

The promise of mifepristone: Perspectives and experiences across Canada

Thesis

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Abstract:

Despite the decriminalization of abortion in Canada in 1988, women still face many barriers to abortion care. With the registration of Mifegymiso® (mifepristone, or RU486) in Canada in July 2015, there is hope that the gold-standard medication abortion could alleviate some of those barriers women face. In this thesis, I used data from a Canada-wide study exploring women's abortion experiences by way of in-depth interviews to investigate mifepristone's potential to alter the abortion care landscape. My thesis is comprised of two articles: one using selections from 174 interviews across five provinces, the other using 13 full interviews from Newfoundland as a case study. These papers suggest that women would be interested in using mifepristone once available in Canada, and identified both benefits of and concerns about this method of early pregnancy termination. Despite many unanswered questions as to how and when Mifegymiso® will become available, the registration of this important abortifacient has the promise to increase access and expand choice for Canadian women.

Résumé:

Malgré la décriminalisation de l'avortement en 1988, les femmes font toujours face à des obstacles de soins. Avec l'enregistrement de Mifegymiso® (mifépristone, ou RU-486) au Canada en Juillet 2015, il y a espoir que ce médicament d'avortement pourrait atténuer certains de ces obstacles auxquels les femmes sont confrontées. Dans cette thèse, j'ai utilisé les données d'une étude qui explore les expériences d'avortements des femmes à travers le Canada. Les données ont été récupérées par moyen d'entrevues en profondeur et enquêtent le potentiel du médicament mifépristone à améliorer le paysage de soins de l'avortement. Ma thèse est composée de deux articles: la première inclut une sélection parmi 174 entrevues dans cinq provinces et la deuxième inclut 13 entrevues comme étude de cas de la province de Terre-Neuve. Ces articles suggèrent que l'intérêt pour la mifépristone pourrait être élevé au Canada après l'intégration de ce médicament, et les femmes perçoivent plusieurs avantages à cette méthode de terminaison prématurée de la grossesse et que les femmes ont certaines préoccupations. Malgré qu'il y ait beaucoup de questions sans réponse quant à la façon et quand Mifegymiso® sera disponible, l'enregistrement de cet important abortif a la promesse d'accroître l'accès et élargir le choix pour les femmes canadiennes.

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Acronyms and abbreviations

ARN- Abortion Rights Network

ARCC- The Abortion Rights Coalition of Canada

BC- British Columbia

CAS- Canada Abortion Study

CCO- Cancer Care Ontario

CIHI- Canadian Institute for Health Information

CPhA- Canadian Pharmacists Association

D&C- Dilation and curettage

D&E- Dilation and evacuation

FDA- US Food and Drug Administration

IHIACC- Interprovincial Health Insurance Agreements Coordinating Committee

LMP- Last menstrual period

MCP- Medical Care Plan

MTAP- Medical Travel Assistance Program

NF&L- Newfoundland and Labrador

NLSHC- Newfoundland and Labrador Sexual Health Center

OAS- Ontario Abortion Study

PCP- Primary care provider

PEI- Prince Edward Island

PI- Principal Investigator

SOGC- Society of Obstetricians and Gynecologists of Canada

SRH- Sexual and reproductive health

TAC- Therapeutic Abortion Committee

USA- United States of America

WHO- World Health Organization

CHAPTER 1: Background

1.1 Introduction and context

1.1.1 Barriers to abortion care in Canada

Abortion procedures in Canada are overwhelmingly safe and incredibly common; it is estimated that nearly one in three Canadian women will access abortion services at some point in their reproductive lives (Norman, 2012). Canada first legalized abortion care in 1969, however the procedure was heavily restricted. These restrictive laws were struck down in 1988 in the *R v. Morgentaler* decision and Canada remains one of the few countries in the world with no federal restrictions on abortion (Kaposy, 2010).

Despite the legal status of abortion in Canada, there are many extra-legal barriers to services. One of the most debilitating barriers across Canada is distance to facility (Sethna & Doull, 2013). There has been a decline in the number of hospitals that provide abortion care in Canada over the past few decades, and free-standing clinics now provide the majority of abortions (Canadian Institute for Health Information (CIHI), 2014). Most of these clinics are located in major urban centres within 150km of the US border, which means that many women need to travel significant distances to access care if they do not live in a city with a providing hospital or clinic (Sethna & Doull, 2013). In addition, many abortion providing physicians are aging out of the healthcare system and few doctors are trained to take their place. Women also face lengthily wait times, often waiting weeks or months to get an appointment (Eggertson, 2001). All of these issues and more exist within Canada as a whole, but there are particular barriers that are more prevalent in certain provinces or territories.

While the federal government in Canada is responsible for enforcing the Canada Health Act, health services are administered by provincial or territorial governments. Some provinces

will fund hospital care but not abortions provided by a clinic, provinces have varied mandated gestational maximums which can force later-term abortion seekers to travel to another province, and there are reciprocal billing issues that make getting abortion care out of the home province difficult and expensive (Shaw, 2006). The province with the least access, Prince Edward Island (PEI), does not have a single abortion provider within the province and provincial insurance only covers hospital-based terminations. In 2016, in response to a lawsuit filed by reproductive justice advocates, the PEI government announced that in-province services would be available by the end of the year (Abortion Rights Network (ARN) celebrates, 2016; Statement by the Prime Minister, 2016). While a promising announcement, women across Canada face inequitable access to abortion care and access is influenced by province/territory of residence, location within province/territory, financial and socioeconomic status, age, and ethnicity (Kaposy, 2010).

1.1.2 Context in Newfoundland and Labrador

After decriminalization in 1988, many provinces enacted legislation that mimicked the federal restrictions on abortions pre- *R. v. Morgentaler*. Many Therapeutic Abortion Committees (TACs) were maintained through hospitals under provincial legislation instead of federal, provincial gestational age limits were set, and procedures were often not funded outside of hospitals (Downie & Nassar, 2007). In some provinces, variations on these restrictions still exist (Shaw, 2006). Henry Morgentaler opened an abortion clinic in St. John's in 1990, which is currently still open as the Athena Health Center (Morgentaler Clinic, 2008). From the clinic's opening until 1998, the Newfoundland and Labrador government did not cover facility fees for abortion procedures in the clinic and instead payed fees to the federal government as a penalty for non-compliance with the Canada Health Act. Full coverage in Newfoundland for all Medical

Care Plan (MCP) card holders began in 1998 (Gushue), however those without an MCP card still need to pay for their abortions in the clinic, which today costs \$740 (Morgentaler Clinic, 2008). In 2015 interprovincial billing were issues addressed federally, but interprovincial coverage is only for hospital-based surgical or aspiration abortions (Reciprocal billing of abortion services, 2015).

Women in Newfoundland and Labrador face distinct reproductive healthcare barriers and barriers to abortion access. These issues fall into three main categories: geographic barriers and location of services, gestational age restrictions, and social dynamics. In terms of geographic barriers, there are no providing clinics or hospitals in Labrador (McLeod, 2014; Newfoundland and Labrador Sexual Health Center (NLSHC), 2013). Hospital access has been decreasing extensively in recent years in Newfoundland, which is a trend that has been noted in many provinces and territories. A 2006 study conducted by Jessica Shaw with Canadians for Choice (CFC) found that three hospitals in Newfoundland provided abortion care, two of which were located in St. John's. Currently however, only one hospital (located in St. John's) provides abortion care (McLeod, 2014). The Athena Health Center is the only providing clinic in the province and it is also located in St. John's. Thus the women of Newfoundland and Labrador who live outside of St. John's must travel significant distances by car, ferry, or plane to get across the island or from Labrador to St. John's (Sethna & Doull, 2013).

Newfoundland and Labrador also has a double ended gestational age restriction, allowing surgical abortions only between seven weeks' and 15 weeks from last menstrual period (LMP) (Morgentaler Clinic, 2008). For women under the seven-week mark, they must wait to get an appointment until they have met the gestational age requirement. While this is not a provincially mandated gestational age restriction, it is a practice that has become facility policy for the

hospital and clinic in Newfoundland and has also become part of the discourse surrounding the lack of access in the province (Whitaker, 2013). This type of longstanding practice often is a result of provider's concern that an ongoing pregnancy might result from a very early term non-medication abortion. However, research has shown that aspiration abortions are effective earlier than six weeks LMP (Barbieri, 2015), which could be achievable in Newfoundland- provided support for equipment, training and evidence-based facility policy is given. For women seeking abortion care past 15 weeks, they must travel outside of the province to access care (Sethna & Doull, 2013).

Newfoundland and Labrador is a large province with a relatively low population, spread along the TransCanada Highway and in towns along the coast of the island and Labrador. This province has the highest proportion of rural residents of the Atlantic provinces at approximately 60%, posing difficulties for delivery of governmental services and access to private business to these rural residents (Simms & Greenwood, 2015). Women in these small towns are often overlooked and isolated by negative health issues (Curran & Church, 1998). Further, Newfoundland and Labrador has undergone significant economic upheaval during and since the fisheries collapse in the early 1990's, causing a shift in industry and employment that disproportionately disadvantaged women in the province (Davis, 1993; Hussey, 2003). Women made up over 40% of the fisheries labour force before the moratorium on cod fishing, however were not generally the target of various labour, social and financial aid programs enacted in the wake of this collapse (Hussey, 2003). Culturally, "men's work" took place on the sea and "women's work" was on the land; disrupting that led to men invading women's spaces and labour markets, creating a "gender antagonism" (Davis, 1993) that in many ways, still exists.

Recent data shows that Newfoundland and Labrador has the largest gender wage gap of any province in Canada, an estimated 0.67:1.00 ratio (Schirle, 2015).

There is a lack of research exploring women's health and sexual and reproductive health (SRH) in Newfoundland and Atlantic Canada. Understanding attitudes toward SRH in Newfoundland is therefore difficult, but some important and revealing studies exist. One such study found that more than half of polled youth in Atlantic Canada think that abortion is "wrong," a higher proportion than any other region of the country (Byfield, 2002). A few studies focused on SRH education and teacher's attitudes towards SRH, such as a study exploring Newfoundland and Labrador's junior high school teachers. This study found that there was a lack of teacher training, a significant focus on abstinence and little emphasis placed on sexual diversity (Ninomiya, 2009). An essay published in 2009 expanded on this theme, describing how educator's silence on particular issues such as sexual diversity and pleasure create is a symptom of their values and discomfort with these subjects, and unconsciously drives the narrative of a "politically correct" but superficial and incomplete sexual education (Ninomiya, 2014). Addressing specific issues within "small-town" culture in Newfoundland has also been investigated. An article on women's attitudes towards breastfeeding in Newfoundland found that many women were influenced by close "small-town" community views, which resulted in low numbers of breastfeeding mothers in Newfoundland compared to the rest of Canada (Bonia et al., 2013). A study that explored women's views on social relationships and their health highlighted issues of social loss and tension as people leave small coastal communities for opportunities elsewhere (Martin & Jackson, 2008). Both studies found that the social structure of small communities are unique and affect attitudes towards health and SRH in general in this region.

Women's health and reproductive indicators and assessments are also often poor in this province. A 1996 study found that pregnant women in Newfoundland are more likely to be HIV positive than women in any other province in Canada (Ratnam, Hogan & Hankins). Women, children and newborns were found to commonly have a Vitamin D deficiency in Newfoundland and Labrador (Newhook et al., 2009), as well as low folate and vitamin B12 levels at first prenatal visit (House et al., 2007). The most recent Healthcare Report Card listed Newfoundland as having the lowest overall score of all the provinces, but marginally better than the territories (Provincial and territorial ranking, 2015). Teen pregnancy rates in Newfoundland and Labrador are higher than the national average, and in contrast with the overarching national trend seem to be increasing (McKay, 2012).

Further, there have been political stirrings and increased media attention around abortion care in the Atlantic provinces in recent years. With the closure of New Brunswick's Morgentaler Clinic in 2014, the elimination of New Brunswick's longstanding regulation that forced women to find two doctors to sign off that her abortion was "medically necessary," and the efforts to begin providing abortion care in PEI, other provinces- including Newfoundland- have been addressing abortion care in the news. Opinion pieces and interviews with the owner of the Athena Health Center's have been published in newspapers and in online media in response to the changes seen in other Atlantic provinces (McLeod, 2014; Rollmann, 2014). In addition, Frank Coleman, a man who quit politics shortly before becoming premier of Newfoundland and Labrador, made the news in 2014 as it was discovered he attends an anti-choice march yearly and although he insisted that his personal views would stay separate from his professional conduct, he faced criticism by the media (Brake, 2014). Newfoundland and Labrador's Health Minister Steve Kent also went on record about abortion issues in Newfoundland in 2014,

admitting that abortion access is not easy for rural women in the province, and that he was open to responding to requests to allow more hospitals to provide services but there has been a lack of doctors interested in providing abortion care outside St. John's (Abortion: Steve Kent, 2014). Critics did not feel that these statements went far enough in supporting and encouraging physicians and hospitals to begin providing abortion care elsewhere in the province (Brake, 2014).

1.1.3 Medication abortion and mifepristone

The majority of abortions performed in Canada are aspiration abortions, with surgical procedures performed at later gestational ages. Currently in Canada, the methotrexate/misoprostol regimen is the only medication abortion method available and is used by roughly 4% of abortion patients (Norman et al, 2014). The methotrexate/ misoprostol medication abortion regimen can be offered by family physicians and is available in both hospital and clinics. Methotrexate is an anti-metabolite and interferes with DNA synthesis by blocking dihydrofolate reductase which in turn inhibits the production of thymidine. Thus methotrexate interferes with rapidly dividing cells and is registered as a drug to treat rheumatoid arthritis (Katchamart et al. 2010) as well as certain types of cancer (Cancer Care Ontario (CCO), 2012). The medication is typically injected intramuscularly with the dosage calculated using the patient's weight, but can also be taken orally. Methotrexate is a front line ectopic pregnancy treatment and in the absence of mifepristone, can be provided to induce abortion in conjunction with misoprostol (Wiebe et al., 2002). Use of methotrexate for early abortion and ectopic pregnancy management is called "off-label." meaning that the drug is prescribed for something other than its approved

indications. Off-label use is common in clinical medicine and professionally acceptable if provision is evidence-based.

Misoprostol is a prostaglandin E1 analog that is used as an abortifacient by itself, with methotrexate, or with mifepristone. It is also used to induce labour, treat gastric ulcers, and treat postpartum hemorrhage. To induce an abortion, misoprostol binds to myometrial cells and causes contractions of the uterus, expelling the tissue. It also causes the softening and dilation of the cervix, which aids in the expulsion process. Misoprostol is absorbed through mucosal surfaces and therefore can be administered vaginally, buccally and sub-lingually (Arns, 1991).

Misoprostol is an important abortifacient in many countries where abortion is illegal, as it is often available over the counter for gastric ulcer prevention, but is very safe as well as quite effective, for use as an abortifacient. This was discovered not by the pharmaceutical industry, but by women in Brazil who spread this information by word of mouth as an alternative to unsafe, ineffective, and sometimes deadly illegal abortion methods (Zordo, 2016).

The methotrexate/ misoprostol method is considered to be less effective, as well as less acceptable to women when compared to the use of mifepristone/ misoprostol regimen for early pregnancy termination. Abortions using mifepristone generally take less time from initiation to completion, necessitating fewer follow up visits to the facility or healthcare professional (Dunn & Cook, 2014). Additionally, mifepristone/ misoprostol has higher success rates compared to methotrexate/ misoprostol (Dahiya et al., 2005), and exhibits fewer side effects including lower levels of associated pain (Wiebe et al., 2002). The mifepristone/misoprostol regimen is also comprised of two different pills, thus it is easier for clinicians to administer and easier for patients to take. These factors combined have earned mifepristone the “gold standard” status for early medication abortion worldwide.

Mifepristone is a synthetic steroid progesterone receptor antagonist that causes placental detachment, softening and dilating of the cervix, and uterine contractions. Mifepristone acts in three ways: it has a high binding affinity to progesterone and glucocorticosteroid receptors, it interacts with the receptor binding pocket, and it causes a transconformation in the ligand-binding domain of these hormones. This disruption of receptor function results in mifepristone acting as a very effective antiprogesterone and antiglucocorticosteroid agent (Cadepond, Ulmann & Baulieu, 1997). Commonly known by its drug development name RU-486, French researchers determined its abortive properties in 1982 and it became available, in conjunction with a second medication, to women in China and France in 1988 (Historical information on mifepristone, 2011). By 2014, over 50 countries had registered mifepristone, and it had been used by nearly 50 million women worldwide (Dunn & Cook, 2014). The World Health Organization's List of Essential Medicines includes mifepristone with the caveat, "Where permitted under national law and where culturally acceptable," (World Health Organization (WHO), 2013).

The global evidence regarding safety and efficacy shows that when mifepristone is used in conjunction with a prostaglandin (such as misoprostol) the regimen is highly effective ($\approx 98\%$) in terminating a pregnancy through nine weeks' gestation (Dahiya et al., 2005; Henderson et al., 2005; Newhall & Winikoff, 2000). Recently, some studies have shown that mifepristone has acceptable efficacy ($\approx 93\%$) through 10-11 weeks' gestation (Ashok et al., 2002).

When taking mifepristone and a prostaglandin, women experience bleeding and cramping as part of the abortion process. The amount of time it takes from ingesting mifepristone to the end of bleeding as well as severity of cramping and bleeding varies with gestational age. Generally, women experience these symptoms for few days, with a gradual tapering over the course of a week to ten days (Henderson et al., 2005). Side effects are generally manageable and

transitory, and include dizziness, fatigue, moderate fever and diarrhea. Rarely, severe complications including hemorrhage and infection can occur. In a very small number of cases (roughly 0.1%) the pregnancy is ongoing after the initial regimen is taken, in which case additional treatment in the form of another dose of misoprostol or instrumentation for uterine evacuation may be required (Chen & Creinin, 2015). There are few contraindications to the use of the mifepristone/misoprostol regimen; thus most women with an unwanted pregnancy of less than nine weeks' gestation are eligible to use this method of medication abortion (Newhall & Winikoff, 2000).

The acceptability of mifepristone among both providers and users has been well documented. Importantly, research demonstrates that a range of health care providers including nurse practitioners, physician assistants, and midwives can offer mifepristone with comparable outcomes to physicians in terms of safety and efficacy (Kishen & Stedman, 2010; Warriner et al., 2011; Foster et al., 2015). Studies also show that integration of medication abortion services can take place in both pre-existing abortion providing clinics and hospitals and in otherwise non-abortion providing clinical settings, such as clinics, clinician offices, and health centres (Leeman et al., 2007). Further, a recent body of evidence has demonstrated the efficacy of telemedicine models, such that women are able to take mifepristone/misoprostol on their own after counseling and eligibility determination (Gomperts et al., 2008; Grindlay, Lane & Grossman 2013).

Research from around the world reveals that women find medication abortion with mifepristone/misoprostol to be acceptable and would recommend the method to others (Swica et al., 2011; Winikoff, 1995). Women often report that medication abortion offers greater privacy, allows for the avoidance of judgemental healthcare workers, is less invasive, and is perceived as more natural than methods that require instrumentation (Gresh & Maharaj, 2011; Hokanen &

Hertzen, 2002; Lie, Robsen & May, 2008; Wiebe, 1997). The overarching themes of control (Fielding, Edmunds & Schaff, 2002) and autonomy (Winikoff, 1995) have also been identified by women as being important factors in choosing medication abortion methods. A review of 12 studies on medication abortion in early pregnancy concluded that, “virtually all of the work assessing acceptability shows a strong preference for medical methods (generally about two-thirds of patients),” (Winikoff, 1995).

Health Canada approved Mifegymiso®, a mifepristone/misoprostol combi-pack, for early pregnancy termination on July 29th, 2015. It is anticipated that the regimen will be available in late 2016. The approved regimen comprises 200mg mifepristone taken orally followed by 800mcg misoprostol taken buccally (absorbed by the mucosal surface of the inner cheek) 24-48 hours later. As directed by Health Canada, the provision of Mifegymiso® is restricted to physicians. The regimen is approved for use through 49 days’ gestation- seven weeks from the first day LMP. In addition, Health Canada has mandated the use of an ultrasound to determine of gestational age and to exclude of ectopic pregnancy prior to prescription of Mifegymiso®. Finally, Health Canada also stipulates that physicians must register as a Mifegymiso® provider and complete an educational module prior to provision (Health Canada, 2015).

The approval of mifepristone/misoprostol for use in Canada was a major victory for reproductive health and rights advocates. Mifepristone has been available in many countries for decades, and the United States approved the medication for early pregnancy termination in 2000. Organizations such as The Abortion Rights Coalition of Canada (ARCC) (Position Paper #28, 2006), individual researchers (Dunn & Cook, 2014), and Canadian citizens (Brake, 2014) have decried of the absence of mifepristone in Canada for years. In the wake of the 2015 approval, other groups such as the Society of Obstetricians and Gynecologists of Canada (SOGC) have

released statements in support of mifepristone’s registration (Health Canada approves Mifegymiso, 2015). However, there is also widespread disagreement and disappointment with the non-evidence-based restrictions that Health Canada imposed on the regimen (Canadian Pharmacists Association (CPhA) Statement, 2015; Paperny, 2016; Prasad, 2016; Scott, 2016).

1.2 Rationale

Significant research has documented that mifepristone as an effective, acceptable drug for early abortion, as was covered in Section 1.1. There is also a great deal of documentation on the process of integration of mifepristone in the healthcare system of a particular country or region, and challenges and barriers to integration into primary healthcare systems (Joffe & Weitz, 2003; Leeman & Espey, 2005; Jones & Henshaw, 2002). Several studies demonstrate the possibility of integration into facilities that do not already provide abortion services (Leeman et al., 2007; Raghavan et al., 2012). From this we know there are many challenges to expanding the types of facilities that provide mifepristone and “recruiting” new practitioners to begin prescribing the drug. This was the case in the United states, as physician uptake of mifepristone provision was low in the years following registration (Espey et al., 2011; Joffe & Weitz, 2003). Impediments to integration included ambiguity over the necessity of ultrasound use, difficulties faced by physicians to order and dispense mifepristone, conflict between the United States Food and Drug Administration (FDA) -approved regimen and the evidence-based regimen, “turf” issues between medical specialties, and patient compliance (among others) (Boonstra, 2002). Physicians already providing abortion care may incorporate the medication option into their practices, thereby increasing procedural options for women seeking abortion care. However, incorporation of

mifepristone into already existing abortion service does not minimize the geographic barriers to abortion access (Espey et al. 2011), an important facet to this medication's potential.

There is some published literature on medication abortion in Canada and abortion care in Newfoundland, but very little to no published information on mifepristone in Canada. To date, no studies have been published on the experiences of Newfoundland women receiving abortion care. Issues of race and ethnicity, age, poverty and inequitable access to healthcare has been shown to impact women's sexual and reproductive health outcomes, limiting contraception and thereby increasing rates of abortion need (Sethna & Doull, 2013; Wiebe, Najafi, Soheil & Kaman, 2011; Wiebe & Sandhu, 2008). It has also been shown that women in Atlantic provinces have the least access to abortion services compared to any other region of Canada (Sethna & Doull, 2013). Using Newfoundland and Labrador as a case study for exploring mifepristone's potential to increase access could highlight how intersectional issues that impact healthcare could be addressed with this new technology.

Original research studies conducted with Canadian participants on abortion exist, yet there are still many gaps in the literature to be investigated within the field. Several studies have taken different approaches to identify numbers and locations of facilities, assessing the geographic barriers and special inequities of facilities (Norman et al., 2014; Sethna & Doull, 2013). A study by Shaw, published in 2006 on hospital access across Canada, also investigates barriers to care. Additional studies with a more specific focus, such as the 2016 study on unequal sex ratio after abortions for India-born women in Canada (Urquia et al., 2016), investigating medication abortion in Canada with misoprostol and methotrexate/ misoprostol (Dunn et al 2015; Wiebe, Trouton & Lima, 2006) and abortion experiences of Muslim women in Canada (Wiebe, Najafi, Soheil & Kaman, 2011) also contribute to our understanding of abortion in this country.

However there remains very little published data investigating the stories of Canadian women who receive abortion care on a national scale. The Canada Abortion Study (CAS) study is comprehensive, and recruitment outside of hospitals and clinics, including women of different age groups, locations within a province, and of both official languages establishes a broad range of experiences that we access.

There is much uncertainty as to how long it will take Mifegymiso® to become available to women across Canada, how different provinces will (or will not) cover the cost of the medication, how much control individual physicians will have toward being trained and registered to provide mifepristone, and what evidence is needed for Health Canada to permit evidence-based practices. Because of provincial jurisdiction of administering healthcare, the answers to these questions may also vary across Canada. In this way, it is unclear how easily mifepristone might be available to women and how long it will take to integrate into each province. Investigating women's prior knowledge of mifepristone, what they know about it, if they would be interested in it, and what their concerns are could help to answer inform efforts to integrate mifepristone/misoprostol into the Canadian health system.

1.3 Specific objectives

I undertook this thesis to understand better the possible reception Canadian women may have to the introduction of mifepristone. Identification of perceived benefits, possible concerns, common questions, and potential acceptability of a suggested regimen were the focus of this project. Using Newfoundland and Labrador as a case study, the project also explores how current barriers to access, including geographical barriers, might be alleviated with the addition of mifepristone for early pregnancy termination.

This qualitative study intends to answer the following research questions:

1. What knowledge of, concerns about, and attitudes toward mifepristone do Canadian women have prior to the registration/introduction of mifepristone?
2. Using the case study of Newfoundland and Labrador, how might the introduction of mifepristone expand access to timely and affordable services?
3. What methods of integration of mifepristone into the healthcare system appear feasible to women?

1.4 Outline of thesis

This thesis is organized as a “thesis by article.” Chapter 1 provides an overview of the body of research that contributed to designing this study, including current data on abortion in Canada, barriers to abortion care in both Canada as a whole and in Newfoundland and Labrador in particular, contextual information about reproductive healthcare in Newfoundland and Labrador, and a background on mifepristone and medication abortion. Chapter 1 also outlines the objectives of the study and includes a statement of contribution. Chapter 2 focuses on methods used and includes information on data collection, data analysis, and the overall conceptual framework. Chapter 3 is a manuscript that we submitted to *Contraception* in March 2016 and was subsequently accepted and published. Drawing from 174 in-depth interviews conducted with women who resided in five provinces at the time of their abortion, this article explores women’s knowledge of, interest in, and concerns about mifepristone. Chapter 4 is a second manuscript that have prepared for submission to *Women’s Health Issues*. The focus of this paper is on the abortion experiences of Newfoundland and Labrador women, the barriers to access that they experience, and how the introduction of mifepristone could address existing disparities. Chapter

5 is the discussion, in which I integrate the results of the two articles, discuss issues related to reproductive justice, and reflect on my positionality. I conclude by discussing the limitations of the study and the significance of the work.

1.5 Statement of contribution

I completed this project in partial fulfilment of the requirements of the MSc. Interdisciplinary Health Sciences program at the University of Ottawa. For this thesis, I used data from the Ontario Abortion Study (OAS) which later evolved into the CAS, a large scale qualitative studies that explores women's abortion experiences. Dr. Angel M. Foster is the Principal Investigator (PI) and many of her graduate and undergraduate students have worked on this study over the last four years. Kathryn LaRoche serves as the overall Study Coordinator, and Julie El-Haddad and Andréanne Chaumont serve as Study Coordinators for the Francophone component of the project. The first article in this thesis (Chapter 3), includes this team of co-authors; all co-authors approved the manuscript prior to submission and publication. In this article I draw from data collected by a number of interviewers and transcribed by a multitude of research assistants and volunteers. I conducted the background research necessary to frame the article, analyzed the data, and led the drafting of the manuscript.

My own role in OAS and CAS has evolved over the years that I have worked on the project. I started as a transcriber and recruiter for OAS and eventually received training to complete interviews. I serve as the Study Coordinator for the Nova Scotia and Newfoundland and Labrador provinces. As such, I led all recruitment efforts in both provinces and conducted all interviews. Because Newfoundland and Labrador is the focus of my thesis, I worked with my supervisor to conceptualize the province-specific study, collected, coded, and analyzed all data,

and led the drafting of the manuscript. The second article (Chapter 4) represents a collaboration between me and my supervisor, as reflected in authorship.

Chapter 2: Methods

2.1 Canada Abortion Study outline

In late 2012, Dr. Foster began a study documenting women's abortion experiences in Ontario. The OAS eventually expanded to CAS to cover all provinces and territories. This study is ongoing, and over the years has involved a large, primarily female study team comprised of undergraduate, masters and PhD students working as recruiters, interviews, and transcribers. Dr. Foster created an interview guide for OAS that remained consistent throughout CAS; it begins with demographic questions, moves on to general reproductive health history including reproductive and primary healthcare, and then delves into the abortion experience(s) that occurred in the five years preceding the interview. The interview concludes with questions about how the participant feels that her abortion experience(s) could be improved, and ends with a description of a possible (evidence-based) mifepristone regimen and a few questions to determine what the women's opinions are on mifepristone. Women are given a \$40 gift certificate to amazon.ca to thank them for their time. To date, all provinces have either begun interviews or have been closed after reaching the desired number of participants.

I have been involved with this project in several capacities over the last three years. In 2013, I worked as a research assistant for Dr. Foster's group, transcribing OAS interviews and as a result I became acquainted with the study and the interview guide. During that period, I also attended and participated in team meetings, which gave me insight into the design and progress of the study. Thus when I joined the MSc program I knew that I would work on CAS for my thesis project. In 2014, I trained with my supervisor and the overall Study Coordinator, Kathryn LaRoche, to become an interviewer and then led the Nova Scotia component of the project as

part of my Directed Study. These experiences helped prepare me to lead the Newfoundland and Labrador component of the overall project as part of my thesis.

For recruitment, we used a multi-modal strategy that involved social media, online advertisements, establishing a study website, circulating announcements on listservs, and posting flyers. We recruited women who had at least one abortion in the five years preceding January 1st of the year of the interview, and purposively recruited two age groups: ages 18-24 and 25 and over. Depending on the size of the province and other geographical factors, we also purposively recruited in specific geographic areas. For instance, in Newfoundland and Labrador we recruited 10 participants from in the provincial capital, and purposively recruited additional women from outside St. John's to ensure that we had a range of experiences. The participant would reach out either by email or phone, and either the Study Coordinator or another member of the study team who was in charge of that province/territory would get in touch via email and begin the eligibility screening. This involves a five-minute phone call outlining details of the study and answering any questions the potential participant had, providing the consent form, and scheduling the interview. Participants were scheduled on a first come first served basis.

Once screened and given the consent form, a trained interviewer conducted the interview. During the audio-recorded interview, the interviewers took notes and engaged in a formal memoing process shortly after the completion of the interview. Participants were then sent a thank you email with the gift certificate. After this process, a member of the study team transcribed the audio recordings, and those were subsequently analyzed using content and thematic analysis. I followed this same general protocol for all interviews conducted with women from Newfoundland and Labrador.

For the first manuscript in this thesis, I analyzed responses to the final section of 174 interviews with women from five provinces (Alberta, Manitoba, New Brunswick, Ontario, and Quebec). In addition to drawing from the final section, I also explored the transcripts for any other content related to medication abortion and extracted routinely collected demographic data. I focused on interviews from these five provinces because the study team had completed data collection in these areas by the spring of 2015, prior to the approval of mifepristone by Health Canada. For the second manuscript, I analyzed the entirety of the interviews with 13 participants from Newfoundland.

2.2 Data analysis

I analyzed these data for content and themes using both deductive and inductive techniques (Fereday & Muir-Cochrane, 2006). For my first article, I focused narrowly on specific sections of the interview (the opening demographic section and the final section related to mifepristone) and searched for any other content in the interview related to mifepristone or medication abortion. For these interviews I began by analyzing content such that I was able to extract demographic and reproductive health history information from the sample. The analysis of this content included “counts” and then the use of descriptive statistics to characterize the sample. I also analyzed these interviews for themes, a process that allowed me to identify patterns across interviews and ultimately interpret the findings (Nuendorf, 2011; Vaismoradi et al., 2016). This was an iterative process that initially involved the creation of a codebook based on predetermined codes and categories and then ultimately resulted in the addition of emergent codes and categories (Nuendorf, 2011). Ongoing discussions among the CAS team, reviewing

memos written by interviewers, and a series of meetings with my supervisor informed my interpretation of the findings (Vaismoradi et al., 2016).

For my second article, I focused on the 13 interviews that I conducted with women from Newfoundland and Labrador. Although I also analyzed these interviews for content and themes, because I conducted all interviews the process was even more iterative and analysis began during data collection. Particular themes began to emerge in early interviews that allowed me to modify the guide and prompt with specific follow-up questions in later interviews. Memoing during the data collection process not only helped me define and establish important themes, but allowed me to identify when I had reached thematic saturation (Vaismoradi et al., 2016). I used my data (the transcripts, memos, and notes) to create a preliminary codebook. This initial codebook largely comprised *a priori* (pre-determined) codes and categories that arose from the interview guide, from study objectives, and observed themes (Fereday & Muir-Cochrane, 2006). I used ATLAS.ti software to manage by data and organize the coding process. As I became more familiar with my data, I added more codes and updated the codebook; I also then went back to previously coded interviews (Nuendorf, 2011). Regular meetings with my supervisor combined with specialized CAS meetings informed my analysis and interpretation. Importantly, we took care to discuss emerging themes in different provinces to ensure that there was consistency and thorough analysis of themes and relationships inter-provincially. In the final phase of the analytic process, I looked at the 13 interviews from Newfoundland and Labrador for vertical and horizontal coherence.

In the first article, we present results using descriptive statistics and illustrative quotes. We have masked all participants and use age and province as a way of showcasing that we are drawing from a number of interviews. In the second article, we focus on themes and use both

illustrative quotes and narrative vignettes. Consistent with the in-depth examination of these interviews, we have given all participants pseudonyms and have redacted and masked personally-identifying information.

2.3 Ethical considerations

This study received ethics approval from the University of Ottawa Health Sciences Research Ethics Board (File # H08-12-08). This can be found as Appendix A.

2.4 Conceptual framework

To fully explore women's experiences with abortion care in Canada, we determined that a qualitative study would best fit the research objectives. Qualitative studies, although not intended to be generalizable or representative, provide an opportunity to explore phenomena in an in-depth, nuanced way that allows for complex and multi-faceted interpretation. This methodological approach also gives researchers access to data "from the inside" and allows for data collection to engage with a particular community/group of people and their experiences (Neuendorf, 2011). This is ideal for research investigating private, sensitive, stigmatized, and/or personal life experiences, and for identifying the interaction and engagement between a healthcare service and the patient.

The study team and I used action research as the theoretical framework for this thesis project; our main focus is to engage with participants in a meaningful and socially-minded way and to enact change on a larger scale (Small, 1995). As is the hallmark of action research, we specifically designed the process to practically address an identified problem. Action research

has a complex history across many fields, however a general definition is described by Reason & Bradbury (2006):

a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview which we believe is emerging at this historical moment. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities.

While action research has no prescribed methodology, it is a flexible process that necessitates self-reflection and mindfulness from the researcher. Consistent with the overarching project, women's experiences and suggestions for improvement drive the recommendations for policy/practice of this thesis, and their participation was and is essential to a productive and worthwhile study outcome (Brydon-Miller et al., 2003). Feminist action research is used specifically within this study, which seeks to lessen the inequalities between men and women and challenge patriarchal dominance. Feminist research does not only focus on documenting struggles with inequality and the lives of women, but also brings attention to those struggles on a larger stage to enact change. This type of action research also places a great emphasis on reflexivity, especially concerning the researcher/ participant relationship and the political and social power structures that exist therein (Small, 1995).

Chapter 3: Article #1

Exploring Canadian women's knowledge of and interest in mifepristone: Results from a national qualitative study with abortion patients

We submitted this manuscript to the peer-reviewed journal *Contraception* in March 2016. The manuscript was accepted for publication in April 2016. A pre-print version of the article is currently available and the manuscript is scheduled for print publication in late 2016. In this chapter I have included the accepted version of the article formatted specifically for the journal.

**Exploring Canadian women’s knowledge of and interest in mifepristone:
Results from a national qualitative study with abortion patients**

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Abstract

Introduction: Although Canada decriminalized abortion in 1988, significant disparities in access to services and an uneven geographic distribution of providers persists. Health Canada registered mifepristone, the gold standard of medication abortion, in July 2015. Our study explored Canadian women's knowledge of, interest in, and perspectives on mifepristone prior to registration.

Methods: From November 2012 through July 2015 we conducted in-depth interviews with 174 Anglophone and Francophone women from Alberta, Manitoba, New Brunswick, Ontario, and Quebec about their abortion experiences and their opinions about medication abortion. We purposively recruited participants from different age cohorts and different regions within each study province to explore a range of perspectives. We analyzed these interviews for content and themes related to mifepristone using both deductive and inductive analytic techniques.

Results: The overwhelming majority of participants had no knowledge of mifepristone at the time of the interview. However, after providing a brief description of an evidence-based mifepristone/misoprostol regimen, more than half of the participants reported that they would have considered this method had it been available at the time of their abortion and most would have been comfortable receiving medication abortion care from a family physician or nurse practitioner. Most women supported the approval of mifepristone and felt Canadian women would benefit from having more options for early pregnancy termination.

Conclusion: Although knowledge of mifepristone among recent abortion patients was low, considerable interest in medication abortion exists. Expanding awareness-raising efforts and supporting the approval of evidence-based regimens and provision of mifepristone appears warranted.

Implications

The approval and introduction of mifepristone for early abortion in Canada promises to increase options and access. Creating tailored and culturally and contextually resonant messages about mifepristone is of high priority. Promoting evidence-based protocols and the inclusion of a full range of qualified professionals in service provision is also warranted.

Introduction

In January 1988, the Supreme Court of Canada decriminalized abortion in the landmark *R. v. Morgentaler* decision. Although there are no federal laws regulating abortion in Canada, disparities in abortion access persist. A body of research has demonstrated that young women, recent immigrants, First Nations women, poor women, and rural residents face significant barriers to obtaining timely abortion care [1,2,3,4]. That these women are at greater risk of unintended pregnancy reflects compounded vulnerabilities with respect to reproductive health. Nearly one in three Canadian women will have an abortion over the course of their reproductive lives [5], yet geographic disparities continue to characterize the abortion landscape. The majority of procedures are performed in free-standing abortion clinics which are concentrated in large urban centers within 150 miles of the US-Canada border [6]. Regulatory, political, public funding, and health systems barriers have resulted in considerable differences both between and within provinces [7,8,9,10]. For many women in Canada, timely abortion care can be difficult to obtain [11].

Although Canada participated in the North American mifepristone clinical trials, as of early 2016 the gold standard medication abortion regimen was not yet available. The overwhelming majority of abortion procedures in Canada take place in the first trimester with aspiration techniques; only a small percentage are performed using methotrexate/misoprostol [5]. That mifepristone is safe, effective, and acceptable to women and can be provided by a range of health service professionals has been well documented [12,13,14,15]. Incorporation of mifepristone into the Canadian health system has the potential to greatly expand access to

early abortion services and promises to make a significant contribution to reducing geographic disparities in access throughout the country [10,16,17].

In 2011, a dossier to register mifepristone was submitted to Health Canada and approval was granted in July 2015 [18]. However, registration of mifepristone alone is not sufficient to expand access. Provincial regulations, insurance coverage, provision protocols, scope of care guidelines, provider training, and political champions will all shape the introduction of mifepristone at both the federal and provincial levels. Further, women's knowledge of and interest in mifepristone will condition demand for expanding medication abortion services.

Over the last three years our research group has undertaken a large-scale national qualitative study to document Canadian women's abortion experiences, explore geographic-, age-, socio-economic-, and language minority status-related barriers to abortion access, and identify avenues by which services could be improved at the provincial and territorial levels. As part of this study we asked women about their knowledge of, attitudes toward, and interest in mifepristone. In this article, we report on the mifepristone-related findings from women who resided in one of five provinces at the time of their abortion.

Methods

From November 2012 through July 2015 our study team conducted in-depth, open-ended telephone/Skype interviews with English- and French-speaking women who had obtained an abortion within five years of the interview. Participants were eligible if they were residents of Alberta, Manitoba, New Brunswick, Ontario, or Quebec at the time of termination and age 18 or older at the time of the interview. We used a multi-modal community-based

recruitment strategy which included posting flyers, circulating study information on listservs, establishing a study website, and placing social media ads. One of our Study Coordinators (KL, JE, or AC) screened women who contacted the study team for eligibility, provided potential participants with the consent form, and scheduled the interview on a first come/first served basis.

The PI (AF), a qualitative researcher with nearly 20 years of experience, and/or a trained member of the all-woman study team comprised of graduate and advanced undergraduate students, conducted all interviews. Interviewers used the same guide which we developed specifically for this study. Our interviews began with questions related to participant demographics, reproductive and pregnancy history, and general experiences accessing health services. The interview then turned to the participant's abortion experience(s) and ways in which services could be improved.

In the final section of the interview, we asked participants about mifepristone. We began by asking participants if they had heard about mifepristone, by name and with prompts (RU486, the abortion pill, and medication/medical abortion). If the participant indicated awareness of mifepristone (with or without prompts) we probed to ascertain the participant's knowledge of timeframe for use, eligibility, process/side effects/complications, and legal/regulatory status. We then provided all participants, irrespective of expressed knowledge, with general information about mifepristone, including the history of use in other countries, a description of the regimen (with misoprostol) through nine weeks' gestation, the physical abortion process, efficacy, and possible side effects and complications. We then asked participants to reflect on whether or not they would have considered using

mifepristone/misoprostol had they been eligible and had the regimen been available. We also asked if they would have been receptive to obtaining medication abortion care from a family physician and/or a nurse practitioner. We concluded by asking participants to reflect on the possible acceptability of mifepristone.

We used a pre-determined sampling matrix to ensure inclusion of participants of different age cohorts (18-24 inclusive and 25 and above), in-province geographic locations, and language minority status (New Brunswick, Ontario, and Quebec). Interviews averaged one hour in length and participants received a CAD40 gift card to www.amazon.ca. With permission we audio-recorded and later transcribed all interviews. Interviewers also took notes during the interview and formally memoed after each interaction, a process that both aided our analysis and fostered reflexivity.

We analyzed our data for content and themes, an iterative process that began during data collection and was informed by regular team meetings. Using ATLAS.ti to manage the data, KV served as the primary coder employing both *a priori* and inductive codes and categories [19]. AF and KL reviewed coding and resolved disagreements through discussion. This article focuses on significant findings using both descriptive statistics and quotes to illustrate major themes; we have removed and/or masked all personally identifying information. This study was approved by the Health Sciences and Sciences Research Ethics Board at the University of Ottawa (File # H08-12-08).

Results

Description of our participants

We conducted 174 interviews with women who resided in Alberta (n=20), Manitoba (n=20), New Brunswick (n=27), Ontario (n=71) and Quebec (n=36) at the time of the abortion (Table 1). One hundred and twenty-nine (74%) of our participants completed the interviews in English and 45 (26%) in French. Our participants ranged from 18 to 52 years of age at the time of the interview and were roughly evenly split between to the two age cohorts. Most of our participants identified as White/Caucasian (59%).

Our 174 participants provided details on 202 abortions; 149 (86%) reported having had one abortion, 22 (13%) two abortions, and 3 (2%) reported three or more abortions in the five years prior to the interview. Consistent with abortion care in the study provinces, 59% (n=119) of all reported abortions took place in a clinic and 40% (n=80) in a hospital. The overwhelming majority of abortions were performed with instrumentation techniques; only 3% (n=6) were induced with medications (either methotrexate/misoprostol or misoprostol alone). Nearly half of our participants (49%, n=86) made the decision to have at least one of their abortions when they were within nine weeks' LMP and would thus have been eligible for mifepristone, had the evidence-based regimen been available.

Knowledge of mifepristone is limited

Overwhelmingly, our participants had no knowledge of mifepristone prior to the interview (72%, n=126). Only 40 women (23%) reported that they had heard of mifepristone, RU-486, or the abortion pill. An additional eight participants recognized this form of medication abortion after being provided with a full description. Of those women who had heard of mifepristone, few evinced meaningful knowledge of the medication and instead conflated it

with other abortifacients and/or emergency contraception. Twenty-five women were able to express some knowledge of medication abortion, in general, or described knowledge of a methotrexate/misoprostol regimen. One woman from Ontario recalled that there had been an adverse event during the Canadian clinical trials in the 1990s. “I mean I know that it’s not approved in Canada because one incident in a clinical trial a long time ago and they stopped the trial, but it’s like widely approved and available in other countries.”

Enthusiasm for mifepristone is considerable

We explained to participants that we did not know what regimen or service delivery protocols Health Canada might approve. However, we described a hypothetical protocol that included counseling and eligibility determination (through 9 weeks’ LMP), in-clinic provision of mifepristone taken orally, administration of a second medication at home 24-48 h later, and in-person or telephone follow-up after 10 to 14 days. Once we provided a standardized description the mifepristone/misoprostol regimen and the basic contours of the physical experience of an early medication abortion, over half (56%, n=98) of our participants indicated that, if eligible, they would have definitely chosen mifepristone had the medication been available at the time. There were three participants who considered traveling out of country to access mifepristone at the time of their unwanted pregnancy. Overall, only 33 women (19%) said that they would not have considered the option of mifepristone and these participants were disproportionately from Quebec (n=12). The remaining quarter of participants (n=42) expressed ambivalence, stating they might have considered mifepristone if they were offered the choice or did not offer an opinion (n=1).

Women's enthusiasm for and interest in mifepristone stemmed from both practical/logistical and social/emotional considerations. Nearly 40% of all of our participants explained that the perceived "ease" of the procedure was especially appealing. As a 22 year-old participant from Manitoba explained:

It sounds easier, which means it makes the whole process easier in your mind. It probably would have been a lot less weight on my shoulders. Just less hassle all around. And I mean, it may or may not actually be less hassle, but it sounds like [less] hassle so it would feel like less hassle.

Women from all of our study provinces explained that one of the most appealing aspects of mifepristone was its potential to reduce the long wait times that women experienced after making the decision to have an abortion. As a 35 year-old woman from Ontario explained, "I think [the option of mifepristone] would have made a difference for me just because I wouldn't have spent that month just sort of waiting, and thinking, and worrying." This was echoed by a 20 year-old participant from Manitoba, "I think so much of the suffering [that] would have been reduced...The wait time, the two weeks of being pregnant and not wanting to be pregnant, really was tough on me." Roughly a third of our participants also explicitly discussed burdens related to travel and the distance between their place of residence and the abortion provider, noting that if mifepristone were to become available in a wider range of geographic locations this option would be especially attractive.

Many of our participants also discussed the social and emotional advantages of mifepristone. Fully one quarter of our participants (n=45) mentioned that mifepristone would afford women more privacy. One 24 year-old woman who received her abortion in Alberta

explained, “[Mifepristone is] good in the sense that it leaves a lot of privacy for the woman [because] it’s just between [her] and the doctor. Now it’s not...Like for me, I probably saw like 50 people that day.” A number of women also intimated that increased privacy would have allowed them to avoid judgmental people and the social stigma surrounding abortion.

The prospect of being able to complete the abortion at home was an especially appealing feature for about 20% of our participants (n=34). As expressed by a 30 year-old woman from Ontario, “To be able to take the second pill in the comfort of your home, you know in a place where you’re relaxed and feel safe, it would be good.” In addition to the perceived privacy and convenience, several women spoke about sources of emotional support and how loved ones could be a part of the medication abortion process. And although about 10% of our participants considered the length of the abortion process to be a negative feature of mifepristone, about 19% of our participants viewed the medication abortion process as “less invasive” or “less traumatizing.” As explained by a 28 year-old from Ontario,

It just seems a lot less invasive. A lot simpler and something that you can kind of go through at home. I mean the amount of time I spent in a hospital or a clinic for that abortion is absolutely ridiculous. And if it’s effective I would choose that probably every time.

Finally, the majority of women (64%, n=112) reported that they would be comfortable receiving medication abortion care from a full range of health service professionals, including family physicians and nurse practitioners. One participant from Quebec explained, “If it’s a nurse or your family doctor who does it, the result is the same.” Many women who reported positive relationships with their primary care providers indicated that receiving abortion care

from a trusted clinician was an advantage of mifepristone. As an Ontarian explained, “In that case of the pill, I would – absolutely [be comfortable receiving care]. I trust him and I adore my doctor.”

Women had many questions and some concerns about mifepristone

Given that so few women in our study had heard of mifepristone before the interview, it is unsurprising that women had many questions. Indeed, when providing standardized information about the regimen, participants often interrupted the interviewer to ask questions and in the majority of cases this section of the interview could be appropriately characterized as a dialogue. Women’s questions focused on safety, efficacy, and the abortion process. For most women, learning that mifepristone had been available in France since 1988 and in the US since 2000 was reassuring. As explained by a 22 year-old Ontarian,

[As] you probably noticed I automatically assumed it was something new...I guess it’s just the stigma of being the unknown, that if it’s not available here and not talked about here that it seems it could be dangerous, even though as you said it’s used worldwide.

However, even after responding to questions, a significant proportion of women expressed concerns about medication abortion with mifepristone. Slightly more than 20% of our participants (n=37) expressed discomfort with the idea of having an “unsupervised” abortion. As one participant from Ontario explained, “I would much prefer to be doing it under medical supervision the whole time.” And while the prospect of having an abortion at home was appealing for some women, others found this feature off-putting and even frightening. As explained by a 21 year-old from Manitoba, “I would feel more secure being in a hospital with

healthcare professionals...[Mifepristone] just sounds like a home abortion to me, that just sounds very scary, like you know what if something went wrong and I didn't know."

Finally, about 10% of our participants (n=17) expressed concern that the introduction of mifepristone could make abortion "too accessible" such that women would forgo contraception and/or "abuse" the medication. As explained by a 28 year-old from Quebec, "I don't know if some people would take other measures [contraception] as seriously if [mifepristone] is available on the market...Because they would say okay this is so easy, let me go get the pill it is done with."

Mifepristone, choice, and social equity

Irrespective of whether or not our participants would have considered the option of mifepristone for themselves, the overwhelming majority of participants from all provinces supported the introduction of mifepristone into the Canadian health system. Participants consistently reported that Canadian women should have a choice in the abortion process and that all high quality services should be made available. As a 26 year-old from Manitoba explained, "[It's] a nice option to have. And I do see why people would fight to have this in the country...It's not such a bad thing to have more options."

Further, many of our participants referenced the fact that increasing the accessibility of abortion services promoted greater social equity. Over a quarter of our participants (28%, n=49) expressed that women in rural, isolated, or northern parts of Canada would benefit from closer access. As a 22 year-old from Alberta explained:

There are so many small towns in Alberta. A lot of people are up North because of the oil rig, and a lot of people do stuff outside the cities and I know that our highways [with] our winter driving, it would really suck to have to drive to the closest city. That could be up to like eight hours.

The possibility that mifepristone could help other Canadian women receive timely, affordable, and acceptable abortion care was viewed as a social good. As a 25 year-old from New Brunswick stated, “Yeah there are plenty of reasons why. Medical abortions should really [be] accessible in Canada. I mean there’s no reasons why they shouldn’t be.”

Discussion

On July 29, 2015 Health Canada authorized Mifegymiso® for the Canadian market [18] and it is anticipated that mifepristone will be available in 2016 [20]. The approved regimen is comprised of 200mg oral mifepristone followed 24-48 hours later by the buccal administration of 800mcg of misoprostol. Only physicians will be able dispense Mifegymiso®, which is approved through 49 days’ LMP [18]. Although the physician-only restrictions and gestational age limitations are not in concert with the global evidence [12,14,15], the approval of mifepristone represents a victory for reproductive health and rights in Canada. However, for the promise of mifepristone to be fully realized concerted efforts will need to be undertaken to incorporate medication abortion into health service professions training and education, increase the pool of providers, expand both sites and models of service delivery, and ensure coverage of Mifegymiso® in provincial and territorial health insurance schemes.

The findings from our study indicate that, once information about mifepristone is offered, Canadian women are quite receptive to medication abortion. Consistent with studies

conducted before or immediately after the introduction of mifepristone in other countries [21,22,23,24,25], participants in our study viewed ease of use, privacy, convenience, and timely and proximate access as the most attractive features of medication abortion. This suggests that the acceptability of mifepristone among women in Canada will likely mirror the experiences of women in other countries.

However, women in our study evinced very little knowledge of mifepristone prior to our interview irrespective of province of residence, age, or first language. As our sample was comprised of women who had had at least one abortion in the five years before the interview one might expect knowledge about abortion methods to be greater in our sample than among women in general. This suggests that significant awareness raising efforts will be required to ensure that women receive medically accurate information about mifepristone. Importantly, our participants did not express significant misinformation about mifepristone. Thus educational and awareness raising efforts may be facilitated by having a relatively blank slate from which to work, as opposed to having to combat significant misinformation from the start.

Our findings point to some of the questions and concerns that women are likely to have about mifepristone once the medication becomes available in Canada. That women's questions centered around safety, efficacy, and the abortion process itself is hardly surprising and addressing these issues is already the mainstay of high quality educational efforts and abortion procedures counseling [26]. However, that 20% of our participants expressed concerns about having an "unsupervised" abortion points to an issue that providers and advocates may want to pay special attention to once the roll out is underway. Our findings also indicate that many women would welcome receiving their abortion care from primary care providers, including

nurse practitioners. Identifying avenues from the outset to support the elimination of the physician-only requirement appears warranted.

Finally, our findings suggest that there is considerable support for mifepristone as a means of increasing social equity. Our participants expressed compassion for other women seeking abortion care and many were cognizant of the current barriers that women in rural and remote communities experience. Our participants also repeatedly emphasized that women should have a choice of procedures and recognized that even if they would not choose a medication abortion for themselves, other women might prefer that option. This signals that messages centered on equity and choice might have particular resonance in the Canadian context.

Limitations

Qualitative methods provide an excellent mechanism for in-depth exploration of participants' experiences, beliefs, and behaviors. However, qualitative research is not intended to yield representative and generalizable results. Although multi-modal recruitment of a large purposive sample of women who resided in five different provinces gives us confidence that the themes we identified are significant, we are unable to assess the degree to which these experiences represent broader trends. Further, participants in our study had all had at least one abortion and thus the perspectives of Canadian women who have never had an abortion are not captured in our data. Finally, we conducted our interviews prior to Health Canada's approval of mifepristone. Given the media attention to mifepristone in the wake of the

decision, baseline knowledge about mifepristone would likely be higher if the study were conducted in/after August 2015.

Conclusion

The approval of Mifegymiso® and the anticipated introduction of mifepristone into the Canadian health system in 2016 will offer women more options for early pregnancy termination and has the potential to expand access to timely, high quality abortion care. Our findings suggest that there is considerable interest in mifepristone among Canadian women who have experienced a recent abortion but knowledge of mifepristone is extremely low. Creating tailored and culturally and contextually resonant messages to help raise awareness about mifepristone appears warranted.

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Table 1: Demographic characteristics of study participants (N=174)

		Alberta N=20 n (%)	Manitoba N=20 n (%)	New Brunswick N=27 n (%)	Ontario N=71 n (%)	Quebec N=36 n (%)	All Provinces N=174 n (%)
Language	English	20 (100%)	20 (100%)	20 (74%)	60 (85%)	9 (25%)	129 (74%)
	French	0 (0%)	0 (0%)	7 (16%)	11 (15%)	27 (75%)	45 (26%)
Age	18-24	10 (50%)	10 (50%)	12 (44%)	35 (49%)	16 (44%)	83 (48%)
	25 and older	10 (50%)	10 (50%)	15 (56%)	36 (51%)	20 (56%)	91 (52%)
Race or ethnicity	White	13 (65%)	8 (40%)	23 (85%)	50 (70%)	9 (25%)	103 (59%)
	First Nations/ Metis/Inuit	2 (10%)	5 (25%)	0 (0%)	3 (4%)	0 (0%)	10 (6%)
	Biracial	1 (5%)	2 (10%)	0 (0%)	7 (10%)	0 (0%)	10 (6%)
	Québécoise	0 (0%)	0 (0%)	0 (0%)	1 (1%)	8 (22%)	9 (5%)
	Black	0 (0%)	0 (0%)	0 (0%)	4 (6%)	0 (0%)	4 (2%)
	Other/ unspecified	4 (20%)	5 (25%)	4 (15%)	6 (8%)	19 (53%)	38 (22%)

**Chapter 4: Article #2: “Not everybody can afford to travel across the province for this”:
Exploring the experiences of women who have had abortions in Newfoundland**

We have formatted this manuscript for submission to the peer-reviewed journal *Women’s Health Issues*. The dissemination plan for CAS as a whole is complex and thus we have not yet submitted this manuscript to the journal. However, we intend to do so once other papers from the project have been accepted. We anticipate that submission will occur in August/September 2016.

**“Not everybody can afford to travel across the province for this”:
Exploring the experiences of women who have had abortions in Newfoundland**

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Abstract

Purpose: Although there are no federal restrictions on abortion in Canada, provincial and territorial policies and the geographic distribution of providers impacts access. In Newfoundland and Labrador, abortion services are only provided by one free standing clinic and a single hospital, both located in the provincial capital. Our qualitative study aimed to explore women's experiences obtaining abortion care in this Atlantic province.

Procedures: We interviewed 13 women who were residents of Newfoundland at the time of their abortion. We transcribed audio-recorded interviews and used deductive and inductive techniques to analyze the data for content and themes.

Main Findings: Women expressed concern with the stigma and lack of social support associated with their abortions, long wait times exacerbated by minimum age restrictions, and lack of geographic access in their province for themselves and other women. Many participants could envision the introduction of mifepristone as a way to de-centralize access from St. John's and break down other existing barriers in Newfoundland and Labrador.

Principal Conclusions: Women in Newfoundland and Labrador face distinct challenges to accessing abortion care. Although the introduction of mifepristone may alleviate some of those challenges, supporting efforts to destigmatize abortion, align provision with evidence-based standards, and increase the number of providing facilities outside of St. John's are also priorities.

Introduction

Abortion was decriminalized by the Supreme Court of Canada in 1988, and Canada remains one of the few countries in the world without federal restrictions on the procedure. Each province and territory is responsible for providing healthcare services to residents in accordance with the Canada Health Act. Although abortion is defined as a medically necessary service and covered by government health insurance schemes, provincial and territorial policies and regulations have resulted in geographic disparities in access (Downie & Nassar, 2007; Kaposy, 2010; Rodgers & Downie, 2006; Shaw, 2006). Further, the concentration of abortion providing facilities in urban centers has resulted in considerable rural-urban disparities within individual provinces (Sethna & Doull, 2013).

In Newfoundland and Labrador, women experience a range of barriers to accessing abortion care. Newfoundland and Labrador has the highest proportion of rural inhabitants among the Atlantic provinces, posing issues to service delivery (Simms & Greenwood, 2015), and abortion care is not an exception. There are two abortion providing facilities in the province – one freestanding clinic and one hospital – both of which are located in the capital of St. John's. Thus, in order to obtain abortion care within the province, women often travel considerable distances by car, plane, and/or boat. Unlike other provinces in Atlantic Canada, provincial health insurance covers abortion care provided at both clinics and hospitals, provided patients have a Medical Care Plan (MCP) provincial health card. Of the 1,051 abortions that were done in the province in 2014, approximately 82% were provided by the clinic (Canadian Institute for Health Information (CIHI), 2014).

Abortion services in Newfoundland and Labrador are only available to women who are between seven and fifteen weeks' gestation. Although both aspiration and medication abortion

can be provided with extremely high efficacy earlier in pregnancy (Barbieri, 2015; Lichtenberg & Paul, 2013), aspiration/surgical abortions are only available after seven weeks at both the clinic and hospital (Morgentaler, 2008). Minimum gestational age restriction is not a result of policy but of longstanding practice patterns. Additionally, women needing an abortion after 15 weeks are required to travel out of Newfoundland and Labrador. These procedures are also covered by provincial health insurance. As is true of Canada in general, mifepristone/misoprostol, the gold standard medication abortion regimen, is not currently available in Newfoundland and Labrador. However, Health Canada approved Mifegymiso® for early pregnancy termination in July 2015 and mifepristone/misoprostol is projected to be introduced into the Canadian health system in the summer/ fall of 2016 (Health Canada, 2015).

Little research has been conducted on reproductive health in Newfoundland and Labrador, let alone research on abortion. In order to understand better women's experiences obtaining abortion care and navigating provincial regulations, we conducted interviews with women who resided in Newfoundland at the time of their termination.

Methods

This study is part of a large-scale qualitative study documenting women's abortion experiences in Canada. The overarching study aims to explore the ways in which geography, age, and language minority status independently and in combination impact access to abortion services, to identify financial and personal costs associated with obtaining abortion care, and to investigate avenues by which abortion care could be improved at the provincial/territorial and federal levels. The study is led by AF, a medical anthropologist and medical doctor with considerable abortion-related research experience and we have previously reported on the

overarching study and the methods employed (Cano & Foster, 2016; Foster et al., 2016; Vogel et al., 2016).

For the Newfoundland and Labrador portion of the study, we used a multi-modal recruitment strategy that included online postings, circulations of listservs, and flyering by local organizations. Women who had obtained an abortion on/after January 1, 2009 were eligible to participate if they were age 18 or older at the time of the interview, residents of the province at the time of the abortion, and sufficiently fluent in English or French to respond to questions. KV, a master's student in Interdisciplinary Health Sciences at the University of Ottawa, led the recruitment efforts and conducted all interviews, after having been trained by AF. With permission, we audio-recorded all telephone/ Skype interviews and KV took field notes during and wrote reflexive memos shortly after each encounter. We analyzed the interviews for content and themes using an iterative, multi-stage process (Deniz & Lincoln 2005). Meetings between KV and AF guided our interpretation as did the discussions within the study team about the national findings.

We received approval for this study from the Health Sciences and Sciences Research Ethics Board at the University of Ottawa (File # H08-12-08). In this article we present key themes that emerged from the interviews with women from Newfoundland and use narrative vignettes to give voice to their individual experiences. We have redacted or masked all identifying information about individual women and clinicians and we use pseudonyms throughout the paper.

Results

Description of participants and their abortions

From October 2014 to February 2016, we interviewed 13 Newfoundland women about their abortion experiences. The participants in the study ranged in age from 20 to 47, roughly split between two age cohorts (18-24 inclusive and 25 and older) for which we purposively recruited. The women overwhelmingly identified as white/Caucasian (n=8), with some identifying as white with First Nations or Inuit partial heritage (n=2). All but three of our participants resided in St. John's at the time of their abortion.

Our 13 participants provided detailed information about 15 abortions that occurred during the five years preceding the interview. Twelve of these abortions took place in the clinic in St. John's, one was performed in the St. John's hospital, and two abortions took place in an out-of-province clinic. The majority of abortions were performed in the first trimester (n=13) using aspiration techniques (n=12); none of our participants had experienced a medication abortion using methotrexate/misoprostol. Eleven of our participants first contacted a facility to obtain an abortion within the first seven weeks' gestation.

Figure 1: Tanya's story

Women's experiences are shaped by stigma and how supported they felt in their decision

As showcased in Tanya's story, women's experiences seeking and obtaining abortion care were often intertwined with stigma and secrecy. As Tanya explained, "What a woman has to go through here in Newfoundland can create a lot of feelings of guilt and shame and you know it sort of makes you feel like, am I doing something wrong? Like why do I have to be so secret and sneaky about this?" Harley, a 20 year-old who had an aspiration abortion in the clinic, also spoke about stigma by comparing accessing abortion care to other sexual and reproductive healthcare services:

When I go and get a pap test everyone tells me that I was doing a really good thing for my health. When I went and had an abortion, while they didn't verbally tell me that it was a bad decision, it was - I don't know it was almost portrayed through body language I guess...

The level of support women received from their social systems also made an impact on their feelings about the process. Many women reported either no support or a lack of support from people close to them, such as partners, family members, or friends. As Stephanie, age 24 from St. John's explained,

It was hard, it would have been nice to have [my partner] there as like a support but I mean he- he just wasn't, he didn't want a part of it. I kind of had to do it just me and my friends, and he didn't agree with the decision.

Three women interviewed reported being in a self-identified abusive relationship at the time of their abortions, and a fourth woman reported a past abusive relationship. Women who experienced intimate partner violence were more likely to have had more than one abortion in the five-year span. These women also expressed more negative feelings about the abortion and appeared to pay more attention to whether staff were supportive or not, compared to women who did not identify as having been in an abusive relationship.

Overall women reported being very satisfied with the abortion care that they received. As Josie explained, "[T]he nurses were so nice and so understanding and so compassionate and empathetic. I mean the people who work [at the clinic] are truly [pause] - makes the experience not as difficult and hard as it could be." However, interactions with both clinicians and frontline staff also shaped women's experiences in a negative way, as 24 year-old St. John's resident Violet explained:

One lady actually down there did say something about how her friend was interested in having a baby and couldn't, and did I want to - had I thought about adoption? And I told her I don't feel like this is the place for you to be discussing that sort of thing...The way I

felt about it was even the clinic wasn't all that supportive [of my decision to have an abortion].

Figure 2: Lia's Story

Minimum gestational age requirements exacerbate long wait times

On average, our participants had to wait 3.4 weeks after making the decision to have an abortion to obtain care while living in Newfoundland, and five women waited four weeks or longer to have an abortion in St. John's. The majority of women interviewed expressed some knowledge of having to wait until seven weeks after the last menstrual period (LMP) in order to obtain an abortion and often this was communicated when they called the facility seeking an appointment. Several women also expressed pregnancy symptoms experienced during wait times affected their lives; as Harley from St. John's who had her abortion at the hospital said,

[B]eing pregnant for eight weeks pending an abortion and having morning sickness is very traumatic. I know they can do it earlier but in Newfoundland they wait for eight weeks, I don't know why. So waiting for eight weeks, having morning sickness and throwing up all the time and not being able to be around weird smells - like it was absolutely horrible.

Women were generally unsure as to why they were unable to receive abortion care before that point. Many women wished that their abortions could have occurred earlier, and were keen to discuss possible avenues for increasing access to early pregnancy termination options.

Figure 3: Kiera's Story

Centralized service in St. John's necessitates time and expense to travel

Of the three women who lived outside of the capital, two had to drive over eight hours to get to St. John's. Of these women, one stayed overnight in town after her procedure, and all three women had family, a friend, or a partner drive them to and from the clinic. Maya, one of the women living outside of St. John's, said that the total cost of travelling across the island and staying overnight in St. John's was CAD700. Because she was on Income Support at the time (Newfoundland social security), she was able to apply for funding to cover her travel and accommodations upfront. As she described,

[F]or people on our side of the island, we have to travel nine, 10 hours to get to that clinic. If they were to ever think about opening one more accessible to people in the west coast of Newfoundland that would be great because you know not everybody can afford to travel across the province for this.

Most of our participants (n=8) knew at the time of their abortion that facilities were only located in the provincial capital. Three women from St. John's expressed unprompted concern for women in their province who do not live in St. John's. An additional eight women expressed concern for women outside of St. John's, specifically on the west coast of the island and Labrador, after prompting about improvements for location or access in Newfoundland. As Tanya, a 30 year-old St. John's resident stated,

I probably had the most privileged situation where I can afford to live [in] downtown St. John's where the clinic happens to be located, I have a car, I can drive, I can afford to pay parking. It is the only place, the only service in the province. And I think that is a huge obstacle for women everywhere in the province.

Women expressed considerable interest in mifepristone

Many of our participants (n=9) were aware of the existence of mifepristone, and around half of those described some detailed knowledge on gestational age restrictions, the requirements for obtaining the medication, and/or the medication abortion process. After describing the

mifepristone/misoprostol method of abortion to women, the overwhelming majority (n=10) said that they would have definitely taken mifepristone over their aspirational/surgical abortion if it had been available and offered to them. Two women said they might have considered it, and another participant was not interested in the method.

Several participants believed that access to mifepristone and accepting mifepristone from their primary care provider (PCP) might have made the abortion(s) more private and their own relationships with their PCPs influenced their interest in accepting abortion care this way. Twelve of our 13 participants said they would be equally comfortable accepting abortion care from both a family physician and a nurse practitioner. Women also often considered a medication abortion with mifepristone to be less “invasive” and an easier process overall. Some women like Davia (a 27-year-old woman from St. John’s) relayed that the ability to access abortion care before seven weeks’ LMP would be important to them: “I would have done it at three weeks. I would have done it like as soon as I decided I wasn’t going to keep the baby...It would have saved me like a month of Hell.”

Discussion

In July 2015, Mifegymiso® was registered in Canada, but as of May 2016 it is still unavailable in all provinces. The Health Canada regulations surrounding Mifegymiso® are not in line with evidence-based regimens in several aspects (Health Canada, 2015). Importantly, mifepristone has been shown to be effective and safe through nine weeks’ LMP (Cleland & Smith, 2015; World Health Organization 2012), but Health Canada only approved provision up to 49 days (seven weeks). There is considerable evidence that mifepristone can be prescribed by a range of health service professionals, including nurse practitioners and midwives, as well as through telemedicine (Foster et al. 2015; Grindlay, Lane & Grossman 2013; Kishen & Stedman

2010; Warriner et al. 2011). Health Canada has restricted provision to physicians who have received specified training. In addition, although studies have demonstrated that ultrasound is not necessary, (Bracken et al. 2011), the Health Canada decision requires clinicians to use ultrasound to date the pregnancy and exclude ectopic pregnancy prior to providing Mifegymiso®. And while as of May 2016 Ontario and British Columbia have incorporated Mifegymiso® under their provincial insurance coverage, it is unclear if other provinces and territories will follow suit (FAQ Mifegymiso, 2016). All of these factors will limit the availability and accessibility of mifepristone in Canada, undermining the potential mifepristone has to address inequities in abortion access. Adherence to evidence-based practice is necessary for mifepristone to fulfill its promise.

Research from other countries indicates that integrating mifepristone fully into the current system takes time and effort, and in most cases, policy change (Boonstra 2002; Joffe & Weitz 2003; Leeman et al. 2007). Our results suggest that if made available in a cost-effective, accessible manner, mifepristone could be a viable and preferable option for Newfoundland and Labrador women. Making services easier to access and being able to avoid anti-choice or judgmental staff or healthcare professionals could decrease stress arising from stigma. The attitudes of many of our participants toward women seeking abortion care who live outside St. John's suggests that women can envision mifepristone being able to decrease travel times. Additionally, our results suggest that offering a form of abortion in Newfoundland that is available before seven weeks' LMP is valuable and could be preferential to many women. However, it is unclear if facility gestational age restriction policies extend to medication abortion provision; if these minimum gestational age requires are imposed provision of Mifegymiso® from these facilities would not be possible. Allowing a range of clinicians (including nurse

practitioners) to provide mifepristone is also supported by the women we interviewed. This is especially important in a province such as Newfoundland and Labrador, because many of the small communities rely on nurse practitioners as a locally accessible PCP (Solutions, 2014).

One of the most pressing barriers to care is the geographic location of the only clinic and hospital providing abortion care in the province. Our study suggests that women who have had abortions are supportive of expanding access to abortion across the province, specifically on the west coast of the island and in Labrador. Expensive and difficult travel as well as needing to disclose to friends/ family in order to obtain transportation were all challenges for some women in our study. Opening a second clinic in another part of the province or proactively supporting abortion provision out of more hospitals in Newfoundland and Labrador is important irrespective of the integration of mifepristone into health services. Limiting aspiration/surgical procedures to over seven weeks' LMP in the currently providing facilities in Newfoundland unnecessarily increased wait times for women in this province. Exploring mechanisms for changing this policy, including supporting provider training and advocacy efforts, appears warranted.

Limitations

As with all qualitative studies, our results are neither generalizable nor representative. However, in part because of the small number of facilities in the province, we were able to obtain thematic saturation and thus we are confident that our results have important beyond the immediate bounds of the study population. Unfortunately, despite much effort we were unable to recruit women from Labrador. Future research would benefit from inclusion of the perspectives of these women.

Implications for Practice and/or Policy

In 2014, Health Minister Steve Kent said that, “The numbers would suggest that there isn’t a need at this point for an expansion of [abortion] services,” (The Telegram). However, he clarified that the provincial government would be open to expansion of services, provided any other providers/facilities came forward to provide abortion services (CBC News, 2014). With the approval of Mifegymiso® there is now an opportunity for additional clinicians to provide abortion care in Newfoundland and Labrador thus allowing for more equitable access to abortion. This would be especially true if Health Canada were to amend its regulations surrounding mifepristone/misoprostol to reflect evidence-based protocols that allow for a range of healthcare providers to prescribe mifepristone through nine weeks’ LMP. However, Mifegymiso® will also need to be incorporated into the provincial health insurance system; Action Canada (2016) currently estimates that Mifegymiso® will cost approximately CAD270 once it is introduced. Finally, the minimum gestational age requirements imposed by providing facilities in Newfoundland should be revised and aligned with best practices of both medication and aspiration abortion provision.

Conclusions

Women in Newfoundland and Labrador face distinct challenges to abortion access in their province. Issues relating to privacy and stigma, geographic barriers, and waiting times were the primary concerns of the women we interviewed. Expansion of services to facilities outside of St. John’s, revision of policy and practice surrounding gestational age limits, and addressing stigma and protecting privacy should be supported in Newfoundland and Labrador. In conjunction with those efforts, Mifegymiso® has the potential to lessen the impact of these

barriers and address women's concerns. However, under current Health Canada restrictions, facility and provincial policy to restrict abortion at gestational age, and limited and centralized providers undermine the potential of Mifegymiso®.

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Figure 1: Tanya's story

Tanya, 30, had just moved to Newfoundland for school from another province with her partner. She found out she was pregnant shortly after moving, and while she could discuss her decision with her boyfriend, she had no other social supports in the province which she found isolating. After a few weeks, she decided to terminate the pregnancy, as she was starting school soon and felt at that time she was unable to parent the way she wanted. She felt much more stigma in Newfoundland than in her home province where she had another abortion years earlier. She felt uncomfortable discussing pregnancy options with her Newfoundland family doctor and felt that the process of setting up her appointment and receiving care was surrounded in a social culture of shame around abortion.

Figure 2: Lia's story

Lia found out she was pregnant very early in her pregnancy, and was immediately sure that she wanted to get an abortion. She was 20 years old and parenting was not in her plans for the near future. She searched for abortion clinics on the internet, and called the Athena Health Center that day. They invited her in for an ultrasound, but because she was not quite 4 weeks LMP they were unable to confirm the pregnancy via ultrasound. After receiving a blood pregnancy test, she was sent home and was told that her appointment would be at the very soonest it was possible in Newfoundland- at 7 weeks LMP. She begged them to do it sooner because she felt that being pregnant was life ruining for her at that time. She wasn't sure why she had to wait, but returned a little over 3 weeks later to have her procedure.

Figure 3: Kiera's story

Kiera had her first child at 17, and found herself pregnant again at 18. She lived in a community on the other side of the island from St. John's but realized after looking up abortion services in the phone book that she did not have any closer options. The man she was with at the time was not a serious relationship, but he supported her decision and drove her to St. John's for the abortion. The drive was eight hours, and they left very early in the morning before the procedure. Despite suggestions that she stay overnight in St. John's to rest, they decided to drive home after the procedure, another eight hours. She described that day as very long, and incredibly tiring. Because she is a resident of Newfoundland, she didn't have to pay for her abortion but she did have to pay for gas to and from the facility. She was very interested in the possibility of receiving mifepristone from her primary care provider and believed that this would be easier and less expensive.

Chapter 5: Discussion

In this chapter, I begin with an integration the results of the two articles. I also address and discuss the significance and policy/practice implications of this project, as well as future steps for this research. I then reflect on these findings through a reproductive justice lens as well as a consideration of my positionality as a researcher and how it relates to this thesis project. I end this chapter and the thesis with a discussion of the limitations of the research and a summative conclusion.

5.1 Integration of results

5.1.1 Knowledge of mifepristone

The process of recruitment and interviewing for Chapter 3 was completed prior to the registration of Mifegymiso® in July 2015. In contrast, the majority of interviews for Chapter 4 were completed after this date, and the responses indicate that there is a difference in baseline knowledge before and after registration. A significantly higher proportion of women were aware of the existence of mifepristone post-registration, probably due to increased news coverage regarding the medication, and coverage relating to issues with limited provision and what this might mean for Canadians in the future (Paperny, 2016; Prasad, 2016; Rollmann, 2014; Scott, 2016 among others). Women from Newfoundland were also found to be more knowledgeable about mifepristone; about half of our participants were able to provide some details on service delivery, timeframe for use, and/or regulatory status (Chapter 4). Again, this knowledge is most likely due to increased media coverage that occurred in the wake of registration. Indeed, several women we interviewed mentioned seeing articles about mifepristone online or on Facebook after July 2015.

5.1.2 Interest in mifepristone

The women we interviewed for both Chapters 3 and 4 indicate that there is significant interest in mifepristone for early pregnancy termination. The majority of participants from Alberta, Manitoba, New Brunswick, Ontario and Quebec showed great interest in the option of mifepristone, as was shown in Chapter 3. In Newfoundland (Chapter 4), our participants were even more enthusiastic about mifepristone; more than three quarters of our participants would have chosen the medication had it been available. The explanation for this finding appears multifaceted, however our analysis identified two major probable contributors. First, as described above, women in Newfoundland had greater baseline knowledge of mifepristone than women from the five provinces where we completed data collection prior to registration. Women might be more likely to express interest in taking a drug that they have heard of and that has been approved for use in Canada than one that is still under consideration. Second, there seems to be a correlational relationship between women from areas of the country with less access, and women being more likely to express interest in using mifepristone. Access to abortion care in Newfoundland is limited and therefore these women might be more likely than those living in urban areas of Ontario and Quebec, for example, to be interested in medication abortion options (see Section 5.1.4 for further analysis).

5.1.3 Mifepristone to reduce barriers

The introduction of mifepristone in Canada has the potential increase access to abortion by allowing more health practitioners to become providers. By allowing family physicians to provide abortion care, services could expand from primarily large urban centers to all over provinces and territories. One of the primary conclusions reached in both Chapters 3 and 4 is that

women can envision mifepristone as way to break down barriers to access. In Chapter 3, our results showed that around a third of participants thought that mifepristone might decrease travel for themselves or for other women in their province. In Chapter 4, an even higher proportion of women - 11 of 13 participants - expressed that for themselves or for other women in Newfoundland, being able to access care closer in proximity to their homes would have a positive impact. The cost of travel was also discussed in the interviews; proximity to the abortion facility influences how much a woman might pay, and for many women the cost of travel is often prohibitive (as exemplified by one participant from Newfoundland who paid \$700 for travel and accommodations related to her procedure). While these indirect costs can be covered by the Newfoundland government through the Medical Travel Assistance Program (MTAP), the full cost of travel is not always covered - there is a \$400 deductible if you live on the island - and applicants still need to pay the costs upfront and are later reimbursed (MTAP, 2016). Elsewhere in Canada, travel assistance schemes vary in coverage, accessibility and availability.

Reducing waiting times for the receipt of abortion care may also be impacted by the introduction of Mifegymiso®. Wait times fluctuate significantly depending on province, facility and provider (Eggertson, 2001). It became clear while conducting our CAS interviews that there remains a huge range of wait times that women face- anywhere from less than a week to almost two months to obtain the abortion after making the decision to terminate the pregnancy. Women reported experiencing negative symptoms of pregnancy such as dizziness, fatigue, and nausea during this waiting period, symptoms that affect their professional and personal lives (Chapter 4). Women perceived that going to a local walk-in clinic or to their family doctor to receive mifepristone could be a faster process. This was a major finding from Chapter 3, where many women cited decreased wait times for their interest in considering mifepristone. Wait times are

an especially complex issue in Newfoundland, as the providing facilities enforce a minimum gestational age policy. As described in Chapter 4, our participants in Newfoundland often envisioned mifepristone as a way to circumvent this policy. There is also the possibility that allowing for earlier abortions in Newfoundland through integration of Mifegymiso® might challenge the policy, and enact change that eliminates the non-evidence-based minimum gestational age restriction.

The provision of mifepristone by a primary care provider could also allow women a more comfortable experience, particularly those women who have a positive relationship with their family physician. As is described in Chapter 3, women often described having an abortion “in the comfort of their own home” to be a positive aspect of the mifepristone delivery regimen. Allowing women to choose whether to go to a clinic, hospital, or their own family doctor to access abortion care increases options and could increase some women’s comfort with the procedure.

Avoiding the judgement or anti-choice sentiments of others was discussed often by the women that were interviewed for CAS, regarding both their perceptions of and experiences with obtaining abortion care, as well as their interest in accepting abortion care from a family physician or nurse practitioner. When women trusted their primary care provider or believed that a facility would be judgement free, supportive, and non-stigmatizing, they expressed interest in accepting mifepristone from them. In the data we collected from interviews in Newfoundland, experiences with hospital and clinic staff significantly influenced women’s perceptions and feelings about their own abortions. As shown in Chapter 4, many women in our study from Newfoundland discussed privacy as a major concern during their abortion experiences, and increased privacy might improve their overall experience. Ability to choose where to go for

abortion care, be that their family doctor, a walk-in clinic, or an abortion clinic/hospital, gives women greater autonomy over their choices, could afford them greater privacy, and could positively affect their overall experience.

5.1.4 Provincial differences

As we purposively recruited different age groups, Francophone and Anglophone women, and women in different locations within provinces, we ensured that a variety of experiences were explored. However, we also found that certain trends were likely reflective of provincial policies, the availability of abortion care within specific provinces, the geographic layout of the province, and province-level societal/ cultural factors. As was briefly mentioned in Section 5.1.2, the article presented in Chapter 3 identified that participants from Quebec expressed less interest in mifepristone compared to the other four provinces involved in that analysis. Conversely, participants in Newfoundland were more interested in mifepristone as an option than any of the provinces discussed in Chapter 3. This could be due to a number of factors, one of which is the availability of abortion services.

Abortion care is easiest to access in Quebec; 46 of the 94 abortion facilities in Canada (48%) are located in Quebec, a province that houses only 23.1% of the Canadian population (Norman et al, 2014). These facilities include free-standing clinics, hospitals, as well as *centre local de services communautaires* (CLSC) (community health centers). Quebec is also a leader in equitable access, as half of all these abortion facilities are in rural areas. The comparatively high level of access comes from dedicated financial resources and promotion from the Quebec government since the 1970s (Vogel, 2015). As one main advantage of mifepristone is the “ease” of the process (Chapters 3 and 4; Lie, Robsen & May, 2008) participants, including those from

Quebec, might have been personally less interested in mifepristone if their own abortion was relatively easy to obtain. This finding does not, however, detract from the overall interest women had from every province to increase choice and reproductive equity in Canada.

In Newfoundland, where abortion services are only located in the provincial capital (something that the majority of participants were aware of), abortion access is perceived as less available, and especially difficult to access for those that live outside St. John's. Expression of empathy and concern for women living great distances from services was something that most Newfoundland participants spoke about when we asked about improvements to abortion services in general, and with regards to mifepristone in particular. These sentiments might contribute to the frequency of expressed interest in mifepristone by the participants from this province.

There were a number of participants from Newfoundland who experienced intimate partner violence or other abuse, or discussed abuse as it related to prior relationships during the interview. One such case not only involved intimate partner violence, but reproductive coercion as well. It is very important to document these types of experiences in order to explore the frequency of these scenarios, and the processes by which intervention by various systems (healthcare, legal, social) take place- or not, as the case may be. The high proportion of our participants who experienced intimate partner violence from Newfoundland and Labrador is not necessarily indicative that abuse is more prevalent in this province than others. According to Statistics Canada, police-reported intimate partner violence in the province occurred at a rate of 579 women per 100,000; the national average for 2011 was 539 per 100,000 women (Sinha, 2013). There are several possibilities as to why we observed this dynamic among such a large proportion of our participants. However, this is likely a function of recruitment in that our

advertisement appeared on a specific listserv or online community forum dedicated to abuse survivors. Future studies would benefit from an explicit exploration of this dynamic.

5.1.5 Health Canada limitations on mifepristone provision

Health Canada announced the registration of mifepristone with several deviations from international and evidence-based protocols. First, Health Canada limited the provision of mifepristone to 49 days' gestation. However, the medication has been proven effective and safe up until nine weeks, or 63 days; in March 2016 the United States FDA approved mifepristone/misoprostol regimen through 70 days (Mifeprex label, 2016). The conservative gestational age limit set by Health Canada needlessly reduces the number of women who could be eligible to choose mifepristone as a form of early abortion care. Research from the Guttmacher Institute shows that when a gestational age limit is extended to 63 days' LMP, a higher proportion of women access medication abortion (Jones & Henshaw, 2002). As a result, restricting the gestational age reduces the positive effect that mifepristone could have to increase access to this form of abortion care. While introducing mifepristone to a country does not mean that overall abortion rates increase, a higher proportion of women are able to access abortion care earlier in their pregnancies, and therefore early abortion numbers go up (Jones & Henshaw, 2002). Further, the earlier gestational age an abortion is performed at, the safer it is for women (Berer, 2000). Thus, not only is this safer in terms of avoiding negative outcomes from the procedure, but according to our participants in Chapters 3 and 4, the reduction in wait time is preferable to many women.

In the Regulatory Decision Summary for Mifegymiso®, Health Canada specified that the drug could only be dispensed by a physician. Further, a training and registration process is

required for physicians seeking to prescribe mifepristone and pharmacists are required to complete a training module to dispense the medication (Scott, 2016). This began in April 2016 (Paperny, 2016). This requirement is incongruent with the Health Canada regulations; there is significant evidence that a range of healthcare practitioners, including nurse practitioners, are able to prescribe mifepristone with equal efficacy, safety outcomes and patient acceptability when compared to physicians (Foster et al. 2015; Kishen & Stedman, 2010; Warriner et al, 2011). In addition, the majority of interview participants involved with this thesis project said they would be comfortable accepting abortion care from both a physician and nurse practitioner equally. Disregarding nurse practitioners as potential abortion care providers of mifepristone could disadvantage rural and Northern Canadian women in particular. While legislation is different in every province, nurse practitioners in recent years have seen an expansion in their role and responsibilities in an effort to increase primary healthcare access in rural and remote communities (DiCenso et al., 2007). As such, many small towns use nurses as their only local point of primary healthcare (Pitblado, 2005; Solutions, 2014). Allowing nurse practitioners to dispense Mifegymiso® could in this way have a great impact on lessening geographic barriers to access.

The Mifegymiso monograph also stipulates that an ultrasound be used before prescribing mifepristone to determine the gestational age and exclude ectopic pregnancy. This is again a restrictive policy; as many physician's practices, walk-in clinics and other facilities do not have ultrasound equipment, limiting the type and number of facilities that can effectively provide Mifegymiso®. Many countries do not necessitate the use of an ultrasound, and instead use the date of a woman's last menstrual period as an effective way to establish if women are eligible for

mifepristone- indeed, this has been found to be an acceptably effective way to estimate gestational age (Bracken et al., 2011).

As of May 2016, only the Ontario and British Columbia (BC) governments have incorporated Mifegymiso® into their provincial insurance systems, assuring coverage of the medication (FAQ: Mifegymiso, 2016). As Action Canada has estimated that the combi-pack will cost patients \$270, this may be prohibitively costly for some women, and a deterrent for others who might otherwise prefer a medication abortion (Scott, 2016). It is unclear if other provinces will also eventually incorporate Mifegymiso® into provincial insurance schemes, and what timeline that would occur on. Yet it is clear from our study (Chapter 4) and other independent research (Sethna & Doull, 2013) that travel and accommodation is often more expensive for some women than \$270, and accessing Mifegymiso® locally may still be the less costly option.

5.2 Next steps

The manuscript in Chapter 3 was accepted for publication by *Contraception* in April 2016. The second manuscript of this thesis (Chapter 4) will be submitted to *Women's Health Issues* as part of the overarching CAS dissemination strategy. In publishing these manuscripts, we intend to inform researchers, policy makers, and advocacy groups on women's abortion experiences. We also intend to fill some of the gaps in the literature regarding not only women's experiences with abortion care in various provinces, and specifically Newfoundland and Labrador, but also the potential acceptance of Mifegymiso® by women in Canada. In addition to the manuscripts, I have attended academic conferences both in Canada and the US and have used these opportunities to disseminate the findings of the studies.

As with all action research, a large emphasis has been placed on dissemination of results that enacts or allows for meaningful change within a community. Limiting dissemination to only academic streams would overlook the pragmatic and progressive nature of action research and our study objectives. To accomplish this, I intend to create a single page report on abortion services and accessibility in Newfoundland and Labrador, with women residing in in this province as the specific target audience. I plan to disseminate this report by sharing it with various organizations that promote health, women’s rights, and reproductive justice in Newfoundland and Labrador. After the publication of the manuscripts in Chapters 3 and 4, I will again share that with organizations and advocacy groups involved with reproductive justice and women’s health in Canada, as well as feminist news outlets and websites. Again, this will allow for women’s voices to be heard through documentation of their experiences, and to inform the general public and healthcare professionals the potential interest women have in Mifegymiso®.

5.3 Reproductive Justice

While the term “reproductive justice” is fairly new- coined by SisterSong, a collective of women of colour in the US in 1994 (Ross, 2011)- work towards reproductive justice has been going on for much longer. Reproductive justice has roots in social justice as well as in the reproductive rights movement, which is mainly concerned with progressing law and policy to allow for freedom of reproduction (Luna & Luker, 2013). However, critics of reproductive rights argued that much of the focus was on individual “choice” which ignored the many other factors that reduce a person’s ability to make that choice. Critics asserted that reproductive rights mainly benefitted white, middle class women, ignoring the voices of women outside this narrow, advantaged group. As well, this ignored women who advocated for policies to support

pregnancy, childbearing, and parenting (Cook & Dickens, 2009). Women who are less able to “choose” are women who are disadvantaged- women of colour, poor women, women with little social support, incarcerated women and disabled women among other marginalized groups (Crenshaw, 1993). As well, reproductive justice applies to the rights to have a child, to not have a child, to parent and control birthing options. Reproductive justice is described as, “the complete physical, mental, spiritual, political, social and economic well-being of women and girls, based on the full achievement and protection of women's human rights,” (Ross, 2006). Thus reproductive justice has a more holistic, intersectional approach than simply increasing reproductive health options or addressing the broad legalities of reproductive rights.

Intersectional feminism plays a key role in the reproductive justice paradigm (Crenshaw, 1993). Intersectionality is named for the intersections of social identities and structures of oppression and discrimination - this includes race, gender, class, ability and sexual orientation. These structures compound discrimination when two or more systems of oppression intersect. This paradigm is an important lens for social and reproductive justice. Not only does reproductive justice fight for the rights of women to have a child, not have a child, and the right to parent and control reproductive processes, but it also fights to promote social/ economic /political conditions that allow those rights to be accessed easily by all (Ross, 2006). In this way, reproductive justice challenges the wider context of systems including racism and colonialism as well as challenging structures of power and oppression.

While much of the reproductive justice movement began in the United States, Canada has followed in a parallel trajectory (Cook & Dickens, 2009). The Department of Justice in Canada appointed the Badgley Committee to investigate abortion law in practice across Canada in the mid-1970s. It was found that the law was being applied inconsistently stemming from public

attitudes, resulting in inequitable access to the (limited) abortion care that was available at that time (Thomas, 1977). Still today, we see women's access to abortion care is inequitable, despite Canada being one of the most progressive countries in terms of federal abortion regulations. These inequities exist both within and between different provinces, and pose real barriers to women who need access to this time-sensitive service. In Canada, therefore, reproductive justice in terms of abortion care has become a battle of ensuring access in an equitable way across provinces.

Canada, among many other countries, has a history and present in which women of colour, and in Canada specifically First Nations, Metis or Inuit women, experience reproductive coercion (Another Saskatoon woman, 2015; Ginn, 1999). Legacies of violence, racism, oppression and “cultural genocide” still have impact today, and put Indigenous women and children at a higher risk of sexual violence and exploitation. Indigenous women in Canada disproportionately are survivors of sexual violence, human trafficking, and sexually transmitted infections in Northern communities (Manning et al., 2014). When conducting sexual and reproductive research with women who identify or have heritage of First Nations, Metis or Inuit (as several of our participants from Newfoundland did) it requires cultural sensitivity and consideration for the complexities of racism still systemic in Canada.

Mifepristone has the potential to impact reproductive justice in Canada to increase access to women who would encounter more barriers to abortion care. However, it is also subject to the same power structures and context that creates those barriers. In countries where mifepristone delivery is not impeded by policy and practice barriers, it usually becomes the most-used form of abortion care among eligible women (Jones & Henshaw, 2002). There are many issues that may limit or impede provision of mifepristone to women seeking abortions; this is not limited to

regional policies and legislation, low uptake by new practitioners to provide, and lack of insurance coverage that places the burden of payment on the woman. Under these circumstances, utilization of mifepristone is limited, and provides less opportunity to address barriers to access (Espey et al., 2010; Joffe & Weitz, 2002). Women who are already at a disadvantage with reproductive and sexual health (young women, women of colour and Indigenous women, women living in remote or rural areas, poor women, recent immigrants among others) would still be at a disadvantage and would benefit less from the incorporation of mifepristone as a choice (Scott, 2016). Indeed, if the introduction of mifepristone only serves as an option for women out of already-providing clinics and hospitals, if it is not covered by provincial insurance, if provision is limited by ultrasound requirements and gestational age restrictions, Mifegymiso® would only marginally address inequities in access. Working toward equitable access to all women across Canada requires change to reflect evidence-based standards, protocols and policy. If this is achieved, mifepristone could indeed challenge inequities to access in a meaningful way and serve as a tool to further the course of reproductive justice in Canada.

5.4 Positionality/reflexivity

Positionality is the interplay of identity and experiences that influence and bias our views, perspectives and interpretations of data. My positionality as a researcher has an affect on the studies I take part in, as well as the overall conclusions and my interpretation of the data. Because the researcher is a tool in qualitative research, it is important to consistently reflect on one's own positionality and acknowledge how preconceived biases, life experiences, education, and research history might affect a study (Bourke, 2014). Incorporating reflexivity into the study itself is necessary to navigate and understand how the interactions between oneself, the research,

and the participant might impact the overall study and the interpretation (England, 1994). It was especially important for me to recognize the inherent power differential between an interviewer and an interviewee, and to have the utmost respect and gratitude for the privilege of having women tell me their stories. In some cases, the researchers are the only ones to know about the abortion experience, and that was not something I ever took lightly.

As a self-identified feminist, and as a Canadian who believes strongly in reproductive justice, conducting interviews on women's abortion experiences was rewarding, challenging, and occasionally emotionally difficult. Specifically, the Newfoundland interviews that involved abusive relationships were challenging for me to hear about, and to respond to in a way that was supportive but not overstepping my role as a researcher. Memoing after each interview gave me the space to reflexively engage and to record my thoughts on each interview soon after it occurred (Vaismoradi et al., 2016). Further, being trained in interviewing techniques and how to conduct this kind of action-oriented qualitative research helped me keep women's stories and experiences at the forefront (England, 1994). Using an intersectional, reproductive justice lens allowed me to appreciate women's experiences, and better understand the barriers to access that were described through women's narratives.

5.5 Limitations

There are several limitations associated with this thesis project. As qualitative research, both Chapters 3 and 4 are not generalizable or intended to be representative of their respective populations (Neuendorf, 2011). Even though Chapter 3 includes a large sample of participants, this is still a qualitative study, with thematic saturation as the end point. However, we believe that the findings have import beyond the study participants and that the findings are transferable.

When describing a possible regimen of mifepristone to women, we used an evidence-based model to predict how Health Canada might provide mifepristone. Unfortunately, Health Canada stipulated several key restrictions that limit the provision of Mifegymiso® - most notably, the gestational age restriction. Thus, the information on which women based some of their answers is not accurate currently. However, we are confident that this does not affect the overall results and study conclusions.

One limitation we were faced with involved recruitment. Unfortunately, we were not able to recruit any women who lived in Labrador at the time of their abortion. Despite advertising through various social media groups, listservs, and the study website, no women contacted us from Labrador. This is not entirely surprising, the population of Labrador (around 23,000 people) are spread out over the coastline and further inland, and access to internet (our main media for recruitment) can be limited (Bella et al., 2005). Social media and websites for advertising generally had little traffic but we reached out to organizations involved in women's health, SRH, and abortion care in the Atlantic provinces to help with recruitment. Some of these organizations did help to disseminate study information on social media, however other groups were reluctant to share our recruitment materials. Because we have no participants who lived in Labrador at the time of their abortions, we were unable to explore their experiences. Future research would benefit from eliciting the perspectives of these women.

Within this overarching study, we did not purposively recruit First Nations, Metis and Inuit women, but many contributed their experiences as participants. Reaching these populations is often difficult to do, due to geography, reduced internet access, and the sociocultural issues specific to these communities (see Section 5.3 Reproductive Justice, pg. 75). A more detailed look into the experiences of First Nations, Metis and Inuit women appears warranted, and a study

design focused on these populations would better be able to address the complexities and nuances involved in this discussion.

Further, as a native English speaker doing analysis on French transcripts, there may have been some subtleties with content and themes that I was not able to identify or correctly define. This is only the case for the manuscript in Chapter 3. However, I worked closely with the Francophone Study Coordinators and my supervisor to ensure that I coded and analyzed transcripts appropriately.

5.6 Conclusion

Approximately one in three Canadian women will access abortion care over the course of their reproductive lives. Despite the necessity of this procedure, there is a great inequity of access between and within each province and territory. The range and severity of these barriers were identified through background research and through analysis from our interviews. Many of these barriers can be addressed in part by the integration of Mifegymiso® into the healthcare system, which is slated to become available starting in 2016.

While participants show that they had limited understanding of the specifics of mifepristone, it seems as though with increased media attention, women are becoming more knowledgeable and interested in this method. Women are often personally interested in mifepristone as a choice for themselves, and many envision that Mifegymiso® could decrease geographical barriers, increase privacy, and affect wait times positively in their province. Using a selection of provinces and Newfoundland and Labrador as a case study, we have found that there is great potential for Mifegymiso® to expand access to abortion across Canada.

Unfortunately, Health Canada has already limited the scope of provision of Mifegymiso® in contrast to evidence-based provision. To reach its full potential, significant steps must be taken to challenge Health Canada's restrictions, encourage provider and patient knowledge and advocate for equitable access to Mifegymiso® across all provinces and territories.

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Appendix A: Research ethics approval

File Number: H08-12-08

Date (mm/dd/yyyy): 11/05/2012



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

University of Ottawa
Office of Research Ethics and Integrity

Ethics Approval Notice **Health Sciences and Science REB**

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Angel	Foster	Health Sciences / Others	Principal Investigator

File Number: H08-12-08

Type of Project: Professor

Title: Safe, legal and hard to get: Documenting geographic disparities in abortion access in Ontario

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
11/05/2012	11/04/2013	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:
N/A



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

University of Ottawa
Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at: <http://www.research.uottawa.ca/ethics/forms.html>

Please submit an annual status report to the Protocol Officer four weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: <http://www.research.uottawa.ca/ethics/forms.html>

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Signature: