

**Exploring womxn's experiences obtaining abortion care through telemedicine  
services in Ontario during the COVID-19 pandemic: A qualitative study**

Thesis

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## **Abstract**

**Background:** Despite the overwhelming evidence that medication abortion care can be delivered safely and effectively through telemedicine services, Canadian abortion care providers have historically underutilized this modality of service delivery. However, the COVID-19 pandemic and the associated public health measures designed to flatten the curve both exacerbated existing inequities in access and prompted service delivery innovations in abortion care.

**Objectives:** This project aimed to explore the experiences of women, transgender men, non-binary folks, gender non-conforming, and Two-Spirit individuals with the capacity for pregnancy (womxn) with telemedicine abortion care. By understanding facilitators and barriers to telemedicine use as well as abortion seekers' satisfaction with remote interactions, we aimed to identify ways of improving and fortifying the abortion care system in Ontario.

**Methods:** Using a multi-modal recruitment strategy, we conducted semi-structured, in-depth interviews with womxn who obtained a telemedicine abortion in Ontario after March 15, 2020. We used inductive and deductive techniques to analyze these data for content and themes.

**Results:** The two Ontarian womxn that we interviewed were highly satisfied with the telemedicine abortion care they received and would recommend this service delivery modality with others.

**Conclusions:** The results from our pilot align with a growing body of research calling for the demedicalization of medication abortion care in Canada. Future research that expands on these findings can have both policy and service delivery implications.

## **Résumé**

**Contexte :** Malgré les preuves accablantes que les soins d’avortement médicamenteux peuvent être dispensés de manière sûre et efficace grâce aux services de télémédecine, les fournisseurs de soins d’avortement canadiens ont historiquement sous-utilisé cette modalité de prestation de services. Cependant, la pandémie de COVID-19 et les mesures de santé publique associées conçues pour aplatir la courbe ont à la fois exacerbé les inégalités existantes en matière d’accès et suscité des innovations dans la prestation de services en matière d’avortement.

**Objectifs :** Ce projet vise à explorer les expériences des femmes, d’hommes transgenres, de personnes non binaires, de genre non conforme et de personnes bispirituelles ayant la capacité de tomber enceinte (womxn) avec les soins d’avortement par télémédecine. En comprenant les facteurs facilitants et les obstacles à l’utilisation de la télémédecine ainsi que la satisfaction des demandeurs d’avortement à l’égard des interactions à distance, nous avons cherché à déterminer des moyens d’améliorer et de renforcer le système de soins d’avortement en Ontario.

**Méthodes :** À l’aide d’une stratégie de recrutement multimodale, nous avons mené des entrevues semi-structurées et approfondies avec des femmes qui ont obtenu un

avortement par télémédecine en Ontario après le 15 mars 2020. Nous avons utilisé des techniques inductives et déductives pour analyser ces données quant au contenu et aux thèmes.

**Résultats** : Les deux femmes ontariennes que nous avons interviewées étaient très satisfaites des soins d'avortement par télémédecine qu'elles ont reçue et recommanderaient cette modalité de prestation de services à d'autres.

**Conclusions** : Les résultats de notre projet pilote s'alignent sur un nombre croissant de recherches appelant à la démedicalisation des soins d'avortement médicamenteux au Canada. Les recherches futures qui approfondissent ces conclusions peuvent avoir des implications à la fois sur les politiques et sur la prestation de services.

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## **List of acronyms and abbreviations**

ARCC	Abortion Rights Coalition of Canada
BTC	Behind-the-counter
COVID-19	Coronavirus disease 2019
DNA	Deoxyribonucleic acid
EVA	Electric vacuum aspiration
FAM	Fertility awareness method
GP	General practitioner
MVA	Manual vacuum aspiration
NAF	National Abortion Federation Canada
ORCC	Ontario Coalition of Rape Crisis Centers
PHO	Public Health Ontario
REB	Research Ethics Board
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2
SRH	Sexual and reproductive health
VBAC	Vaginal birth after cesarean delivery
WHO	World Health Organization

# **Chapter 1: Introduction**

## ***Background***

### **Womxn**

Most of the literature regarding abortion care focuses primarily on women. However, this study recognizes that any person who has the capacity to become pregnant can want or need an abortion, and this includes more than just individuals who identify as women. I will use the term “womxn” throughout this thesis to signify women, transmen, non-binary folks, gender non-conforming, and Two-Spirit folks with the capacity to become pregnant (Reyes et al., 2021; Womxn’s Center for Success, 2021). This term also recognizes that the overwhelming majority of those who want and need abortion care identify as women and girls. When referring to the work of others, I will use the terms used in the original source.

### **Abortion definition and methods**

Induced abortion is both a common health service and a human right (Costescu et al., 2020). Abortion is typically defined as a procedure done to terminate a pregnancy so that it does not result in a live birth (Liu et al., 2019; Simmonds, 2021). An induced abortion can occur through the use of medications (medication abortion) or via an instrumentation procedure, including the use of aspiration methods (aspiration abortion) (Simmonds, 2021).

Aspiration abortion is an effective and safe method of abortion, with success rates over 99%, typically performed throughout the first trimester in a medical facility, i.e., a clinic or hospital, where a trained healthcare provider will insert a slim tube inside

the uterus emptying its content through suction (Ipas, 2021; Options for Sexual Health, 2020; Stevenson & Taylor, 2020). This procedure can happen through two methods: manual vacuum aspiration (MVA) where a hand-held syringe creates the vacuum, or electric vacuum aspiration (EVA) during which an electric pump creates the vacuum (Kapp & Lohr, 2020).

An alternative to aspiration abortion is medication abortion. This refers to the process of taking medications, either alone (misoprostol) or in combination (mifepristone-misoprostol or methotrexate-misoprostol), to induce an abortion during the early weeks of pregnancy (Borkowski et al., 2015; Moss et al., 2015; Options for Sexual Health, 2020). Misoprostol acts by ripening the cervix and causes the uterus to contract to empty out its contents (Krugh & Maani, 2021; Macnaughton et al., 2021).

Mifepristone inhibits the body's natural production of progesterone, a hormone necessary for implantation and the continued development of the endometrium.

Methotrexate inhibits thymidine production, which is necessary for DNA synthesis, consequently interfering with cell growth, in general, and rapidly dividing cells (Dunn & Brooks, 2018; Hannoodee & Mittal, 2021; Macnaughton et al., 2021).

### **Brief history of abortion in Canada**

In 1988, the Supreme Court of Canada's ruling in *R. v. Morgentaler* decriminalized abortion and deemed criminal restrictions a violation of the Charter of Rights and Freedoms (*R. v. Morgentaler*, 1988). To date, Canada is one of very few countries to have decriminalized abortion meaning criminal law does not regulate it, nor is abortion care restricted by indication or gestational age (Ennis et al., 2021; Singh et

al., 2018). Abortion care is instead treated like any other medical service and is regulated through provincial/territorial policies and professional bodies (Ennis et al., 2021; National Abortion Federation [NAF] Canada, n.d.-b). Although all provinces and territories offer abortion care, its availability and accessibility vary considerably (NAF Canada, n.d.-a).

In July 2015, Health Canada approved the use of the medication abortion drug mifepristone as part of a combination package with misoprostol (under the brand name Mifegymiso®) for early abortion (Jones et al., 2017; Shaw & Norman, 2020). However, the drug was not commercially available to the public until January 2017 (Action Canada for Sexual Health and Rights [Action Canada], 2019; Shaw & Norman, 2020). Prior to its approval in Canada, abortion care providers provided medication abortions through the off-label use of a methotrexate-misoprostol regimen, which had a significant failure rate (Burnett, 2019; Jones et al., 2017).

Annually, about 100,000 induced abortions occur in Canada (Costescu & Guilbert, 2018, p. 754). Approximately 31% of Canadian women will experience an induced abortion during their lifetime (Costescu et al., 2016, p. 369; Murray et al., 2019, pp. 1325–1326). In 2019, among those aged 15 to 44, more than 80,000 abortions took place in Canada, and of these, the province of Ontario (ON) reported more than 25,000 abortions to have taken place (Abortion Rights Coalition of Canada [ARCC], 2021, p. 2).<sup>1</sup>

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<sup>1</sup> These numbers are underestimates because the Canadian Institute for Health Information does not collect information about medication abortions offered through primary care facilities.

## **The COVID-19 pandemic in Ontario**

As stated by the World Health Organization ([WHO] 2020), the novel coronavirus disease 2019 (COVID-19) is an infectious disease attributable to the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). On March 11, 2020, the WHO declared the COVID-19 outbreak a global pandemic, and that same month, on March 17, 2020, Premier Doug Ford declared a state of emergency in Ontario; the province has since experienced significant social disruption brought on by the ongoing pandemic (Elawady et al., 2020; Nielsen, 2020; Ontario Newsroom, 2020).

In response to the pandemic, public health safety precautions – such as stay-at-home orders, hand sanitization, mask requirements, physical distancing, quarantine requirements, travel restrictions, small business closure, restrictions on large gatherings indoors and outdoors, etc. – were put into place (Ennis et al., 2021; Ontario Newsroom, 2020; Public Health Ontario [PHO], 2021). This was an effort to minimize the spread of the virus, prevent healthcare systems from being overwhelmed, protect immunocompromised individuals and their caretakers, and save lives (Ontario Newsroom, 2020). However, these measures also had both direct and indirect consequences on health services, in general, and sexual and reproductive health (SRH) services in particular.

## **Impact of COVID-19 on abortion care in Canada**

At the beginning of the pandemic, the federal government and many provincial governments declared abortion care an “essential service” given that it is time-sensitive (Action Canada, n.d.). However, the pandemic exacerbated existing barriers to

accessing abortion care (Action Canada, n.d.; Monchalin, 2020). In late March 2020, there was a 30% increase in calls reported by Action Canada (n.d.) – which operates a 24/7 Access Line program offering support, information, and SRH service referrals – from people concerned about a lack of access to abortion care and being unable to schedule an appointment (Action Canada, 2021; Cohen, 2021, p. 281). The NAF Canada hotline also witnessed a surge in requests abortion-related information and support after the onset of the COVID-19 pandemic (Demont et al., 2023).

Furthermore, according to the ARCC (2022), certain barriers to accessing abortion care brought on by the pandemic included the following: temporary closure of abortion clinics due to staff shortages or service hour reductions; restrictions on catchment areas of private clinics to abide travel restriction; instrumentation abortion services temporary sidelined or shut down by some hospitals to focus on the pandemic; and patients being reluctant or unable to travel due to fear of risk exposure. The addition of travel restrictions, stay-at-home orders, and required quarantine periods increased the difficulty in accessing abortion care for those living in rural or remote areas (Monchalin, 2020; PHO, 2021).

Public health stay-at-home directives were put into place to minimize the spread of the virus. Although these interventions supported public health and safety, they also created unique challenges for those at risk of experiencing violence at home, as many have had to shelter in unsafe environments (Cohen, 2021; Ontario Coalition of Rape Crisis Centers [OCRCC], 2020). As a result, women, girls, transgender men, and non-binary people were at higher risk of experiencing violence at home during COVID-19 isolation measures (OCRCC, 2020). Throughout the pandemic, reports of domestic

violence-related calls and rates of sexual assault increased, and consequently, unintended pregnancies likely increased as well (Cohen, 2021; Maxwell et al., 2018). Prior to the pandemic, accessing support was difficult as there remains unequal access to abortion throughout the country (Burnett, 2019). Canada's uneven population distribution, differential provincial/territorial policy environments, diverse belief systems, and abortion stigma have contributed to inequalities, and abortion clinics face the threat of harassment from protesters (Burnett, 2019; Foster et al., 2020). Other documented barriers to accessing abortion care in Canada include financial resources (high cost of travel for procedure, indirect costs associated with time off work and child care), geographic location (scarcity of providers in rural areas or no nearby services), immigration status (which can result in the abortion seeker needing to pay for the procedure or medications), delays (long wait times), confidentiality concerns, anticipated harassment at clinics, and healthcare providers refusing to provide abortion care on moral or religious grounds (Action Canada for Sexual Health and Rights, 2018, 2019b; Foster et al., 2020; Raymond et al., 2019).

The pandemic heightened many of these barriers and increased the challenges associated with obtaining abortion services. For example, when the stay-at-home orders were in effect, people had limited access to SRH services as well as options for in-clinic abortion care, especially if they lived in rural communities where standalone clinics are already limited (Cohen, 2021; Hukku et al., 2022). The pandemic caused significant economic disruptions that appear to have changed pregnancy intentions (Hukku et al., 2022). Moreover, the pandemic, and the associated job loss and economic insecurity

that many experienced, made it difficult for individuals to obtain the necessary funds to cover the costs associated with abortion care (Hukku et al., 2022).

### **Telemedicine abortion**

The term “telemedicine” first emerged in the 1970s and translated to “healing at a distance” (Ellis & Russell, 2019; Fok & Mark, 2018). Over the years, telemedicine has evolved to include the use of communication networks for healthcare delivery and medical education from one geographical region to another (Fok & Mark, 2018). This term refers to “a service that seeks to improve a patient’s health by permitting two-way, real-time interactive communication between the patient and the physician [health care provider] at a distant site” (Kichloo et al., 2020, p. 1). Moreover, four essential components make up this healthcare service: 1) offers clinical support; 2) overcomes geographical barriers and connects users located in different areas; 3) uses various sorts of information and communication technologies; and 4) seeks to improve health outcomes (WHO Global Observatory for eHealth, 2010). However, it is important to note that the term “telemedicine” should not be used synonymously with the term “telehealth,” which is a broader concept and instead refers to ‘the use of telecommunications and information technology (IT) to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance’ (Centers for Medicare & Medicaid Services, n.d., para. 1; Kichloo et al., 2020, p. 1).

A central aspect of telemedicine is the geographical distance between a patient and a health service provider, making telemedicine an ideal way to provide medication

abortion (Fok & Mark, 2018). Therefore, telemedicine abortion care refers to the combination of medication abortion and telemedicine; aspiration abortion care, by definition, requires an in-person encounter (Endler et al., 2019; Ennis et al., 2021).

Despite the overwhelming number of studies in support of delivering medication abortion care through telemedicine (Gill & Norman, 2018; Grossman & Grindlay, 2017; Jong et al., 2019), prior to the COVID-19 pandemic Canadian abortion care providers still underutilized this modality of service delivery. A number of researchers have evaluated the effectiveness, accessibility, acceptability, and safety of the delivery of medication abortion through telemedicine services; all of these studies show that telemedicine abortion care is safe and enables people to seek care over significant geographic distances (Aiken et al., 2021; Endler et al., 2019; Jong et al., 2019). One study by Aiken and colleagues (2021) reported that telemedicine services for medication abortion proved to be effective, safe, acceptable and improved access to care. Another study found that the provision of medication abortion through telemedicine was highly acceptable to women and healthcare providers (Endler et al., 2019). These studies also show that the success rate and safety outcomes are similar to those reported for in-person medication abortion care (Aiken et al., 2021; Endler et al., 2019; Jong et al., 2019).

The COVID-19 pandemic and pandemic response compromised access to in-clinic abortion services, and healthcare practitioners had to modify their methods of providing abortion care. Ennis and colleagues (2021) found through two surveys that healthcare practitioners across the provinces and territories – Quebec excluded –

reported there being a robust and rapid transition from in-person abortion care towards telemedicine care to ensure individuals still had access to services amid the pandemic.

### **Who uses telemedicine services, in Canada?**

In general, a wide range of individuals use telemedicine services in Canada. This includes both healthcare providers and patients of various age groups, genders, geographic areas, and socioeconomic backgrounds (Bhatia et al., 2021; Chu et al., 2021; Glazier et al., 2021; OECD, 2023). For instance, in Ontario studies show that telemedicine use is more prevalent among urban populations compared to those living in rural areas (Chu et al., 2021; Glazier et al., 2021; OECD, 2023). Additionally, given that access to and usage of the internet and technology are strongly correlated with income, telemedicine use was higher among individuals in the highest income quintile (Glazier et al., 2021; OECD, 2023; Patterson et al., 2022). It is important to note that although there might be variations in virtual care use among income levels and geographic areas, there is still a general interest and willingness to use these services in Canada (Chu et al., 2021; Glazier et al., 2021; Patterson et al., 2022).

Prior to the COVID-19 pandemic, the use of telemedicine services for remote care was not widespread in Canada. Although its uptake was relatively slow compared to other countries, studies found that a portion of the Canadian population was utilizing this service before the pandemic (Canadian Medical Association et al., 2022; Hafner et al., 2022). In 2019, the use of remote care in Canada was approximately 22%, compared to 66% in the United Kingdom and 77% in the United States (Hafner et al., 2022, para. 8). However, its usage drastically increased to approximately 60% at the

height of the pandemic (Canadian Medical Association et al., 2022, p. 4; Hafner et al., 2022, para. 9). In Ontario, studies reported a rise in remote care use from approximately 1.2%–1.6% in the second quarter of 2019 (pre-COVID-19) to approximately 70.6%–71.1% in the second quarter of 2020 (COVID-19) (Bhatia et al., 2021, p. E107; Canadian Medical Association et al., 2022, p. 5; Glazier et al., 2021, p. E200). Renner and collaborators (2023) highlight there is little data available in Canada regarding telemedicine used for first-trimester medication abortion, the number of abortion providers, and the barriers to providing these services (p. 687).

### **Satisfaction with telemedicine abortion services in the pre-COVID era**

Before the COVID-19 pandemic, numerous studies outside of Canada have evaluated patients' experiences obtaining medication abortion through telemedicine. In the United States (US), a study by Kerestes and colleagues (2021) explored the impact of direct-to-patient telemedicine abortion on access to abortion care. The authors reported that access to the clinic was a challenge for patients, to the extent that some would not have been able to obtain an abortion (Kerestes et al., 2021). Patients described their experiences with telemedicine abortion as being more convenient and accessible than going to a clinic, it alleviated privacy concerns they associated with in-person abortion care, and for some, it was their sole option to obtain an abortion (Kerestes et al., 2021). Additionally, patients in this study preferred the option of having the service (telemedicine abortion) brought to them instead of going to it (in-person clinic), thus removing the barrier of not having an abortion provider nearby (Kerestes et al., 2021). Overall, participants found direct-to-patient telemedicine abortion highly

acceptable (Kerestes et al., 2021). These recent results echoed those from Grindlay and colleagues (2013), another study done in the US; they evaluated patients' and providers' experiences with telemedicine provision of medication abortion and found the service to be highly acceptable to both patients and providers (Grindlay et al., 2013).

### ***Rationale***

In 2020, Dr. Angel M. Foster's research group, in partnership with NAF Canada, received a grant from the Social Sciences and Humanities Research Council of Canada to explore the impact of COVID-19 on abortion care in Canada. This study includes multiple components, including understanding womxn's experiences obtaining abortion care after the onset of the pandemic. As part of this project, in 2020-2021, Dr. Foster's research group interviewed 23 Canadian women in six provinces about their abortion decision-making and care-seeking experiences during the pandemic (Hukku et al., 2022). However, none of their participants obtained medication abortion care through telemedicine.

This project aimed to address this gap in the research on reproductive health in Ontario and fill an identified need by both advocacy organizations and providers.

### ***Research questions***

My study focuses on the experiences of Ontarian womxn. My specific research questions are:

- 1) What are Ontarian womxn's experiences using telemedicine medication abortion services during the COVID-19 pandemic?

- 2) From the perspective of patients, how can telemedicine medication abortion care be improved in Ontario?

### ***Outline of thesis***

I have written this thesis using a thesis-by-monograph approach and divided it into four chapters, outlined below:

1. Chapter one is the introduction and provides a definition of the term “womxn,” a brief history of abortion in Canada, the COVID-19 pandemic in Ontario and its impact on abortion care in Canada, and telemedicine abortion services and satisfaction with the modality of delivery prior to the COVID-19 pandemic. This chapter also contains the study rationale, the study questions, and the outline of the thesis.
2. Chapter two describes the study's methodology, including the recruitment strategy, interview process, details about the analytic approach, and research ethics.
3. Chapter three presents the results of the in-depth interviews with study participants.
4. Chapter four discusses the findings, policy implications, and limitations. This chapter also includes a section on reflexivity in the context of this thesis, a statement of contribution to the overall study, and the final conclusions. The bibliography and appendices are located at the end of the document.

## **Chapter 2: Methodology**

As my study builds on a previous study conducted by Hukku and colleagues (2022), we determined that a qualitative approach was the most appropriate method to investigate our research questions. To investigate the experiences of womxn who obtained abortion care through telemedicine services in Ontario, we aimed to conduct in-depth interviews with those who had sought or obtained this form of care.

### ***Participants***

The project focused on in-depth interviews with Canadian womxn. We recruited participants by reaching out to the community through social media (Instagram, Facebook, Kijiji, Reddit, etc.), as well as through clinics, university clubs, faculties, and community organizations. Individuals were eligible to participate if they:

- 1) Were sufficiently fluent in English or French to answer interview questions;
- 2) Were between the ages of 15 to 49 years of age (inclusive);
- 3) Sought out or obtained telemedicine medication abortion care during the COVID-19 pandemic (after March 15, 2020); and
- 4) Resided in Ontario at the time of seeking or obtaining medication abortion care through a telemedicine service.

I based the age range of this study on Statistics Canada's definition of "childbearing years" (Fostik & Galbraith, 2021, p. 8) as well as the definition used in the precursor study (Hukku et al., 2022).

## ***Interview process***

We used the interview guide from the precursor study and made some modifications to adapt it for the telemedicine study before the recruitment process. We then later refined the guide once we began interviewing participants. Before the interviews, we sent potential participants a consent form with detailed information about the research project and the study's goals. Because we held our interviews over audio-Zoom and phone, the interviewer orally reviewed the consent form and objectives to ensure that participants understood the purpose of the study. We reassured participants that participation was completely confidential and voluntary; they were free to ask that the recording device be turned off at any given time or withdraw from the study at any point without penalty. With the participants' permission, we audio-recorded interviews which averaged around 50 minutes, and we asked participants to participate in the interview in a private and comfortable location.

The interviews began with a series of demographic questions (i.e., name, age, educational background, occupation, race and ethnicity, country of origin, pronouns, types of social support, etc.) before moving on to questions regarding the participant's general reproductive health history. We then asked participants questions about their experiences with the abortion decision-making process, the process of obtaining abortion care, and the abortion process itself. The interviews concluded with a discussion of ways that services could be improved and two hypothetical scenarios touching on advance provision and behind-the-counter (BTC) status. As a 'thank you' for participating in the study, we gave participants an online CAD40 gift certificate to [www.amazon.ca](http://www.amazon.ca).

During the interviews, I took notes on the participant's experiences with the abortion care she/they received through telemedicine services and her/their reflections on how to improve these services. After the interviews, I engaged in memoing to reflect on the participant's experiences.

### ***Analytic approach***

I started reviewing the data as soon as we collected them. My thesis supervisor provided me with feedback on the transcripts and codebook after reviewing them. Following the interviews, I engaged in formal memoing to record my reflections and insights (Birks et al., 2008). This helped me to identify and acknowledge potential biases and assumptions that may have influenced my interpretation of the data. Using an iterative analysis approach, I was able to gain a better understanding of the data collected from the interviews (Srivastava & Hopwood, 2009). My aim was to identify recurring themes that emerged through the interviews and determine when we reached thematic saturation (Lowe et al., 2018).

During the first phase, I transcribed the interviews and engaged in careful and repeated listening to explore and understand the content. The project's second phase involved developing an initial codebook based on a priori (pre-determined) codes and categories from the interview guide and notes that I had collected during the interviews. I developed the initial codes and categories based on the aims of the research study and my research questions. I derived insights from my field notes, which acted as supporting documentation for this research project (Birks et al., 2008). I defined and described each code and added new codes as I reviewed the transcripts. I then shared

my codebook with my supervisor. Once I coded the transcripts, my next step was to identify the key sub-themes that expressed more relevant distinctions in the transcripts. The final phase focused on interpreting and connecting ideas and combining the results. I used the ATLAS.ti software to manage my data, including notes, transcripts, and memos.

To equip myself with the necessary skills for the analytic and interpretive process, I attended and participated in regular group meetings held by my thesis supervisor. I also participated in a two-day qualitative methods workshop during the first year of the program. Moreover, the feedback I received on the abstract and poster I presented during the second year of the program assisted me in improving my ability to communicate the findings.

### ***Narrative vignettes***

In reporting the results, I used illustrative quotes to showcase themes and ideas. To provide thick description and illustrate womxn's experiences obtaining abortion care through telemedicine services in Ontario during the COVID-19 pandemic, I also present narrative vignettes. Narrative vignettes are gathered information about participants' experiences related to a specific topic or situation based on the close review of in-depth interview transcripts (Gourlay et al., 2014; MacFarlane et al., 2017; Nara et al., 2019; Tousaw et al., 2017). These narrative vignettes serve as short stories to summarize participants' experiences (Gourlay et al., 2014).

### ***Ethical considerations***

This study received ethics approval from the Social Sciences and Humanities Research Ethics Board (REB) at the University of Ottawa (File #S-04-18-551). I have included the REB certificate of approval in Appendix A. Throughout this thesis, I have used narrative vignettes to provide a picture of the participants we interviewed, and I quote participants to showcase central themes. I have redacted or masked all personally identifying information. Additionally, I have used pseudonyms throughout. These pseudonyms were either assigned by the interviewer or chosen by the participant.

## **Chapter 3: Results**

### ***Recruitment***

The recruitment efforts for this study encompassed a multi-modal strategy and an array of materials. First, we developed recruitment materials in both English and French, which included social media recruitment text and flyers. Both recruitment materials included a brief study description, eligibility criteria, and contact information for questions concerning the project. I have included the English and French recruitment flyers at the end of this document in Appendix B and C, respectively. Moreover, I facilitated the involvement of HSS4901 students in the recruitment process by providing them with the necessary materials. With their assistance, we continuously posted online advertisements for the study on Reddit and Kijiji using the social media recruitment text.

A significant aspect of the recruitment process involved networking with national organizations and various community organizations. Some national organizations included ARCC, NAF Canada and Action Canada since Dr. Foster has relationships with these groups. I e-mailed information regarding the study to various community organizations, which included university clubs and clinics/health services, reproductive health organizations, and abortion clinics based primarily in Ontario and some in Quebec. I tried focusing recruitment efforts in Francophone venues, as this is often the most challenging population to recruit. I circulated the recruitment materials to our research group and my personal and professional networks. Unfortunately, not a lot of these community organizations were receptive or responded. However, those who responded then spread the information by posting it on their annual calendar or by posting it on social media (Instagram, Twitter, Facebook).

### **Caitlin's story**

Caitlin is a 27-year-old Caribbean-Middle Eastern woman who lives in Ontario with her two roommates. She went to school for visual arts and works part-time in independent galleries. Due to lockdowns and closures, Caitlin reported being unemployed for a while during the pandemic. The public health measures put in place in response to COVID-19 also negatively impacted her overall health since she was unable to exercise and ate more.

When Caitlin discovered she was pregnant in January 2021, she felt “worried [and] wanted to get it confirmed right away.” Caitlin had not previously thought of becoming pregnant because she was “trying to find [a] good job and [finish] school.” Caitlin did not intend to become pregnant; she was on oral contraceptive pills prior to going on vacation but had not brought them with her and skipped them for a few weeks. Caitlin had a discussion with her then-partner, and they came to the conclusion they “weren’t ready to take it to the next level [and] weren’t in a kind of financial position to kind of have a kid too.” Caitlin “decided that abortion would be the way to go,” and her then-partner agreed.

Caitlin described the overall process as “smooth” with no issues, and the abortion care she received as “less personal” since most of it had been by phone due to the pandemic. She thought the process of getting the abortion overall was “good” and had no complaints. She felt the provider had done a “pretty good job” and would recommend them and medication abortion to other people, having found it “convenient” and “effective” not having to go through an “invasive” abortion process. However, she thought more education on the abortion options available would be a significant improvement in abortion services. Caitlin was very receptive to both advance provision and behind-the-counter modalities of medication abortion service delivery, as she felt these would be convenient, more accessible, and save time.

### ***Participant demographics***

We conducted two in-depth interviews with Canadian womxn. Participants averaged 27.5 years of age; one was 27, and the other was 28 years old. Both participants were living in Ontario at the time of their abortion and held primary residency in Toronto. Participants self-identified as Caribbean-Middle Eastern (n=1) and Hispanic (n=1). At the time of the abortion, participants were both at approximately 6 weeks gestation. Both participants confirmed they had at least one telemedicine abortion after March 15, 2020.

At the time of the interview, one of the participants was single and had only been pregnant that one time, while the other participant was married with two children. Moreover, concerning their living arrangements, one participant was living with two roommates, while the other was living with her partner, their two children, and her grandfather.

Both participants had obtained at least some post-secondary education through college or university. One participant mentioned her part-time employment, while the other stated she was a stay-at-home mom. Finally, participants stated that their primary sources of emotional and social support consisted of family, friends, partners, roommates, and neighbours.

### ***General reproductive health history***

#### **Wide range of reproductive health experiences**

When asked about their reproductive health status overall, both women self-reported being in good health. When asked about important reproductive health events that had occurred in their lifetimes, one participant did not have anything to report. However, the other did recall when she learned she had two dermoid cysts the size of “golf balls” when she was 21 years old that turned out to be non-cancerous. Neither participant reported any current problems or conditions regarding their reproductive health.

## **Different experiences with sources of care and services**

One participant reported not having a primary care clinician because she had not been able to find one. Instead, she uses walk-in clinics for sexual and reproductive health services, finding them more convenient, being able to go in without an appointment, and always having physicians available to address any questions. The other participant reported having a general practitioner (GP) she often contacted whenever she had questions.

## **Pregnancy history**

When asked about their pregnancy history, one participant reported only having one pregnancy that resulted in an abortion. The second participant reported four pregnancies: one miscarriage, two deliveries, and an abortion between the two pregnancies carried to term. This participant suffered a miscarriage at 4 weeks gestation for her first pregnancy and described it as someone pulling a large tampon that was too far up in her abdomen. She contacted her GP and went to the emergency room for a standard ultrasound to confirm everything was fine. She delivered her second pregnancy at 42 weeks gestation via caesarean at the hospital, where she had an obstetrician and doula. She described this delivery as a traumatic experience, having been in labour for two days before being taken to the operating room. Despite trying for a vaginal birth after caesarean (VBAC), she delivered her fourth pregnancy at 39 weeks gestation via caesarean at a different hospital because she had decided to go with a midwife, and her midwife had privileges there. This was within the context of COVID-19, but the participant expressed that she had not minded there not being as many people

around in the same way. She described this delivery as an amazing experience compared to her first.

### ***The decision-making process***

#### **Contraceptive use**

Both women we interviewed reported using contraception inconsistently in the month they became pregnant. One participant reported being inconsistent with her use of contraceptive pills, and the other reported using the fertility awareness method (FAM) at the time of the unintended pregnancy.

#### **Learning they were pregnant**

One participant suspected pregnancy when she noticed she had skipped her period. The other participant had, at the time, been 10 months post-partum and had not had a period since giving birth to her firstborn. However, she suspected pregnancy when she experienced an electric sensation while nursing her infant. Both women decided to take a take-home pregnancy test after noticing some sort of change in their bodies.

So, [my baby] was 10 months old. I had been breastfeeding. Everything was fine... And then basically [my baby] went to latch one morning when [they'd] woken up, and I felt a very tingly sensation when [my baby] latched and it [really] hurt. And I said, 'Okay, well, I think I'm pregnant,' immediately. Because [that]

was my first sensation when I had fallen pregnant with [my baby], [my] nipples were super sensitive. (Annalie, age 28)

When asked about how they felt about the pregnancy, Caitlin recalled, “I was worried. So, I wanted to get it confirmed right away.” The other participant reported that she and her husband were both unhappy and terrified about the results of the take-home pregnancy test.

So, I took [the pregnancy test] with my partner in the bathroom. And we do everything together, so I figured he should be there for this terrifying, terrifying truth. So, we were in the bathroom, and it was not the same experience as when we found out we were pregnant with [our firstborn]. It was like ‘oh no.’ [...] We are not happy. We looked at each other’s faces, and we are not happy. We were equally terrified. (Annalie, age 28)

### **Timing of pregnancy is an important factor**

When asked about their feelings regarding pregnancy before finding out they were pregnant, one participant reported that she had not thought about it; she was finishing her education and focused on finding employment. However, both women expressed that they were simply not ready to move forward with the pregnancy due to the circumstances surrounding it.

When asked about what factored into their decision to terminate the pregnancy, a primary finding among these women seeking an abortion was the importance of

financial stability. Both women reported that they were not in a financial position to support a child or an additional child; one participant reported her unemployment status at the time, and the other mentioned her partner getting laid off three times during the pandemic. Other factors included a lack of support during the pandemic and poor mental headspace. Moreover, when asked if there was any consideration related to COVID-19 for the abortion, one participant reported that it had not been a factor in her decision to terminate the pregnancy.

So, I was with my ex at that time. And well, I got pregnant, but we weren't ready to take it to the next level. We also weren't in a kind of financial position to kind of have a kid too. (Caitlin, age 27)

We wanted to give [my firstborn] the best experience possible in the time that we had, and [it] was during this time of pandemic. We didn't have the most support. My parents are still working age. [My husband's] parents are still working age. He was laid off. He was between jobs. We were going through our savings. I was not in a place to have another child, mentally. I did not have the headspace for another kid at the time. (Annalie, age 28)

### **Feelings of certainty were common**

We asked participants to reflect on what options they had considered once they learned they were pregnant. Both women reported having discussed this with their partners and came to the conclusion that they wanted to end the pregnancy. They both

felt certain of their decision to terminate the pregnancy after discussing it with their partners.

I decided that abortion would be the way to go, and [my then-partner] agreed...Yeah, I knew that I wanted the abortion. (Caitlin, age 27)

So [my husband] was like 'okay, you're at peace with this, I'm at peace with this. Let's get the ball rolling.' And I was like, 'let the record state that it is my decision. It was my idea.' (Annalie, age 28)

### ***Process of obtaining care***

#### **Similar process of obtaining care experiences**

We asked participants to share their experiences about how they obtained care. Both women recounted a similar sequence of events. First, following their decision to terminate the pregnancy, both women contacted healthcare providers to schedule an appointment. Neither participant reported long wait times between first contact and appointments or to receive confirmation results of their pregnancies. Participants mentioned having to fill out some paperwork and having an ultrasound done to confirm how far along the pregnancy was. Afterwards, both participants recalled being given information on their abortion options and opted for a medication abortion. Both women stated they had their abortion and associated services, such as urinalysis, blood test requisition, and ultrasounds, at no cost. Finally, when they received confirmation of their pregnancy by phone, both women reported their provider faxing their medication

abortion drug prescription at their local pharmacy. Following their abortions, both participants reported following up with their provider to confirm that the abortion had been successful.

So, I went in for an appointment, had to fill out a bunch of forms. And then they gave me another blood test to confirm [how] long I had been pregnant for. Because I think there's different criteria for eligibility. And then they told me I was eligible for abortion, and I got to choose between the pill or the surgery, and then I chose the medication because it's less invasive. And yeah, and then things just kind of went from there. (Caitlin, age 27)

[My GP] basically, was like, 'This is the deadline that you have, for it to be the medication. This is the deadline. After this time, it's so and so, the procedure is different.' And I said, 'uh-oh.' And I was very grateful that I was at 4 weeks at that point...But knowing that it was the 2-step pill, made it that much easier to make up my mind. Like I knew it wasn't going to be the 'medical abortion' like the one [where] it's like you're an in-patient and everything. (Annalie, age 28)

### **COVID-19 precautions**

When asked about if there were any COVID-19 precautions, both participants reported that there were precautions put in place. For instance, one participant reported there being a lot of typical precautions in place at her initial visit to the clinic, and the

other participant reported she was not able to go in for an in-person appointment with her GP.

[A] lot of masks, and we had to wait outside for our appointment instead of waiting inside, and they call us in. And I noticed that the waiting area [the] chairs were removed, so you wouldn't like, sit down and then hand sanitizers everywhere. Yeah, like the typical precautions, I guess. (Caitlin, age 27)

That was because of the pandemic. You basically weren't seen unless you were dying. (Annalie, age 28)

#### **Annalie's story**

Annalie is a 28-year-old Hispanic stay-at-home mom living with her husband, two infants, and her grandfather in Ontario. Due to COVID-19, Annalie reported they faced financial strain; her partner went through three layoffs during the pandemic which resulted in them blowing through their savings and then living paycheck to paycheck.

Annalie describes her reproductive health overall as fine. Her pregnancy history consists of four pregnancies; one miscarriage and one abortion which occurred between two deliveries. Annalie and her partner's main contraceptive method includes utilizing FAM; she explained that they planned their dates of conception, except for the one pregnancy that occurred when she was about 10 months post-partum and had previously been told by a nurse, she would not conceive during the first year if she was actively nursing.

Annalie discovered she was pregnant in October 2020, after she had breastfed her firstborn, and felt a "tingly sensation when he latched." When she took a home pregnancy test to confirm her suspicions, she and her partner were "not happy" and both "equally terrified." She brought up the idea of aborting the pregnancy to her partner, who was a bit emotional at the idea, but once she put it into perspective, they both agreed it was best to terminate the pregnancy since they were "not in a place to have another child."

Once Annalie made her decision, her first initial contact was her GP over e-mail. Most of Annalie's interactions with her GP were over e-mail because of the pandemic; she

explained that “you basically weren’t seen unless you were dying.” She was sent in for a urinalysis appointment to confirm the pregnancy and an ultrasound pre-abortion. Both were in-person. When her GP received the confirmation results confirmed it to Annalie and sent over the medication abortion prescription to her local pharmacy. She recalled feeling the effects immediately after taking the first pill; she described it as “a really aggressive cycle” and mentioned, “[she] was really sensitive, really queasy.” Finally, she stated receiving an e-mail from her GP who sent her in for a post-abortion ultrasound to confirm the abortion was successful.

Annalie reported being satisfied with the care she received given the circumstances and would recommend her GP and clinic to others, as well as the telemedicine abortion model to someone else using medication abortion. She and her partner “look back on it [as] the best decision [they’ve] ever made and a positive experience.” Annalie was very receptive to the different models of service delivery. She felt it would be “great” to continue telemedicine abortion after COVID. In terms of lean-away from associated services like urinalysis and ultrasounds but keeping counselling and information provided over Zoom/phone/e-mail, she felt “it’s good to know the urinalysis [and] that would be something [she] would have wanted to do either way.” When asked about her thoughts on advance provision (refill and advance prescription), she expressed interest in this model and stated it was “handy” and would be “one less step,” and it “[made] sense to have it.” When asked for her thoughts on the BTC model, she felt it was also “great” and noted its similarity to Plan B but with a consult.

### ***Telemedicine medication abortion process***

#### **Encounters with the health system**

Our first participant went to the pharmacy to get a pregnancy test and took it there. A week later, she went to a walk-in clinic and had a blood test requisition done to confirm the pregnancy. A few days later, the walk-in clinic confirmed her pregnancy by phone and provided her with some options for abortion clinics in her area. A few days after contacting the abortion clinic, she went in for her appointment where they gave her another blood test and an ultrasound to confirm the pregnancy gestation. When they received her results, they called her to confirm her pregnancy and faxed her medication abortion prescription to her local pharmacy where she was able to pick it up. A few days

after taking the medication abortion drugs, she returned to the abortion clinic for a follow-up to confirm that the abortion had been successful.

Our second participant took a pregnancy test and then contacted her GP by e-mail, who sent her in for a urinalysis and an ultrasound at a local walk-in clinic lab to confirm the pregnancy. When her GP received her results, she confirmed it with Annalie over the phone and sent over her medication abortion prescription to her local pharmacy, where her husband went to go pick it up. After taking the medication abortion drugs, her GP sent her in for a follow-up; she went to the hospital for a follow-up with a sonographer to confirm the abortion had been successful. A few days later, her GP got the report and called her to inform her that everything had been successful.

### **Women's abortion process overall**

When asked about the process of obtaining the medication abortion, both women expressed that they had no issues obtaining their prescription from their local pharmacy and that it was pretty straightforward. When asked about the abortion process itself, one participant recounted taking the first pill before going to bed and recalled experiencing some bleeding, which lasted about three days, with heavy bleeding on the first day. The other participant reported feeling the effects immediately after taking the first pill. She described it as an aggressive cycle and feeling sensitive and queasy. We asked both women to characterize the abortion process overall. One participant characterized the process as smooth; she did not find any bottlenecks or issues with the process and had no complaints. The other participant characterized the process as one of the great decisions of her life.

## **Feelings about telemedicine abortion care received**

When we asked participants about how they felt receiving remote/telehealth/no touch care, both women expressed feeling satisfied with the care they received given the circumstances and found it convenient. However, one participant expressed that the remote nature of the care she received made it feel less personal.

I think, because a lot of it was done over the phone... It felt less personal, especially given the result. But it was the nature of the pandemic. So, it was okay, and the phone was kind of convenient as well, because I could take it from anywhere, so I didn't mind it so much. (Caitlin, age 27)

We also asked participants how they felt about their decision to have an abortion in retrospect. Both women expressed that they did not regret their choice to terminate the pregnancy. One participant mentioned having told her roommates and her mother about her decision to have an abortion and stated they had been understanding and supportive of her decision.

I mean, it's still sad, obviously...But like we look back on it on one of the best decisions we've ever made, and a positive experience, and grateful we had the support, grateful that access to an abortion date...grateful we had access to the abortion at the time that we found out we were pregnant. In so many ways it was a great experience, and we're happy we did it. (Annalie, age 28)

## ***Improving telemedicine abortion care***

### **Recommend telemedicine abortion care to others**

Both of the participants stated they would recommend their provider to other people seeking abortion services. One participant explained that it was because they had done a good job, and the process was as expected. The second participant expressed that she always recommended her GP and family clinic to anyone who asked. However, this participant noted that her experience with one sonographer, pre-abortion, had been uncomfortable because they asked too many family planning questions assuming that she was continuing the pregnancy. She would have preferred that they not ask her anything. The participants' positive recommendation of their abortion providers suggests a positive overall experience with the services received and highlights the importance of avoiding assumptions about their reproductive choices or intentions.

When asked if they would recommend medication abortion to other people seeking an abortion, both women stated that they would. One participant explained that it was because she had found it convenient and effective and did not require an invasive procedure. The other participant explained it was because it could be done in a comfortable environment. The positive experiences and recommendations provided by these participants highlight the satisfaction and convenience that abortion seekers can experience when choosing medication abortion as a method to terminate a pregnancy.

I would say, you're taking charge of a situation where you can medically induce it in the comfort of your home...Rather than being somewhere like a clinic, in a new

environment with people you don't know... Possibly, you know, engaging with people that you might not want to during a very sensitive time of your life. You could be hormonal. Like do you really want to have to do all that just to have basically like a medically induced cycle. (Annalie, age 28)

### **Need for education on abortion options**

When asked about how abortion services could be improved, both participants brought up the need for education on abortion options. One participant had previously been unaware that medication abortion was an option. She suggested there be more education on the options available. Another participant, however, had a fair amount of knowledge about medication abortion when she found out she was pregnant. She explained she had gotten her information from the internet, pamphlets, and reading the posters on the wall at her GP's office. This highlights the importance of comprehensive and accessible education on abortion options for individuals seeking reproductive healthcare.

Really great that there's [the medication abortion] option available. I had no idea. I thought you would need to get a surgery. (Caitlin, age 27)

### **Need for education on post-partum myths**

One participant reported that a public health nurse told her she would not conceive during the first year if she was actively nursing. She had been 10 months post-partum when she conceived; she was still actively nursing and was not using contraceptives other than the FAM. This participant's experience highlights the potential

misinformation and lack of knowledge surrounding the contraceptive effects of breastfeeding among healthcare providers, which can lead to unintended pregnancies among post-partum individuals.

And then there was the one, that one case that we're talking about, for the study which was when I got pregnant when I was 10 months post-partum, but I was actively breastfeeding. And I remember the public health nurse said, 'For the first year you will not conceive if you are actively nursing'...and I was like this is fantastic! Natural birth control, right? Which I wasn't on anything...We were just using FAM and that was it, you know. (Annalie, age 28)

### **Continuing with telemedicine abortion services post-COVID-19**

We spoke with both women about continuing the efforts of streamlining medication abortion care through telemedicine services post-COVID, including the implementation of a no-touch/no-test or low-touch/low-test protocol. We asked participants how they would have felt if they had not had the initial visit for blood work, urinalysis, or ultrasound, and both women expressed some hesitation. One participant thought there could be a miscalculation of the gestation period, which could lead to complications if not confirmed. When asked about what they thought about not needing to meet with the clinician unless they wanted to but that the counselling and information could happen electronically, we had a participant who felt that it was a great idea. Finally, we asked participants about how they would have felt if the follow-up had been

entirely by phone. Both women expressed that they would have wanted to do a follow-up in-person to confirm that the abortion had been successful.

I feel like it's good to know the urinalysis. I feel like that would be something I would have wanted to do either way, just to make sure I actually am pregnant...So, I wouldn't want to take [the medication] if I wasn't actually pregnant, so I would've wanted confirmation...And I would have wanted to make sure that I passed that all, even though I was only 4 weeks, I would've wanted to make sure that everything was okay. (Annalie, age 28)

#### **Hypothetical scenario: Advance provision**

One possibility for increasing access to abortion care in Canada is to provide the medication abortion drugs in advance of need. For example, a clinician could provide a refill for mifegymiso [medication abortion] so that if a woman or pregnancy capable person needed another medication abortion in 1-2 years, she would not need to see a clinician again.

Another option would be for a primary care clinician to write a prescription for medication abortion to all sexually active pregnancy capable patients in advance of need. For example, if a woman came in to renew her prescription for oral contraceptive pills, after discussion with her clinician, she would also receive a prescription for mifegymiso in case she experienced contraceptive failure.

#### **Hypothetical scenario: BTC status**

There is some work underway to change the way that medication abortion is provided. In this model, a woman or pregnant person could go directly to a pharmacy and have a consultation with the pharmacist. The pharmacist would then determine if the person was eligible for mifegymiso – if so, she/they would get the medication there and it would be paid for by provincial or territorial insurance. If the pharmacist thought the person needed blood tests, an ultrasound, or a physical exam, the pharmacist would refer the patient to an abortion provider.

### ***Hypothetical scenarios***

Both women expressed openness to a hypothetical advance provision where a clinician could provide a refill for the medication abortion drugs if a pregnancy-capable patient needed another medication abortion in the future. One participant explained that she thought it would be convenient and any additional information she would have wanted, concerned if it was the same version she had previously taken and if there were any additional side effects. The other participant explained that if someone was confident enough to know they wanted an abortion, it should be accessible. She thought it would be time efficient if the person seeking the abortion were already aware of the process, risks, and benefits. Additionally, both women expressed intrigue to a hypothetical advanced provision prescription model, where a primary care clinician can prescribe medication abortion to all sexually active pregnancy-capable patients in advance of need.

That's definitely interesting. I mean having that refill kind of handy...I feel like, if you're confident enough to know that you want an abortion, you should have access to it...You already had one. So, I mean like, if the medication is already there, you know the process, you know the risks and the benefits. And you're educated on that. Then sure, I feel like a refill, I mean would be one less step. You're familiar, you know. Yeah, I feel like that's a good call. (Annalie, age 28)

Both women also expressed considerable enthusiasm for a hypothetical behind-the-counter model of medication abortion service delivery, where a pregnant person

could go to a pharmacy and have a consultation with the pharmacist to obtain the medication. One participant thought that it would be more accessible and time efficient.

[If] the pharmacy based on kind of the interview, they indicate that you are eligible for [the medication abortion], then I think that saves time. (Caitlin, age 27)

The findings from these hypothetical scenarios indicate that participants are open to alternative models of medication abortion provision. The participants met the hypothetical scenarios of advanced provision and BTC models with openness, intrigue, and enthusiasm. They saw these models as convenient, time-efficient, and accessible options for other patients seeking medication abortion care. It is worth noting that while there was enthusiasm expressed for these alternative models of provision, participants did express they still would have wanted the reassurance of confirming the pregnancy or confirming the abortion had been successful.

## **Chapter 4: Discussion & conclusion**

### ***Study findings & significance***

Because of the challenges with recruitment, this thesis effectively served as a pilot of the recruitment strategy and study instruments. Although the design of the in-depth interview was informed by the larger Abortion in the COVID-19 era in Canada study, we were also able to learn from these two interviews and modify the guide for further research. The in-depth interviews suggest that there is a growing interest in and acceptance of telemedicine services for obtaining abortion care; this is something that will need to be explored further in future research. The abortion experience for both participants was very similar, and there were no significant differences in the abortion care they received through telemedicine services. However, the interviews also highlight that the definition of telemedicine is complex, as both patients had in-person and virtual/phone visits as part of their care. This will need to be taken into consideration when recruiting participants in the future.

There were similarities in the findings between both participants. Both women expressed that the timing of the pregnancy was an important factor in their decision-making process. Additionally, the importance of financial stability was a common finding between the two participants. As mentioned by both participants, the pandemic and pandemic response made it difficult for steady employment.

Both participants expressed certainty regarding their decision to terminate the pregnancy. This aligns with other research on abortion patients in Canada (Foster et al., 2017, 2020; Hukku et al., 2022; LaRoche & Foster, 2020). Another common finding was the feeling of satisfaction with the telemedicine abortion care participants received. Both

participants declared that they would recommend this service delivery modality to others.

The in-depth interviews highlighted the need for more education on abortion options. One in-depth interview participant mentioned she had been unaware that medication abortion was an option available to her; research both prior to and after the introduction of mifepristone in Canada found that knowledge of this abortion modality was low (LaRoche & Foster, 2020; Vogel et al., 2016). This participant suggested that there be more education on the abortion options available. The in-depth interviews also highlighted the need for education on post-partum myths.

One recommendation gathered from participants during the in-depths interviews consists of the need for education and awareness for the general public on the abortion options that are available to them. Similarly, Sethi & Park (2023) report there are gaps in knowledge of available abortion options among Canadian women. According to their survey, which sought to learn about Canadians' current knowledge of abortion methods, preferences, and availabilities of options present in Canada, only 58% are aware they have access to medication abortion (p. 2). Moreover, despite 8 out of 10 (79%) Canadians knowing they have access to at least one abortion method, aspiration or medication, only 52% are aware of both (p. 2).

It is important that those with the capacity to become pregnant but wish to terminate the pregnancy receive all the information they need to obtain an abortion using the method that is best suited to their personal preferences and needs (American Academy of Pediatrics, 2023; Vogel et al., 2016). Comprehensive changes in the sex education curriculum (grade 7 – 8) should be made to equip the general public from an

early age with the information on all abortion options available to them so they are able to make sound decisions concerning their health and well-being before they find themselves in a position to need it (Ministry of Education, 2019). Information should also be disseminated to the general public through clinics (private and walk-ins) and hospitals using posters or pamphlets, or through public health campaigns using social media.

Furthermore, another recommendation drawn from the interviews concerns improving education on post-partum myths among healthcare providers. Better education on post-partum myths, for both healthcare providers and the general public such as post-partum pamphlets, could help prevent the spread of misinformation and thus reduce the chances of unintended pregnancies among post-partum individuals.

Finally, our interviews revealed the openness and enthusiasm expressed toward different modalities of medication abortion service delivery, including advance provision and BTC access. Hukku and colleagues (2022) also found that there was enthusiasm for demedicalized strategies of offering abortion care. Future research should explore the possibility of operationalizing innovative service delivery strategies.

The evidence is clear that demedicalization is clinically acceptable and medication abortion drugs should be made available to the general public whenever it is needed. Several studies support the findings from this study; that demedicalized models of access to abortion can be an effective model of abortion care (Moseson et al., 2020; Yanow et al., 2021). The findings of this study echo the findings of other studies that suggest that demedicalization can be achieved through advanced prescription

provision, its availability over the counter, or even through pharmacy dispensing (Advancing New Standards in Reproductive Health et al., 2018; LaRoche et al., 2020).

Furthermore, the findings of this study aligns with the emerging evidence about how abortion care seekers are interested in the usage of telemedicine as a modality of service delivery. Sethi & Park (2023) report that if faced with a pregnancy termination situation, there is a high preference (40%) among Canadian abortion seekers for medication abortion, and 64% would be comfortable using medication abortion at home if prescribed through telemedicine services (pp. 3–4).

### ***Similar findings from other studies***

Since the COVID-19 pandemic a few other studies have been conducted on the interest in, and acceptance of, telemedicine abortion. For instance, a study conducted by Somefun and colleagues (2023), explored the acceptability of telemedicine implementation for early medical abortion in South Africa. Similar to the findings in my study, the authors found that participants express interest in telemedicine as a service modality delivery for abortion care due to the convenience of being able to reach their healthcare providers from their home or workplace (p. 5). Another study, conducted by Chong and collaborators (2021), explored the expansion of a direct-to-patient telemedicine abortion service in the United States and experience during the COVID-19 pandemic. Their findings resemble the findings of my study. Through surveys, they found satisfaction among participants with the service they received (Chong et al., 2021). A third article explored the experiences of women in Scotland who obtained medical abortion using a telemedicine abortion service (Boydell et al., 2021). Like this

research project, the article found that some participants still had some in-person interactions with the healthcare system to collect the medication, preferring to have a “sense of control over the process” (Boydell et al., 2021, p. 1756). Similar to our findings, the convenience of being able to contact their provider remotely was expressed as well as their experience using telemedicine services being a positive one (Boydell et al., 2021). Additionally, one of our participants expressed the benefit of taking charge of a situation in the comfort of their own home, which was also described by the participants of their article (Boydell et al., 2021). Overall, like these studies, the findings of this research project provide evidence in support of telemedicine as a service delivery modality that can make medication abortion more accessible beyond outbreak events, such as the COVID-19 pandemic.

### ***Challenges & limitations***

As is true of all qualitative research, by definition, our findings are not generalizable nor statistically representative of the population. Our study focused on the experiences of womxn who obtained abortion care through telemedicine services in Ontario during the COVID-19 pandemic. We had hoped that in interviewing a sufficient number of womxn to reach thematic saturation, we would be able to identify transferable findings.

One significant challenge encountered in this study was the recruitment of participants, which resulted in an exceedingly small number of participants in the study. Despite our efforts to collaborate with organization such as NAF Canada and circulating information about the study through social media, university clubs, community

organizations, and clinics in Ontario, the recruitment process was difficult and did not yield a diverse group of participants. Given the limited number of interviews conducted for this study, it was not possible to reach thematic saturation. Consequently, the findings obtained from this study are not transferable. Rather, this study should be viewed as an exploratory pilot that future researchers can build on.

Another limitation concerns my study focusing specifically on participants who resided in Ontario at the time of their abortion and participants who were able to participate in an interview in English or French. From the outset, I was not going to capture the perspectives of those in other provinces or territories or those who sought care in other languages.

### ***Statement of contribution***

I completed this study in partial fulfilment of the requirements for the Master of Science in Interdisciplinary Health Sciences program at the University of Ottawa. As the study coordinator, I was responsible for the translation of interview guides, recruitment of participants, data collection, interview transcription and data analysis.

As the principal investigator of the overall study, Dr. Foster reviewed all the components associated with this project. Dr. Foster played a pivotal role in guiding me throughout different stages of the research, such as developing the thesis proposal, acquiring approval from the REB, providing feedback and guidance on study tools, and being easily accessible to address any concerns I had. Additionally, Dr. Foster oversaw the project in its entirety, which encompassed reviewing transcripts and approving the codebook and overall analysis of the study. Finally, Dr. Foster aided in the recruitment

process by distributing information regarding the study to her professional social networks.

Moving forward, the next steps include preparing a brief report of the findings to be share with our two participants. The collected findings have the potential to serve as a basis for additional exploration and expansion of the study on the provision of abortion care through telemedicine services in Canada. Further investigation has the potential to improve and strengthen the abortion care system in Ontario.

### ***Conclusion & future directions***

The findings of my thesis align with the growing body of literature advocating for the de-medicalization of medication abortion care in Canada. Moreover, my project illuminates the telemedicine abortion care experiences of womxn residing in Ontario during the COVID-19 pandemic. The results obtained from this study may serve as an initial foundation for addressing the research questions outlined in this thesis.

### ***Positionality & reflexivity***

Positionality refers to a researcher's recognition and declaration of their position(s) within society in a piece of academic work (Rogers et al., 2013a). It describes how their identities (i.e., race, class, gender, sexuality, and ability status) can influence their research questions, data collection, analysis and interpretation, and perspectives of the world (Massoud, 2022; Warf, 2010). Reflexivity refers to the process of examining the ways that one's positionalities shape how the data are generated, analyzed, and interpreted (Rogers et al., 2013b). A key strength of qualitative research

is a researcher's ability to create a relationship with the participant and explore their experiences in depth. However, researchers should also acknowledge their subjectivities throughout the research process. My attendance in weekly group meetings, participation in qualitative methods workshops, and extensive interview training prepared me to gather data appropriately and ethically. Throughout my training, I acquired skills that enabled me to foster a confidential, safe, and judgment-free environment for all participants while ensuring that their participation in this study was voluntary. Moreover, I was able to engage in active and nonjudgmental listening, as well as increase my sensitivity to each participant's story.

My positionality as a researcher was an important consideration throughout the recruitment, data collection, and analysis processes. As a person of colour and Caribbean descent, I was prepared to create a culturally sensitive and appropriate environment for the interviews and to engage in nonjudgmental active listening. Additionally, I have my own experiences accessing the healthcare system and acknowledge that participants may have had different experiences than mine. When I created the narrative vignettes, I ensured that participants' narratives stood independent of my own experiences.

As a bilingual Canadian citizen, I am well-versed in the country's official languages – French and English. I expected this would facilitate communication with participants and foster a natural and comfortable space for the interview; I was especially excited about recruiting Francophone participants. However, I was not able to conduct the interviews in French as we were not able to recruit many participants for the study.

My status as a Canadian graduate student necessitated that I gather data appropriately and ethically. Taking my academic background into consideration, as someone with a bachelor's degree in Health Sciences I may have had more exposure to womxn's health topics than participants, and I acknowledge that not every participant may have been exposed to these topics. Moreover, my graduate student status allowed me to reach out to community-based organizations, university clubs and organizations, and clinics and allowed me to gain their help in advertising this study.

My status as a young woman with no abortion-related experiences may have influenced the data analysis and interpretation process. Although I am mindful of the sensitivity surrounding the topic of abortion care, my lack of personal abortion experience may have made it difficult for me to relate to the participant's stories. However, my open-mindedness and belief in a person's right to bodily autonomy allowed me to work with data in a respectful manner and helped me in data analysis.

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# Appendix A: REB certificate

16/06/2023

**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**

<b>Numéro du dossier / Ethics File Number</b>	S-04-18-551
<b>Titre du projet / Project Title</b>	Documenting people's abortion experiences
<b>Type de projet / Project Type</b>	Recherche de professeur / Professor's research project
<b>Statut du projet / Project Status</b>	Renouvelé / Renewed
<b>Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)</b>	16/07/2018
<b>Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)</b>	15/07/2024

### **Équipe de recherche / Research Team**

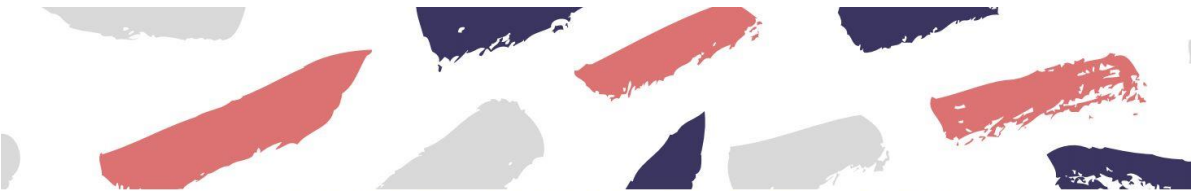
<b>Chercheur / Researcher</b>	<b>Affiliation</b>	<b>Role</b>
Angel FOSTER	École interdisciplinaire des sciences de la santé / Interdisciplinary School of Health Sciences	Chercheur Principal / Principal Investigator

**Conditions spéciales ou commentaires / Special conditions or comments**

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Appendix B: English recruitment flyer



**HAVE YOU HAD AN  
ABORTION IN CANADA  
THROUGH TELEMEDICINE DURING  
THE COVID-19 PANDEMIC**

Researchers at the University of Ottawa would like to conduct **90-minute telephone interviews** with Canadian residents who have had an abortion in Canada since the beginning of the **COVID-19 pandemic** through a telemedicine provider.

All participants will receive a **\$40 gift card** to Amazon.ca. Participation is both voluntary and confidential. You are eligible if your abortion took place on or after March 15, 2020.



If you would like more information about the study, please email the study team at: [ws-stu01@uottawa.ca](mailto:ws-stu01@uottawa.ca)



uOttawa



## Appendix C: French recruitment flyer

# AVEZ-VOUS UTILISÉ LA PILULE ABORTIVE AU CANADA PENDANT LA PANDÉMIE COVID-19?

Des chercheurs à l'Université d'Ottawa voudraient conduire des **entretiens téléphoniques de 90 minutes** avec des résidents du Canada qui ont eu un avortement médicamenteux avec la pilule abortive mifepristone par télémédecine depuis le début de la **pandémie COVID-19**.

Tous les participants vont recevoir une **carte-cadeau Amazon.ca de 40\$**. La participation est volontaire et confidentielle. Vous êtes éligible si votre avortement a eu lieu après le 15 mars 2020.



Si vous voulez plus  
d'information à propos de  
l'étude, envoyez l'équipe de  
recherche un courriel à  
**[ws-stu01@uottawa.ca](mailto:ws-stu01@uottawa.ca)**



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