02*
Not recorded/not applicable	19	49	<0.03*

NAF: National Abortion Federation

Action Canada: Action Canada for Sexual Health and Rights

* p-value <0.05

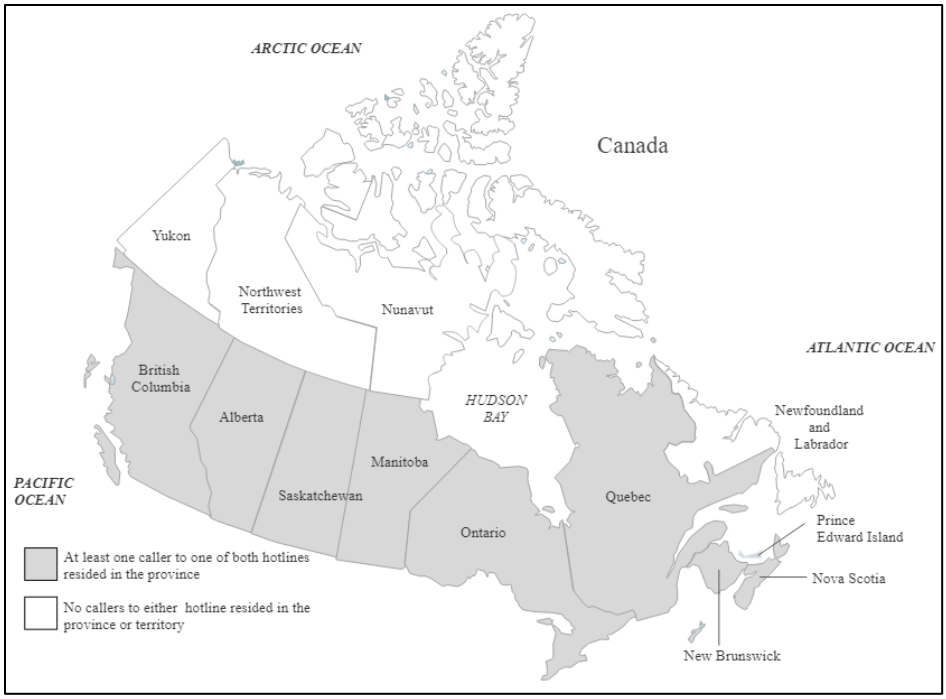

Figure 1: Map of Canada with hotline

Chapter 5: “I don’t know why they don’t do abortions”: A qualitative exploration of Canadian women’s experiences obtaining later gestational age abortion care

We intend to submit this article to *Perspectives on Sexual and Reproductive Health*. The article conforms to the structural, word count, and formatting requirements of this peer-reviewed journal. However, for the purposes of this thesis we have not blinded author and institutional information as is required by the journal.

"I don't know why they don't do abortions": A qualitative exploration of Canadian women's experiences obtaining later gestational age abortion care

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Abstract

Introduction: Canada decriminalized abortion in 1988 and there are no legal restrictions on when in pregnancy an abortion can take place. However, abortion after 16 weeks gestation is not available in large parts of the country. We aimed to explore Canadians' experiences seeking and obtaining later gestational age abortion care.

Methods: We conducted interviews with 15 women who obtained an abortion at or after 16 weeks gestation while residing in Canada. We analyzed these interviews for content and themes using inductive and deductive techniques.

Results: Our participants reported on 16 later gestational age abortions. The complex life circumstances of many of our participants influenced both the detection of pregnancy and the timing of the abortion. Participants who needed abortions after 17 weeks for non-fetal indications experienced considerable geographic and financial barriers to obtaining abortion care and four participants traveled outside of their home province or to the United States for care.

Discussion: Women seeking abortion care at later gestational ages in Canada face a number of barriers to accessing this essential health service. Expanding the gestational age limits in existing facilities to ensure that abortion seekers can obtain care closer to home would address a significant need. Identifying ways to strengthen the supports offered to those seeking later abortion care and fortifying efforts to destigmatize later abortion care also appears warranted.

Keywords: abortion, Canada, later abortion, second trimester termination

"I don't know why they don't do abortions": A qualitative exploration of Canadian women's experiences obtaining later gestational age abortion care

Introduction

Abortion has been fully decriminalized in Canada since 1988. As a result, there are no federal restrictions on abortion care and it is treated like other medical procedures and regulated through provincial and territorial health systems and professional bodies.[1,2] Abortion is a common medical intervention and approximately 1 in 3 Canadian women will have an abortion during their lifetime.[3] The Canadian Institute of Health Information (CIHI) estimates that between 85,000 and 100,000 abortions take place in Canada each year.[4,5] However, these estimates do not include the experiences of those who obtain medication abortion care through the primary care system, who obtain abortion care at some private or freestanding clinics, or who travel outside of Canada for abortion care.[2,5]

The overwhelming majority (90%-95%) of abortions take place in the first trimester of pregnancy in Canada.[6] Excluding Quebec, Canadian hospitals reported performing 2,679 abortions after 13 weeks gestation, including 652 after 21 weeks gestation in 2020.[5] However, abortion care after the first trimester is not available in all provinces and territories. These gestational age limits are not due to legal restrictions but are instead a function of patient volume, facility regulations, facility capacity, and clinician training.[2,7-8] However, in both Prince Edward Island (PEI) and Nunavut abortion care is only offered through the first 13 weeks of pregnancy and there are no abortion services beyond 16 weeks gestation in New Brunswick, Newfoundland and Labrador, or Nova Scotia.[9-11] A handful of facilities in British Columbia,

Ontario, and Quebec provide services up to 23 weeks and 6 days and there are no providers in-country that consistently offer services beyond 24 weeks gestation.[9,11]

Over the last decade several policy and regulatory changes have shaped the abortion landscape in Canada. In 2015, Health Canada approved the use of mifepristone and misoprostol for early pregnancy termination; the medication abortion regimen became available as a combination package in 2017.[12] Subsequently, primary care providers in different parts of the country began to offer abortion services.[13-15] In 2017, abortion services also became available in PEI for the first time in over three decades.[16] These changes in service availability increased access to first trimester abortion care. However, women, transgender men, gender non-binary individuals, and Two-Spirit folks (womxn) who are pregnancy capable and in need of abortion care after the first trimester continue to face significant barriers and experience stigma when seeking and obtaining care.[17-19] These barriers are further heightened at more advanced gestational ages and when the desired abortion is because of an unwanted pregnancy rather than a maternal-fetal indication.[17-18]

However, little is known about Canadians' experiences seeking and obtaining later gestational age (LGA) abortion care, defined here as abortion at or after 16 weeks gestation.[20] Although previous research has documented that a significant portion of those seeking LGA abortion care must travel outside of the province or territory of residence,[21-22] previous studies have not centered the lived experiences of those seeking care. Through this qualitative study we aim to shed light on Canadians' motivations, decision-making processes, and experiences seeking and obtaining abortion care after 16 weeks gestation and their perspectives on how services could be improved.

Methods

Data collection: The Canada Abortion Study interviews

The Canada Abortion Study was a large-scale, national qualitative study led by AMF, a medical doctor and medical anthropologist with extensive experience in global abortion research, that aimed to document women's abortion experiences in Canada prior to the introduction of mifepristone. From 2012-2016, the Canada Abortion Study team conducted 305 in-depth, semi-structured interviews with Anglophone and Francophone women who resided in all provinces and territories at the time of the procedure. We have reported in detail on the study design, as well as on various findings, elsewhere.[23-28] In brief, we used a multi-modal strategy to recruit women[3] who had obtained an abortion in the five years prior to the interview while living in Canada. We purposively recruited participants from across the country who were over the age of 18 at the time of the interview. Our interview guide included domains of inquiry related to participant demographics, reproductive health history, information about the index pregnancy and the abortion decision-making process, experiences seeking and/or obtaining care, the abortion experience, and perspectives on how services could be improved. We audio-recorded all telephone/Skype interviews, took notes during the encounter, and memoed immediately after the interview in order to reflexively engage with interviewer positionality, reflect on the interview process and content, identify early themes, and establish thematic saturation.[29-30] All participants received a CAD40 (USD30) gift card to Amazon.ca. For this study we identified 12 interviewees (4% of all participants) who reported having at least abortion on or after 16 weeks gestation and included these in our analysis.

[3] For the Canada Abortion Study, we used gendered recruitment materials and all of our participants identified as women. However, we acknowledge that anyone who is pregnancy capable, irrespective of gender identification, may need and abortion.

Data collection: Interviews with residents of the Maritimes

In September 2021, we launched a follow-up to the Canada Abortion Study. For this new study we specifically recruited women, transgender men, gender non-binary individuals, and Two Spirit people who obtained an abortion after 16 weeks gestation while living in the Maritimes. We chose this region because in New Brunswick, Nova Scotia, and PEI there are no abortion providing facilities offering care after 16 weeks and we intended to explore the experiences of abortion seekers who had to travel outside of the Maritimes for care.

We used a multi-methods strategy to recruit participants who were at least 15 years old at the time of the interview and sufficiently fluent in either French or English to complete the interview. To be eligible, prospective participants must have either sought or obtained an abortion after 16 weeks gestation after January 1, 2011 while residing in the Maritimes. CD, a graduate student in interdisciplinary health sciences at the University of Ottawa, conducted these interviews using a guide similar to that used in the Canada Abortion Study. With participant permission, CD audio-recorded the phone and Zoom audio interviews, took notes during the interviews, and analytically memoed immediately after the interactions. Participants received a CAD40 (USD gift card). Interviews averaged 60 minutes in length. We completed three interviews during this phase of the overall project.

Data analysis

We combined the two datasets and analyzed the interviews for content and themes.[30-31] CD developed an initial code book based on the literature and the interview guide. She initially analyzed transcripts, notes, and memos from the three new interviews from 2021; she used

inductive techniques to refine the codebook based on interview content. Next, she analyzed the 12 interviews from the Canada Abortion Study dataset using this codebook and further adapted the codebook. After coding all of 15 interviews, CD used inductive and deductive techniques to identify patterns and themes and explore concordance and discordance based on province of residence. AMF oversaw data collection for both projects and provided ongoing guidance during the analytic phase of the project. We used Google Maps to calculate the distance participants travelled for abortion care by using the participant's city of residence and the city in which the abortion took place.

Ethical considerations

This study has received ethics approval from the Social Sciences and Humanities Research Ethics Board at the University of Ottawa in Canada. We assigned a pseudonym to each participant. We also removed or masked any personally identifying information.

Results

Participant characteristics

Our 15 study participants had obtained 16 abortions at or after 16 weeks gestation. We provide basic demographic information about our participants and details about their abortions in the Table. Our participants were all Canadian citizens and hailed from seven provinces; seven resided in one of the three Maritime provinces at the time of the abortion. All of our participants identified as women, all but one were Anglophone, and 11 identified as white. Of the 16 abortions described by our participants half (n=8) occurred between 16 weeks and 17 weeks

gestation. The other half occurred between 17 weeks and 19 weeks and 6 days gestation (n=3) and on or after 20 weeks gestation (n=5), including one that took place after 28 weeks.

Participants had an array of reasons for seeking LGA abortion care

Among our participants the reasons for needing a LGA abortion were varied and often complex and multi-faceted. Almost all of our participants explained that they had an abortion because it was "not the right time" for them to carry a pregnancy to term and parent. Most of our participants explained that they were in abusive relationships, suffered from substance abuse issues, were not financially, physically, or mentally capable of carrying a pregnancy to term, and/or were housing insecure or living in an unstable situation. Often a combination of these circumstances shaped their need for abortion care. Helen, a 26-year-old who obtained two abortions after 16 weeks outside of her home province of PEI, described her life at the time of her first LGA abortion:

> I wasn't happy but I wasn't ready, I knew I wasn't… financially and just the situation that I was in, it just wasn't going to work. My ex-boyfriend, he just was into drugs and stuff and I didn't know about it and I found out about it shortly in our relationship and he was very violent, like he tried to beat me up and he got charged for it.

For many of the women who spoke with us, their lives were in disarray when they became pregnant. This combination of life circumstances also contributed to them missing initial pregnancy symptoms, mistaking pregnancy symptoms for period-related symptoms, being in denial and ignoring pregnancy systems, or postponing seeking services due to delayed decision-making. Thus, the complexity of their lives resulted in both a need for an abortion and created barriers to them being able to seek abortion care earlier in pregnancy.

Several of our participants spoke of being pressured to have an abortion from either a partner or a family member. For these women, the delay in obtaining and abortion was due in part to trying to resist this pressure and carry the pregnancy to term. Lia, a 25-year-old student from Newfoundland and Labrador wanted to continue her pregnancy but her boyfriend pressured her to have an abortion.

> I was 100% that I did not want to get an abortion. 100%. Every now and then I would have a mild flash that said "maybe you should do this, like do you really want this person in your life for the rest of your life?"…But the way I felt about [the abortion] at that point was that it wasn't an ok thing, it was murder, and that what I was doing was very wrong. I felt morally wrong.

Finally, three of the participants in our study obtained abortions after 16 weeks because of fetal conditions. All three of these women had wanted pregnancies and obtained information about the health of their fetus after the first trimester. As a result, they obtained abortion care later in pregnancy.

For those with wanted pregnancies the decision-making process was complex

All of our participants, regardless of the circumstances surrounding the pregnancy, described making a thoughtful and considered decision regarding the abortion. For those with wanted pregnancies who sought an abortion after receiving a diagnosis of a fetal condition, the decision-making process involved multiple and ongoing discussions with their partner. In addition, these women often involved other loved ones and professionals in their decision-making. Evelyn, a 35-year-old wife and mother from New Brunswick, found out at her 18-week ultrasound that the fetus had Turner's Syndrome. After taking the next few days to reflect and do some research, she described the discussions that she has with her husband and the maternal-fetal medicine specialist:

> And so we kind of saw [the physician and told him] what we had seen [online]…I said to him that [my husband] and I were struggling with the decision on whether or not to proceed with the pregnancy. I think I worded it…like "Do I want to go through like, life with having a child that's going to have all kinds of challenges and, you know, physical and potentially mental difficulties?" [The physician] explained that on the Internet most of the information that's available is about people, you know, babies that do become full term babies from Turner's syndrome. And what they don't say is that probably 90 percent of, or well, less than 10 percent of fetuses that have Turner's actually become full term babies…So basically what my choice was: did I want to go ahead and schedule the termination or did I want to just wait and let it happen naturally?

Our three participants who terminated their pregnancies for a fetal indication all described receiving support from multiple sources, including partners, family members, and health services professionals. But they all reported that they made the decision about the abortion with their partner as a couple.

Our participants who obtained an abortion after experiencing an unwanted pregnancy the decision-making process was more varied. For some, the decision was quick and straight forward. Sydney, a 26-year-old from British Columbia with consistently irregular periods, found out she was pregnant at 13 weeks explained "So, I guess it [having an abortion] was sort of a no brainer to me. I didn't really give…much thought to anything else, honestly". Others felt more ambivalent or conflicted and thus deliberated on the decision longer. Most of these women consulted with at least two other people as part of their decision-making process.

Barriers to accessing abortion care increased with increased gestational age

All of our participants received their abortion care from a freestanding clinic or hospital and participants had an average of 2.5 in-person appointments related their abortion care. Twelve of the 16 abortions described by participants in this study occurred in the woman's province of residence; in the other four cases the woman travelled outside of her province in Canada or to the United States. The majority of participants (n=9) travelled over 100 km (62.5 miles) each way

for their abortion care and a significant portion (n=6) travelled more than 300 km (187.5 miles) each way for their care.

The three women in our study who obtained abortion care after a fetal diagnosis were all able to receive care in their province of residence; all participant who had an abortion before 17 weeks were able to obtain care in their home province. However, for those needing abortion care at or after 17 weeks that was not for a fetal indication (n=6) the process was more complicated. As shown on Figure 1, these participants received later gestational age abortion care in five cities in Alberta, Nova Scotia, Ontario, and Quebec as well as in the United States (Boulder, Colorado). These participants reported having more than four in-person consultations to obtain their abortion care and all travelled at least 150 km (93.75 miles) each way; one participant travelled more than 1800 km (1,125 miles) each way to receive care.

Several of our participants were confused as to why they were not able to access services closer to home. Christine, a 22-year-old lived near Lethbridge, Alberta and travelled roughly 212 km (132 miles) each way to obtain an abortion just before 19 weeks gestation in Calgary. She explained: “I mean Lethbridge is big and they have a hospital. So I don’t know why they don’t do [abortions]. Or maybe it’s because I was further along than other people.”

Participants expressed a desire for more accessible LGA abortion care in Canada

Most of our participants reflected positively on their LGA abortion experiences. However, all participants expressed that there is a need to increase the accessibility of LGA abortion care across Canada. Our participants from the Maritimes were especially emphatic about this issue. All 15 of our participants supported expanding the gestational age limit in their home province. Jessica, a 32-year-old professional from New Brunswick, travelled to the United

States to have her abortion at 28 weeks gestation. Due to her limited knowledge of abortion access in New Brunswick, and the only resource she knew was available was Clinic 554, which was open at the time, but could not offer her services. She went through a hectic two weeks of phone calls and scheduling matters before she was able to schedule her procedure in Colorado, USA. In reflecting on the need to expand the gestational age limits of abortion care in New Brunswick she stated:

> It's almost necessary. I think like, I mean again, I'm going back to my own experience and I don't mean to say it this way, but for people like me who don't know what's going on, by the time you figure it out and…try to get help, it's too late.

Our participants also explained that expansion of gestational age limits should be approached in tandem with other changes in the abortion care system. Improvements in the sex education to increase knowledge about pregnancy and abortion, better counseling services for those seeking abortion care for wanted pregnancies, more privacy throughout the abortion process, streamlined appointment services, and external funding and supports for those who need to travel for care were all identified as areas for improvement.

But our participants tied the expansion of gestational age limits to the need for broader shifts in attitudes toward abortion. Tanya, a 30-year-old from Newfoundland and Labrador stated, "I think the biggest thing needed is a bit of a culture and attitude shift, a little bit to a more, a more open view of abortion". A number of participants echoed this statement by explaining that there are multiple factors that play in to a LGA abortion and there needed to be less stigmatization directed at those that need these services. Elizabeth, 37-year-old from New Brunswick who had her termination at 23 weeks gestation due to a fetal anomaly explained:

> It's just, it's so unfortunate because I think the part of it is that [the public] have just such a narrow scope of what they think abortion is or who has abortions. And I mean, it can

just, it can just happen to anyone under different circumstances.

Discussion

Our study showcases the lived experiences of Canadian women who have obtained abortion care after 16 weeks gestation. Their stories highlight the complexities of obtaining specialized care[32] that is not readily available in all regions of the country. For our participants living in the Maritimes, the absence of an abortion provider in the region offering services beyond 16 weeks gestation constituted a considerable burden. Canadian advocacy organizations have repeatedly called for expanding and strengthening later abortion services in Canada and extending the definition of cost coverage to include costs associated with travel for abortion care.[9,33-34]

Our results also shed light on the range of reasons that women seek later gestational age abortion in Canada. Consistent with global research on second-trimester abortion care,[17] most of our participants had a multitude of reasons for obtaining a LGA abortion and their complicated personal and contextual circumstances shaped both the timing of the detection of pregnancy and the abortion. Our participants lived experiences included histories of inter-personal violence, substance abuse, undertreated mental health issues, and housing and financial insecurity. Reproductive health intersects with all of these issues and is a reminder that there is a continued need to support and strengthen social safety nets and broader health and social services in Canada.

Our findings also indicate that stigma featured prominently in the experiences of those seeking LGA abortion care. Our participants needed LGA abortion care for a range of reasons and made thoughtful and considered decision. Yet stigma surrounds abortion, in general, and LGA abortion, in particular.[26-27,35-36] Identifying ways to continue to normalize abortion,

including LGA abortion, within the health system, working with health service professionals to provide non-judgmental care, improving supports for those who encounter stigma inside and outside of the Canadian health system appears warranted.

Limitations

Based on the timing of recruitment and our eligibility requirements, participants in our study obtained care over a 14-year period. A number of changes have occurred in the abortion landscape during that period.[21,24,34,37] Our study may not capture the impact of these changes. Although in the more recent study we specifically recruited those who had sought but had not obtained an abortion, we had no participants who were unable to secure their desired abortion. Future research would benefit from capturing these perspectives. Finally, all of our participants in both studies identified as women. Future research would benefit from exploring the abortion experiences of transgender men, gender non-binary individuals, and Two Spirit people.

Conclusion

Women seeking abortion care at later gestational ages in Canada face a number of barriers to accessing this essential health service. Expanding the gestational age limits in existing facilities to ensure that abortion seekers can obtain care closer to home would address a significant need. Identifying ways to strengthen the supports offered to those seeking later abortion care and fortifying efforts to destigmatize later abortion care also appears warranted.

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Table: Characteristics of study participants (N=15) who had an abortion at or beyond 16 weeks gestation

Characteristic	Total
Age of participants (in years)	(N = 15)
18-24	2
25-30	6
30-35	4
36-40	3
Racial/ethnic identification	(N = 15)
White	11
White/Indigenous	1
Biracial/multiracial	1
Missing	2
Pronouns	(N = 15)
She/her	15
Language of the interview	(N = 15)
English	14
French	1
Gestational age the time of the abortion	(N = 16)
16 weeks, 0-6 days	8
17 weeks - 19 weeks, 6 days	3
20 weeks - 22 weeks, 6 days	3
23 weeks - 27 weeks, 6 days	1
>28 weeks	1

Figure 1. Map showing participants' city of residence and city-level location of the abortion providing facility for participants who had an abortion at or after 17 weeks gestation not due to a fetal condition

Chapter 6: Discussion

6.1 Integration of results

The results from all components of this study showcase the complexities surrounding LGA abortion care in Canada. This project brings together existent literature, the perspectives of those working in the field, data from patient support and navigation systems, and women's experiences seeking and obtaining care. We also conducted formal interviews with key informants that will inform future work. In centering the experiences of those needing a relatively rare but important health service, this project identified a number of ways that services could be improved in Canada.

6.1.1 The patient experience obtaining LGA abortion care

Globally, there are only a few studies that focus on women's experiences of second or third trimester abortion for reasons other than fetal malformation (Andersson et al. 2014; Kimport, 2022; Purcell et al. 2014) and none of these are specific to Canada. Prior studies found that women had ambivalent feelings toward their situation, had a range of reasons for needing later abortion care, reflected positively on the abortion care they received, and felt shame and stigma associated with seeking a LGA abortion (Andersson et al. 2014; Purcell et al. 2014). Our results are consistent with these findings.

Our qualitative work with abortion patients found that women across the country experienced a number of barriers when seeking an abortion at or beyond 16 weeks gestation. However, our participants who resided in the Maritimes appear to have experienced even greater barriers. In addition to having to travel outside of their province or region for care over 16 weeks, participants from the Maritimes experienced considerable internalized and externalized

stigma. This finding is perhaps not surprising given that a lower percentage of the Maritimes population compared to other Canadian regions identify as pro-choice (Shrybam, 2021). Indeed, according to a poll published by the National Post in January 2020, 55% of respondents in Atlantic Canada (New Brunswick, Newfoundland and Labrador, Nova Scotia, and Prince Edward Island) believed abortion should be illegal during the second trimester (Dart & Maru, 2020). This suggests that intentional efforts to destigmatize LGA abortion care – especially among clinicians – is especially important.

Many of our topic experts and key informants explained how seeking a LGA abortion can be a trauma-inducing experience. In particular, LGA abortion providers and nurses and support staff that work with LGA abortion patients explained that womxn obtaining an abortion at or beyond 16 weeks gestation have "a lot going on". Interviews with women who obtained LGA abortion care confirm this impression; many of our participants had lives that were in disarray. This suggests that there is a real need for social supports. Immediately, these needs may be met by hotlines and abortion-specific resources and advocates. However, reproductive health is integrated within all components of womxn's lives and thus this study points to some gaps in broader health and social safety nets.

6.1.2 The provider experience with LGA abortion care

Through different components of this project we are also able to shed light on providers' attitudes toward and experiences with LGA abortion care. Abortion is one of the most commonly performed procedures among reproductive age women in North America (Cessford & Norman, 2011). However, findings from our scoping review and our conversations with topic experts suggest that there is shortage of abortion providing clinicians in Canada, particularly at later

gestational ages. Previous research suggests that this is, in part, because Canada is not providing enough abortion-specific training opportunities to those who are willing to learn (Harris, 2008). Indeed, a survey of all Canadian Obstetrics and Gynaecology residency programs between 2014-2015 revealed that 69% of residents desired more abortion training during residency (Liauw et al. 2016). However, this survey did not include any medical schools east of Quebec. This raises concerns about the future availability of late-term abortion in Canada, generally, and across the Maritimes, in particular (O'Connell et al. 2008). Creating opportunities for routine training in abortion care in medical school and mandating exposure to abortion care for those in specific residency programs could begin to address this issue (Myran et al. 2018).

6.1.3. The role of supports in LGA abortion care in Canada

We are also able to highlight the necessity of physical, social, emotional, and financial supports for those seeking LGA abortion care. Findings from our hotline data analysis, the scoping review, and in-depth interviews all found that there is a lack of support for those who need a later abortion. However, to navigate the abortion system and patient support systems, LGA abortion seekers also need to have awareness about the available supports. Identifying ways to increase the visibility of these hotlines, and other organizations providing support to those seeking LGA abortion care, appears warranted.

6.2 Policy implications

There are multiple policy avenues that could alter the LGA abortion landscape in Canada. First, Canada needs to expand the gestational age of existing services and ensure the availability of consistent post-viability services in-country. The uneven distribution of later abortion

providing facilities across the country leads to inequitable access for many LGA abortion seekers and the lack of consistent service availability of services beyond 24 weeks requires Canadians to travel abroad for an essential health service. This increases the costs, time, and stress associated with obtaining the procedure.

Second, redefining cost coverage to include travel and accommodations for those who need care within their province of residence, between provinces, or outside of Canada is critical. Charities and non-profits exist to fill gaps in public sector services but should not be the main source of funds for an essential medical service and the costs associated with obtaining that care. All levels of government have an obligation to support abortion seekers, especially LGA abortion seekers, and the public sector should bear the costs of help these patients navigate the system and obtain care (Costescu et al. 2022).

Finally, implementing permanent supports for hotlines and patient navigation services that help those needing abortion care is critical. These supports offer individualized support during a time can feel alienating and stigmatizing for many. Those seeking abortion care at later gestational ages especially benefit from the work of these organizations.

6.3 Significance and dissemination

Providing womxn across the Maritimes with access to safe and legal abortion services is essential to realizing and protecting their fundamental human rights. To date, very little has been published about later abortion care in Canada, let alone womxn's experiences. The results of this project not only add the literature on LGA abortion in Canada but help orient future research. In order to disseminate our findings, we have or will submit all three articles for publication in peer-reviewed journal. However, we will also develop a short brief of the findings – in English

and French – which we intend to share with both key stakeholders (including those who participated in the scoping review and key informant interviews) and women who participated in the qualitative study (both phases). We are also working with the team of lawyers and advocates in New Brunswick who are challenging the provinces restrictions on clinic funding and will share our research with these provincial stakeholders.

6.4 Limitations

This project had a number of limitations. Originally, I had intended to conduct a de novo study with womxn from the Maritimes who had sought and/or obtained and abortion after 16 weeks gestation. However, recruiting a sufficient number of participants to obtain thematic saturation was not possible. The recruitment challenges we encountered were not unexpected but were still disappointing. The combination of this being a very small population and there being a significant amount of stigma surrounding abortion likely resulted in my inability to execute this study as planned. However, we were able to pivot and include womxn from across Canada who has obtained abortions after 16 weeks gestation. Although we gained tremendous insight by exploring the lived experiences of these women, future research would benefit from a targeted study in the Maritimes, as I had originally outlined in my proposal.

Ultimately our sample of 15 women from different parts of Canada showcased a range of barriers that those seeking later gestational age abortion care encounter. However, all 15 participants identified as women, all were Canadian citizens, the overwhelming majority were Anglophone (n=15), and most were white (n=11). Future research would benefit from more diverse perspectives with respect to gender identity, nativity, primary language, and race/ethnicity. Further, we were not able to recruit anyone who sought an abortion but was

unable to obtain one. Although this is likely a very small population in Canada, the perspective of those who could not obtain wanted abortion care is critical.

Finally, we believe that a qualitative approach was appropriate to answer our primary research questions and objectives. However, as is true of all qualitative research, our findings are not meant to be representative or generalizable. We believe that our findings are transferable to beyond the bounds of this particular study but we concur with many of our topic experts who expressed a need for quantitative information about later gestational age abortion provision in Canada.

6.5 Positionality and reflexivity

Discussing positionality and reflexivity is important when conducting qualitative research. The term positionality both describes an individual's worldview (an individual's beliefs, assumptions and overall reality) and the position they adopt about a research task and its social and political contexts (Holmes, 2020). Reflexivity is a self-monitoring of, and self-responding to, the thoughts, feelings and actions of the research as that person engages in different phases of the project (Cassell, Cunliffe & Grandy, 2018). Reflexive help researchers appreciate their own positionalities in relation to the research questions (Cassell, Cunliffe & Grandy, 2018).

I am aware that my own social positions may influence my interaction with participants and my interpretation of the findings. Therefore, it is important for me to reflect on the personal experiences that have shaped my thesis topic. I am a white, cisgender woman of reproductive age who is fully bilingual. I was born and raised in the Maritimes – specifically Moncton, New Brunswick. I lived there my whole life until moving to Ottawa, Ontario for my undergraduate

and graduate studies. Living in the Maritimes is where my passion for womxn's SRH stems from. I have had first-hand experience with the inadequate healthcare services the province offers and have been a witness to the turbulent accessibility of abortion services, especially for the Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, plus (2SLGBTQIA+) community in New Brunswick. Furthermore, being a pro-choice advocate in a politically conservative region and being from a province that does not fund procedural abortion services outside of hospitals has perpetuated my battle for reproductive justice.

Completing the work of this master's project has been my first opportunity to make an impact in the sexual and reproductive health world - particularly in the world of abortion service provision - and I am extremely humbled. This experience provided me with insight into the challenges and barriers womxn face when seeking access to LGA abortion services. Throughout the research process, I made ongoing reflections about how my positionality could have affected the way I conducted interviews and analyzed data. Moving forward, I feel competent and confident that I will be able to expand on the results of this thesis to further advocate for increased access to comprehensive reproductive health services in the Maritimes and across Canada.

6.6 Conclusion

Between 2015-2019, almost half of all pregnancies in Canada were unplanned and 37% of those pregnancies ended in an abortion (Guttmacher Institute, 2022). Canada's decriminalized approach to abortion is widely recognized as an example of how to ensure reproductive rights and autonomy. However, disparities in access to later gestations age abortion care persist and these disparities are largely based on geography. Identifying ways to strengthen and expand later

abortion services within different regions in Canada, providing funding for organizations that offer financial and patient navigation supports to those seeking later abortion care, and supporting efforts to destigmatize abortion in Canada are priorities for future action.

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Appendix A: REB Approval Letter – Component II

13/04/2022

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE I CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	S-04-21-6920
Titre du projet / Project Title	Assessing changes in the use of the National Abortion Federation Canada's hotline in the COVID-19 era
Type de projet / Project Type	Recherche de professeur / Professor's research project
Statut du projet / Project Status	Renouvelé / Renewed
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	14/05/2021
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	13/05/2023

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Angel FOSTER	École interdisciplinaire des sciences de la santé / Interdisciplinary School of Health Sciences	Chercheur Principal / Principal Investigator

Conditions spéciales ou commentaires / Special conditions or comments

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Appendix B: REB Approval Letter – Component III

13/06/2022

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	S-04-18-551
Titre du projet / Project Title	Documenting people's abortion experiences
Type de projet / Project Type	Recherche de professeur / Professor's research project
Statut du projet / Project Status	Renouvelé / Renewed
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	16/07/2018
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	15/07/2023

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Angel FOSTER	École interdisciplinaire des sciences de la santé / Interdisciplinary School of Health Sciences	Chercheur Principal / Principal Investigator

Conditions spéciales ou commentaires / Special conditions or comments

NOTE: This approval only covers the English version of participant documents (data collection tools, consent forms). French materials will need to be submitted to the REB (via a modification request) and reviewed before they are covered under the approval.

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