

Documenting Women's Experiences Obtaining Abortion Services while Residing in Yukon Territory

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Abstract

Although abortion has been decriminalized in Canada since 1988 and is covered as a medically necessary service through territorial health insurance schemes, anecdotal evidence suggests women in Canada's north face significant barriers to accessing care. With a population of fewer than 34,000 spread across an area that is larger than California, geographic remoteness impacts health care access and quality in Yukon Territory. This qualitative study aimed to explore the dynamics shaping access to abortion care in the Yukon, provide an opportunity for women to share their experiences, and identify possible avenues for improving service delivery. In 2015-2016, the study team conducted 16 in-depth interviews with women and 11 key informant interviews. We used an iterative analytic approach allowing for the identification of emerging codes and themes. Our findings reveal that women face a number of barriers when accessing abortion services in Yukon. Specifically, a physician referral is required, as are several pre-procedure appointments, with no one central location to obtain these services. Women expressed concerns of privacy, overcoming logistical constraints, lengthy wait times, and lack of follow-up supports. Challenges were further amplified for women residing outside of Whitehorse, the sole location to obtain abortion services in the territory. Facilitating efforts to create a more transparent and streamlined service would ease the process for women seeking care and appears warranted. The recent registration of mifepristone could serve to alleviate certain barriers, presuming that the approved regimen is affordable, evidence-based, and available at more service delivery points.

Résumé

Bien que l'avortement a été décriminalisé au Canada depuis 1988 et est couvert en tant que service médicalement essentiel par le biais des régimes d'assurance-santé territoriales, des évidences non confirmées suggèrent que les femmes vivant au Nord du Canada font face à des obstacles importants quant à l'accès aux soins. Avec une population de moins de 34,000 habitants réparti sur un territoire d'une superficie supérieure à celle de la Californie, les effets de l'éloignement géographique sur l'accès et la qualité des soins de santé dans le territoire du Yukon sont considérables. Cette étude qualitative visait à explorer la dynamique qui façonne l'accès aux services d'avortement au Yukon, fournir une occasion pour ces femmes de partager leurs expériences et d'identifier les alternatives possibles pour améliorer la prestation de ces services. En 2015-2016, l'équipe de recherche a effectué 16 entrevues avec des femmes et 11 entrevues avec des informateurs/acteurs clés, et avons utilisé une approche analytique itérative permettant l'identification d'une codification et des thèmes émergents. Nos résultats démontrent que les femmes font face à un certain nombre d'obstacles lors de l'accès aux services d'avortement au Yukon. En effet, une recommandation médicale est requise, de même que plusieurs rendez-vous pré-procédure et un manque de services centralisés. Les atteintes à la vie privée, les contraintes logistiques, les longs temps d'attente et le manque de suivi sont des contraintes exprimées par nos participantes. Ces défis sont encore plus important pour les femmes habitant à l'extérieur de Whitehorse qui est le seul endroit pour obtenir des services d'avortement sur le territoire. Promouvoir les efforts visant à créer des services plus transparents et simplifiés faciliteraient le processus pour les femmes qui requiert des soins et semblent nécessaires. La récente introduction de la mifépristone pourrait alléger certains obstacles, en supposant que le médicament adopté est abordable, fondé sur des preuves scientifiques, et disponible à plusieurs points de services.

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Abbreviations

CAS: Canada Abortion Study

CBC: Canadian Broadcasting Corporation

FDA: Food and Drug Administration

MOA: medical office assistant

NIHB: Non-Insured Health Benefits

OB/GYN: Obstetrician/Gynecologist

PI: Principle Investigator

REB: Research Ethics Board

SI: Senior Investigator

STI: sexually transmitted infection

Chapter 1: Introduction

1.1 Background

Canada is a geographically enormous country, with the majority of land being sparsely populated. Urban and rural populations are distinguished based on population density, with the term rural meaning not concentrated or low in population density (Statistics Canada, 2011a). Statistics Canada defines a rural area as having a population density of fewer than 400 people per square kilometre and/or having a population of fewer than 1,000 people. In 2011, 6,329,414 people, or 19% of Canada's population, resided in rural areas (Statistics Canada, 2011b). Located in the northwest of Canada, Yukon Territory, has a population of 33,897 people spread across 474,712 square kilometres, with a population density of 0.1 persons per square kilometre. The territory however, has an enormous gap in population distribution, with 26,028 people, or 76.8% of Yukon's population, living in the territory capital of Whitehorse (Statistics Canada, 2016). Refer to Appendix A for a map of Yukon Territory. Between the 2006 and 2011 censuses collected by Statistics Canada, Yukon Territory had the largest percent increase in population of all provinces and territories in Canada, with the majority of growth occurring in Whitehorse (Statistics Canada, 2016).

Yukon's population is comprised of 23.1% Aboriginal peoples, with the majority of Aboriginal peoples identifying as First Nations (Yukon Bureau of Statistics, 2014). Of the 14 First Nations across Yukon Territory, 11 have land claim and self-government agreements with the federal government. These agreements recognize First Nations as self-governments as opposed to Indian Act bands, allowing each community to make their own decisions over their land, government, resources, and programs (Indigenous and Northern Affairs, 2008). Self-government empowers First Nations peoples by allowing each community to govern itself and

determine which initiatives to implement depending on priority (Indigenous and Northern Affairs, 2008). Of the more than six hundred recognized First Nations across Canada, very few are self-governing, making Yukon Territory a unique climate and a leader in Aboriginal land claims and self-government in Canada (Indigenous and Northern Affairs, 2008). Aboriginal peoples in Yukon with Indian status are covered under Non-Insured Health Benefits (NIHB) for most of their health care services, as opposed to territorial health insurance for non-Aboriginal peoples (Government of Canada, 2016; Health Canada, 2016). NIHB is a federal program that delivers medically necessary services to registered First Nations and Inuit clients (Government of Canada, 2016).

For non-Aboriginal peoples, health care is under jurisdiction of provincial and territorial governments; however, they must adhere to federal government guidelines in order to receive funding. The Canada Health Act, a piece of federal legislation, sets forth the core principles that underlie Canada's universal health care system and shape health care services (Madore, 2005). One of the Canada Health Act's five principles is accessibility, stipulating that health services are available to all Canadians regardless of financial, economic, and other barriers. This legislation aims to achieve two overarching objectives with respect to health care: first, that Canadians have timely access to all medically necessary health care services regardless of their ability to pay; and second, that no Canadian has to endure undue financial hardships in order to pay for health services (Madore, 2005). Due to the geographic remoteness of Canada's north, populations in the territories face added barriers to accessing timely and comprehensive health care services. Although literature on sexual health in the Canadian territories is limited, health indicators and anecdotal evidence suggest that women experience barriers accessing sexual and reproductive health services. These obstacles have led to poor outcomes including higher rates of

sexually transmitted infections, negative birthing experiences, and higher rates of infant mortality (Canadian Federation for Sexual Health, 2007).

Induced abortion is an extremely common health care procedure performed in Canada. Using national statistics, Norman (2012) calculated that 31% of women aged 45 in 2005 had an abortion during their reproductive years. The procedure has been legal in Canada without restriction since the ruling in *R. v. Morgentaler* in 1988. This ruling struck down the requirement for a woman to seek approval from a therapeutic abortion committee to obtain care, as this requirement violated section 7 of the Canadian Charter of Rights and Freedoms, which protects a person's right to life, liberty and security (Kaposy, 2010). Although this ruling has been instrumental in increasing rights for Canadian women, this legal, available service is not necessarily accessible to all women. Studies and anecdotal evidence demonstrate that women still face barriers accessing abortion services across the country, particularly with respect to financial, geographical, age, and cultural constraints (Foster et al., 2016; Kaposy, 2010; Sethna & Doull, 2013; Shaw, 2006). As Laura Eggestson (2001) wrote, "The availability of abortions in Canada now depends on a woman's location and the size of her pocketbook" (p.847).

Prominent barriers to accessing health care exist in Canada's north due to physician shortages (Romanow, 2002), high staff turnover (Ng et al., 1997), and geographic distance to the nearest provider (Shaw & Downie, 2014). These barriers could be further amplified when accessing sexual and reproductive health services due to stigma, social taboos, and traditional/cultural beliefs. The ability for a woman of reproductive age to become pregnant is evenly distributed throughout the country, yet health care providers of sexual and reproductive health services are not. Currently, 8.2% of physicians are located in rural areas (CIHI, 2015a), even though approximately 19% of Canada's population resides in rural areas (Statistics Canada,

2011b). In terms of diversity of health care providers, significant differences exist between provinces and territories. For example, Ontario's physician pool is comprised of 50% family physicians and 50% specialists, whereas Yukon's ratio is 86.1% and 13.9%, respectively (Canadian Institute for Health Information, 2015a). With few specialists working in rural areas in Canada, rural family physicians fill these gaps in care by increasing their clinical scope of practice (Canadian Institute for Health Information, 2005). This dynamic also shapes the provision of abortion services. With lower numbers of women obtaining abortion services in rural regions, abortion care usually constitutes only a fraction of a rural provider's practice. This is mirrored in findings of the British Columbia Abortion Providers' Survey (BCAPS); none of the rural abortion providers reported family planning services constituting the entirety of their practice. (Norman et al., 2013). Five of the urban providers reported that they exclusively provided family planning services (Norman et al., 2013).

In conjunction with the differences in providers of abortion care in urban versus rural populations, there is also a contrast in types of abortion facilities. In Canada as a whole, abortion services have shifted from being provided mainly in hospitals to mainly in freestanding clinics. In 1994, 32% of abortions took place in private clinics (Erdman, 2007), whereas in 2014, of the 81,897 abortions reported in Canada, 47,966 or 58% occurred in private clinics (Canadian Institute for Health Information, 2015b). Furthermore, the total number of abortions occurring in private clinics is likely to be an underestimate; hospitals are mandated to report all induced abortions performed annually whereas private clinic data are submitted voluntarily to the Canadian Institute for Health Information (Canadian Institute for Health Information, 2015b; Sabourin & Burnett, 2012). Although service provision trends as a whole have shifted,

freestanding clinics are exclusively located in urban centres (CIHI, 2015; Kaposy, 2010; Norman, 2012); rural communities offering abortion services provide care only in hospitals.

That the majority of procedures are now performed in freestanding clinics carries a number of advantages. First, women may feel more comfortable and supported in a health care setting that is specialized to provide sexual and reproductive health services (Downie & Nassar, 2007; Shaw, 2006). Second, hospital-based services often require a physician referral, which can create delays in care. Women are required to navigate a possibly complex or not well-advertised system if they do not have a family doctor or cannot get an appointment with a clinician in a timely manner (Downie & Nassar, 2007). They also may face the risk of encountering an anti-choice health service professional at multiple points in the process (Downie & Nassar, 2007). The Society of Obstetricians and Gynecologists of Canada as well as the Canadian Medical Association stipulate that although a physician should not be compelled to participate in pregnancy termination, it is still his/her responsibility to direct patients to an appropriate referral so as to not delay the process (Sabourin & Burnett, 2012). Third, hospitals often do not have a dedicated abortion service, thus resulting in lower gestational limits for performing the procedure in comparison to dedicated clinics; this creates a smaller window of time that a woman has to access the service. For example, the one facility in Yukon Territory only performs the procedure through 12 weeks' gestation (Yukon HealthGuide, 2016); this is partially because as mentioned above, the service is offered by family physicians with added training in abortion care, as opposed to obstetrician/gynecologists. Fourth, women may prefer a freestanding clinic as the process tends to involve fewer appointments; often all care can be received in one appointment, reducing conflicts with transportation and scheduling. Finally, women also face the risk of longer wait times in a hospital if the procedure takes place in the general surgical suite (Dube, 2007).

Without a dedicated space abortion procedures may not be given priority compared to other types of surgeries, creating logistical constraints to book operating room time, nurses, and anesthesiologists.

In a study examining abortion providers' experiences in British Columbia, researchers identified a number of discordant themes between urban and rural providers' experiences (Dressler et al., 2013). Rural providers discussed challenges with delays in operating room booking due to conflicts with more urgent non-abortion services and difficulties in scheduling operating room staff to accommodate staff who refused to assist in abortion provision. Other scheduling concerns raised pertained to setting up counselling services and ultrasound appointments for women. Another overarching theme was personal and professional isolation, especially for physicians who were the sole provider in their community. Many felt the need to "fly under the radar" in their small town (Dressler et al., 2013, p.3), and expressed concerns with safety for themselves and their families. Furthermore, urban providers were not concerned about the ability to find new physician replacements and training opportunities in their location, whereas rural providers expressed challenges to recruit colleagues to assist with abortion care in their communities (Dressler et al., 2013).

A mystery client study in which researchers phoned Canadian hospitals to inquire about abortion services demonstrated that barriers to obtaining care can go beyond geographic obstacles. When contacting Yukon's sole abortion providing facility, the researcher was passed around to four different numbers and phone transfers before speaking to someone who was aware of the service. However, this staff member was still not able to provide detailed information about how to access the procedure (Shaw, 2006). Thus, even with an available

service, lack of knowledge in navigating a complex referral system can create delays and obstacles to access care.

The recent approval of mifepristone, often referred to by its drug development name RU486, by Health Canada has the potential to address many of the barriers experienced by rural and remote populations. Mifepristone, a type of medication abortion, provides an alternative to surgical/aspiration abortion care (Kulier et al., 2011). Using mifepristone, an anti-progesterone, in conjunction with misoprostol, a prostaglandin, provides a regimen for pregnancy termination that is up to 98% effective through at least 63 days' gestation (Clarket al., 2007; Yarnall et al., 2009). In March 2016, the U.S. Food and Drug Administration (FDA) approved the medication abortion regimen to be used through 70 days' gestation (FDA, 2016). Mifepristone is taken orally and followed 24-48 hours later by a dose of misoprostol (which can be taken sublingually, buccally, or vaginally). The woman experiences bleeding and cramping that is similar to or heavier than a monthly period and bleeding tapers off a week or so after the use of mifepristone. This regimen provides some advantages over aspiration abortion procedures, as a range of providers can provide the medication (Foster et al., 2015) and the abortion process takes place outside of a facility. Some women prefer medication to aspiration/surgical abortion because it is a more 'natural' experience that can take place at home and timed to the woman's schedule (Kulier et al., 2011).

Although not yet available, Health Canada approved mifepristone for early pregnancy termination in July 2015 (Health Canada, 2015). However Health Canada has placed two prominent restrictions on provision that will prevent women from fully benefitting in these advantages. Mifepristone/misoprostol is only approved for use in Canada through 49 days' gestation and provision is restricted to physicians (Health Canada, 2015).

In 2014, 102 induced abortions were performed in Yukon Territory, and 121 Yukon residents obtained abortion care in Canadian facilities as a whole (CIHI, 2015). The total number of Yukon residents obtaining services in Canadian facilities is likely to be an underestimate, as hospitals are mandated to report induced abortions to the Canadian Institute for Health information, whereas freestanding clinics submit statistics on a voluntary basis. The discrepancies between abortions performed in territory versus Yukon women obtaining care outside of the territory could account for Yukon women living in other areas of Canada but still under Yukon health insurance, or Yukon women who travelled from their residence to obtain abortion services in another facility.

1.2 Rationale

As mentioned above, challenges surrounding geographic remoteness, health care provider shortages, and lack of resources are known to affect populations accessing health care services in Canada's north. A number of these challenges are amplified for women accessing sexual and reproductive health services, and particularly abortion services. Anecdotal evidence suggests that women face barriers accessing abortion care in Yukon Territory, however, there has been no qualitative research performed to explore their lived experiences accessing these services. Additionally, from an institutional and organizational perspective, key stakeholders' opinions have not been documented regarding challenges in accessibility and availability of services. The voices of women, as well as involved stakeholders, must be documented in order to gain perspective on the current access to and experiences obtaining abortion care in the Yukon and to explore mechanisms by which abortion services can be improved.

1.3 Specific Objectives

The purpose of this study is to explore and document women's experiences obtaining abortion services while residing in Yukon Territory. This study also examines key informants' perspectives on barriers to access and avenues for improving service delivery. This study addresses the following research questions:

- 1) What are the experiences of women who accessed abortion services while residing in Yukon Territory, including travel to and from the facilities?
- 2) What are the facilitators and barriers associated with accessing abortion care in Yukon Territory, including economic and personal costs?
- 3) What are women's insights into how abortion care can be improved in Yukon Territory?
- 4) What are key stakeholders' perspectives on the facilitators and barriers shaping access to abortion in Yukon, as well as suggestions for improvement?

1.4 Outline of Thesis

This thesis is written in a "thesis by article" format, consisting of six chapters. The thesis begins with an introductory chapter, followed by a methods chapter and three original research articles, and concludes with a discussion integrating the study findings and exploring wider implications.

Chapter one begins with an introduction and background to the context of abortion care in Yukon Territory, followed by a rationale for the study. I outline the specific objectives of my study, and provide an outline of the thesis. Chapter two discusses the methods of the thesis; I provide information about the structure of the in-depth interviews with women and key

informant interviews, the process of analysis and obtaining ethics approval. I conclude with a discussion of my research approach.

Chapters three, four, and five are original research articles developed specifically for this thesis. The first article (Chapter 3) is a literature review of sexual and reproductive health services in the Canadian territories. I submitted this manuscript to a special issue in the *Interdisciplinary Journal of Health Sciences* in January 2016. The article aims to determine the current state of knowledge of sexual and reproductive health in Canada's three territories, including documenting health indicators, identifying current services available, and ascertaining whether women's experiences have been explored.

We submitted the second article (Chapter 4) entitled "“They made me go through like weeks of appointments and everything’: Documenting women's experiences seeking abortion care in Yukon Territory, Canada” to *Contraception* in May 2016. This article focuses specifically on the in-depth interviews with women.

Entitled, ““There's a lot of hoops that the women have to jump through to get to us’: Dynamics shaping abortion care in the Yukon”, we submitted the third article (Chapter 5) to the *International Journal of Circumpolar Health* in March 2016. This article incorporates the findings from the two phases of data collection for this thesis. The manuscript documents women's voices as well as key informants' perspectives on the facilitators and barriers shaping access to abortion care in the territory. We have formatted each article for the requirements of the respective journals and all co-authors have signed off on the content on the manuscripts.

Chapter six provides a discussion of the study findings. In this chapter I integrate the findings from the three articles, outline the role of reproductive justice in my research, and discuss the significance and implications of findings, including an outline of dissemination

activities. Next I make specific recommendations based on the study's results, discuss strengths and limitations of the study, provide a statement of contribution, and end with concluding thoughts. Although each article contains its own reference list, I have also included a reference list for the entire thesis at the end, as well as a map of Yukon Territory (Appendix A) and a copy of my executive summary report for key informants (Appendix B).

Chapter 2: Methods

2.1 In-depth Interviews

My study is centred on hearing the voices of women. In order to document women's experiences obtaining abortion services in Yukon Territory, I collected information through in-depth phone interviews with eligible participants. This phase of the study is embedded in a larger Canada Abortion Study (CAS) currently being conducted by Dr. Angel M. Foster and her research team, entitled, "Location, location, location: Documenting women's abortion experiences in Canada". This study involves conducting in-depth phone/Skype interviews with Anglophone and Francophone women of different age cohorts from across Canada to document their experiences obtaining abortion services in their province or territory of residence. This study aims to identifying economic and personal costs associated with obtaining services, women's perceptions of how access can be improved, and women's opinions of the recently registered medication mifepristone.

Before beginning data collection for Yukon Territory, I received training in conducting in-depth interviews from my supervisor and the CAS study coordinator. This training period was part of my directed study course in my first year of this degree. Training began with familiarizing myself with the interview guide and receiving instruction on the strategies of questioning, probing, and responding appropriately. Next, I observed CAS interviews and discussed tactics with the study coordinator. I began conducting CAS interviews under the supervision of the study coordinator, and I had an opportunity to debrief after the interviews and discuss my strengths and weaknesses with my supervisor and colleagues. I formally memoed and transcribed the interviews verbatim. Listening to the recordings of my interviews also served as a

valuable exercise for reflection, critique, and growth of my interviewer skills. After extensive training and feedback I was prepared to begin the data collection for my thesis.

In alignment with the overarching structure of CAS, I conducted in-depth interviews using a semi-structured interview guide. The semi-structured nature of the interview ensures that a core list of questions is consistently asked across all interviews, while allowing room for flexibility for the participant to share her story. Questions can be asked and content can be discussed in any order that creates a more natural flow of discussion (Cohen & Crabtree, 2006). Flexibility also allows the researcher to probe on certain content mentioned by the participant that is not necessarily on the interview guide. Conducting interviews by phone carries a number of advantages. First, this modality creates an added confidentiality that face-to-face interviews cannot offer for collecting sensitive information from the participant (Neutens & Rubinson, 2010). A phone interview scheduled at a time that is convenient for the participant also allows for the participant to choose her own location for the interview that she deems appropriate for discussing the subject matter. Lastly, the researcher is able to take notes during the interview without risk of creating discomfort for the participant that may occur in a face-to-face interview. This interview modality was consistent with CAS interviews for other provinces and territories, and it is a practical choice to save time and money for collecting data from more than 300 women across a geographically vast country.

The eligibility criteria for participation in this phase of the study are self-identified women who:

- 1) Are aged 18 or older;
- 2) Have had an abortion on/after January 1, 2005
- 3) Resided in Yukon Territory at the time of the abortion; and

4) Are sufficiently fluent in English or French to answer interview questions

Although participants were interviewed at age 18 or older, they may have been minors at the time of their abortions in the past, therefore this criterion still creates the possibility to capture the experiences of youth obtaining abortion services. We arbitrarily chose the second eligibility criterion to be feasible for the relatively small study population. With fewer than 150 women from Yukon Territory obtaining abortion services annually (CIHI, 2014; CIHI, 2015b), the window of ten years allows us to find the targeted goal of 15 to 20 participants, the number we anticipated would be required to reach thematic saturation. The third criterion does not restrict eligibility to participants that are currently residents of Yukon Territory, but rather that they were residents at the time that they obtained abortion services. The fourth criterion allows interviews to be conducted in Canada's two official languages. Although 10.8% of Yukon's population does not report English or French as their mother tongue, only 0.3% of the population reports having no knowledge of either official language (Statistics Canada, 2012), thus offering the interview in these two languages allowed for inclusion of the overwhelming majority of eligible participants.

I used a multi-model recruitment strategy to recruit eligible participants. First I began by posting advertisements for participation on online classifieds such as kijiji. I periodically re-posted this advertisement over the span of my data collection. With few responses solely using this first method, I moved to community-based recruitment methods (Community-Campus Partners for Health, 2013; Small, 1995). I phoned Yukon's sexual health phone line for suggestions and resources (Government of Yukon, 2016), and contacted clinic staff members at the new Yukon Sexual Health Clinic (Joannou, 2014) about possibly posting an advertisement in their clinic. I also reached out to national reproductive and sexual health organizations online

who kindly agreed to post my recruitment advertisement. I posted my ad on a variety of social media platforms including twitter, tumblr, and facebook. Lastly, I was contacted by a reporter from CBC North to interview me about my study. After consulting with my supervisor, I answered the reporter's questions over the phone and she wrote an article about the study (CBC News North, 2015), creating a final avenue for eligible participants to hear about the study.

After receiving an email or phone call from a participant, I spoke to her on the phone following an intake call script. I told her more about the study and what would be discussed during the interview, and reinforced that participation would be completely voluntary and confidential. Emphasizing that information will be kept in confidence allows trust to be established so the participant feels safe sharing personal details in the interview (Mack et al. 2005). If the woman was still interested in participating, I ensured that she met all eligibility criteria, and then we scheduled the interview. Each participant received a consent form by email, and I asked her to read it prior to the interview.

I obtained verbal consent from the participant at the beginning of each interview. I audio-recorded each interview with the participant's consent. Interviews lasted up to 90 minutes in length; we deemed this as an appropriate amount of time to sufficiently cover all questions in the interview guide, based on previous interviews for CAS. We compensated participants for their time with a CAD40 gift certificate to amazon.ca. We strategically designed the interview guide to follow an arc, creating a comfortable space for the participant to answer personal questions. The interview began with simple questions about the participant's general demographics, including living arrangements, relationship status, self-identified race or ethnicity, and sources of support. Beginning with "lighter" questions allowed for rapport to be established between the interviewer and the participant. Next I asked the participant about her reproductive

health history and where she typically obtains health services for her reproductive and sexual health care. In the third section of the guide, I delved into questions surrounding the pregnancy which was terminated, including reasons for the decision made, health care providers and facilities contacted, sources of support, wait times, direct and indirect costs, perception of accessibility of the service, emotions experienced, and satisfaction with care received throughout the process. Lastly, I finished by asking the participant's suggestions on service improvements based on her experience(s), and her opinion on the use of mifepristone as an alternative method of abortion care.

I took notes during each interview and engaged in a formal memoing process immediately after each interview. Memos allowed me to reflect on the interview and document my initial reactions to and my influences on the interview. Memoing also served as a way for me to determine when I established thematic saturation in my data collection. I transcribed each interview verbatim and wrote a brief summary discussing both the unique aspects of the participant's experience as well as the comparable elements to other participants' experiences. We did not return transcripts to participants for their review. Giving participants the opportunity to review and change their responses offers advantages and disadvantages to the data collection process (Burnard et al., 2008). As this study was part of the overarching CAS, "member checking" would have created a lengthy and tedious process in a national study with over 300 interviews. With each interview lasting up to 90 minutes in length, participants had sufficient time to recall and share their experiences, and interviewers had sufficient time to probe on certain responses in order to capture each participant's comprehensive abortion experience at the time of the interview. My supervisor reviewed initial interviews, transcripts, and memos in order to monitor my progress and provide feedback on my interviewer skills and strategies.

2.2 Key informant interviews

We purposively sampled participants for the key informant phase of the study, as there are a limited number of stakeholders who would have the knowledge and/or experience to provide insight about sexual and reproductive health services in Yukon Territory specifically. I established initial contact with one clinician involved in sexual health initiatives in Whitehorse, and she kindly agreed to be interviewed. Beginning with this first point of contact, I employed snowball sampling techniques. After receiving word about my study from this first point of contact, other key informants reached out to me via email with interest in setting up an interview. At the end of each interview, I also asked each participant whether he/she had any suggestions as to relevant stakeholders I could speak with. I created a general invitation for participation that I requested key informants forward to any potential colleagues and acquaintances that they felt could provide more insight into abortion services specifically, or sexual and reproductive health services more broadly, in Yukon Territory. I reached out to other key informants using publicly available contact information and professional affiliation. Anticipated participants included abortion providers in the territory, other health care providers, and representatives from relevant community organizations.

Before the scheduled interview, I emailed a consent form to each participant and asked him or her to read it over prior to the interview. I obtained verbal consent for participation at the beginning of each interview, including determining whether the participant's quotes could be attributed to his or her name, and/or as a representative of his or her organization. I conducted the interviews following a semi-structured interview guide to ensure that I consistently asked certain questions to every key informant, but also to allow for discussion of varying aspects of

sexual and reproductive health and health services, facilitators, and barriers, depending on the participant's background and expertise. The semi-structured guide began with questions about the informant's education and career background, and experience with women's sexual and reproductive health. Next I asked about his/her opinions of current abortion services, probing on specific facilitators and barriers to care. I asked the informant's insights on how services could be improved, and what he or she feels are priorities for future initiatives. I asked for opinions about mifepristone and how services would be changed following approval and availability of the medication in the territory. Each interview lasted between 30 and 60 minutes in length, and I audio-recorded each interview with the participant's consent. I took notes during the interview and memoed after the interview. Memos documented my initial reactions, including concordant and discordant information that was arising when making comparisons to my in-depth interviews with women that were already conducted. I transcribed all interviews verbatim. We did not return transcripts to key informants for their review, however I distributed a summative report to participants for their review and discussion during dissemination activities, as outlined in the discussion section of this thesis.

2.3 Analytic Approach

Data consisted of field notes taken during the interviews, memos written immediately after the interviews, audio-recordings and transcripts. I employed a multi-phase iterative analytic approach, beginning the initial phases of analysis concurrently during data collection (Vaismoradi et al., 2013; Saldaña, 2009). My analytic plan centered on content and themes and used both deductive and inductive techniques. Both content and thematic analysis are necessary, but not sufficient in isolation, to comprehensively analyze the data collected for the Canada

Abortion Study. Using content analysis allowed me to systematically code and categorize my data to determine trends and patterns across interviews (Vaismoradi et al., 2013). This included noting the frequency and relationships of certain words used in communication, and comparing measurable aspects of the service delivery such as wait times and number of appointments.

While content analysis systematically categorizes the manifest content (Elo & Kyngäs, (2008), thematic analysis requires interpretation of the manifest content to ultimately identify and analyze the latent content (Braun & Clarke, 2006). Thematic looks at data across a set rather than within a set, and is comprised several phases (Braun & Clarke, 2006). In the first phase, I deductively developed an initial code book using *a priori* (pre-determined) codes based on the interview guide, overall study objectives, and background literature review. Codebooks used for CAS province data that were already analyzed or undergoing analysis informed the development of the initial codebook for CAS Yukon. My supervisor reviewed my initial codebook before moving forward. In the second phase, I employed inductive analytic techniques given that there was no previous qualitative literature on abortion services in northern regions of Canada; I derived additional codes and categories directly from the data to understand this new area of research (Vaismoradi et al., 2013).

Developing and assigning codes promotes reflection and exploration of ideas. Rather than data reduction, it allows the researcher to expand ideas, identifying emergent themes and forming relationships (Williamson & Johanson (eds), 2013). In this role, codes are essentially “heuristic devices for discovery” (Seidel & Kelle, 1995, p. 58); assigning codes is not just labeling, but linking data to ideas (Saldaña, 2009). The third phase of analysis involved identifying themes and forming relationships between developed categories and the ideas gathered. Using thematic analysis, I identified overarching patterns and themes throughout

assigning codes, forming categories, and memoing. A category is a description of the manifest content, whereas a theme is more abstract and is a description of latent content. Overarching themes provide a coherent integration of separate pieces of the data that aim to answer the pre-determined research questions (Vaismoradi et al., 2013). I analyzed the in-depth interview transcripts and memos and the key informant interview transcripts and memos separately, examining coherence both horizontally (within an interview) and vertically (among different interviews). However, in the fourth phase of analysis I integrated the findings from the two components of my study, with specific attention to concordant and discordant results. The final stage of both content and thematic analysis is characterized by the identification of emergent themes in the data (Vaismoradi et al., 2013). I used ATLAS.ti software to manage my coding and analysis. I discussed my iterative findings with my supervisor and the CAS study team throughout data collection and analysis for assistance and added insight. Regular meetings with my supervisor guided me in interpreting my findings; we resolved differences through discussion.

2.4 Ethics

Our research team obtained research ethics board approval for CAS from University of Ottawa's Social Sciences and Humanities REB. Our file was expanded to include in-depth interviews for Yukon Territory in November 2014 (File#H08-12-08). For the key informant phase of the study, we submitted a *de novo* REB application in March 2015. We received approval from University of Ottawa's Social Sciences and Humanities REB in April 2015 (File# 03-15-25). Because data collection took place by phone and we were not physically present in the Yukon, we were not required to obtain a Scientific Research License.

2.5 Research Approach

The structure of my study centers on action-oriented research. Action-oriented research is broken down into four models: action, participatory, empowerment, and feminist (Small, 1995). Action-oriented research tends to reject traditional notions of the positivist paradigm that aim to seek an objective truth, separate the researcher from the study population, create a superiority of the researcher over the study population, and view the research process as value neutral (Small, 1995). Consistent with the goal in action-oriented research of empowering participants (Small, 1995), my qualitative study centers on hearing the voices of women and allowing them to share their lived experiences accessing abortion care. I conducted qualitative interviews with the understanding that the participant was the expert in the phenomenon being researched. Furthermore, allowing key informants to discuss their experiences and express concerns in their respective field of work engages them in the research process in order to evoke change and improvement.

Although we documented women's past abortion experiences, the aims of the study were future directed (Small, 1995). Action-oriented research is intended to identify and combat specific issues in order to create practical solutions (Small, 1995), therefore it is pivotal that study results are shared with the participants. The final phase of my thesis involved a community engagement dissemination project, in which I travelled to Whitehorse, Yukon to meet with key informants. During the project I presented my study findings and collaborated with stakeholders, identifying strategies and avenues to further disseminate my findings in an effective manner that would evoke improvements in sexual and reproductive health services in Yukon Territory going forward. When considering ethical implications of research, action-oriented researchers expand

concerns and intentions of preventing participant harm to ensure they are also not exploiting participants. Participant exploitation includes using research subjects solely for the benefit of the researcher (Small, 1995). Consistent with action research, dissemination activities were paramount to the design of my project overall to ensure the participants benefitted from the study findings.

CHAPTER 3: Article I: Exploring access to sexual and reproductive health services in Canada's territories

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Abstract

Objectives: Explore the current knowledge about sexual and reproductive health in Canada's territories, identify facilitators and barriers that women face when accessing health services, and ascertain whether women's experiences have been documented.

Methods: This is a review of peer-reviewed publications and grey literature. The search strategy used academic and government databases, NGO websites, and media articles. I used specific key words and excluded materials published before 2000 or written in a language other than English.

Results: Sexual and reproductive health indicators in the Canadian territories stray from provincial averages. Teenage pregnancy and STI rates are above the national averages, especially in Nunavut. Studies show that youth are lacking education in sexual health topics. Federal policy mandates that women from northern rural areas travel to urban centres to deliver, creating a stressful process for Aboriginal women especially, who are not able to carry out traditional community births. All three territories have at least one hospital offering abortion services, but no freestanding clinics. Many women are travelling out of their home territory to access abortion care.

Conclusions: Evidence suggests there are significant barriers to obtaining timely, high quality, and culturally resonant care. However, there is a gap in knowledge surrounding women's experiences obtaining sexual and reproductive health services in Canada's North.

Keywords: *Nunavut, Northwest Territories, Yukon, sexual health, reproductive health*

Introduction

The Canadian territories make up a significant portion of Canada's land mass, yet have the three smallest populations compared to all provinces, with population densities ranging from 0.02 people per square kilometer in Nunavut to 0.1 people per square kilometer in Yukon Territory (Statistics Canada, 2015a). Thus, inhabited communities in the North tend to be geographically isolated, as evidenced by the majority of communities in Nunavut being accessible only by air, sea, and snow machine (Collins et al., 2012). Geographic remoteness is one of many factors that contribute to the significant health disparities among residents in the territories compared to the rest of the Canadian population. These communities face additional challenges to achieve and maintain good health, particularly because of lack of access to adequate health services (Reading & Wien, 2009).

Knowing that barriers exist, the purpose of this literature review is to gain a more thorough understanding of existing research regarding sexual and reproductive health services in Canada's territories, and to identify gaps in the literature. In achieving these goals, this review serves as a starting point to identify further concrete areas for research. As a qualitative researcher, I am especially interested in capturing literature on women's lived experiences accessing sexual and reproductive health services in the territories. Therefore, this review maintains a broad scope in order to search for literature that documents women's voices.

Referring to the Public Health Agency of Canada's twelve determinants of health (PHAC, 2011), this review touches on a number of determinants including physical environments, gender, and culture. As outlined in the title however, this review focuses on health services in the territories, and how access to and availability of these services affect women's sexual and reproductive health.

Methods

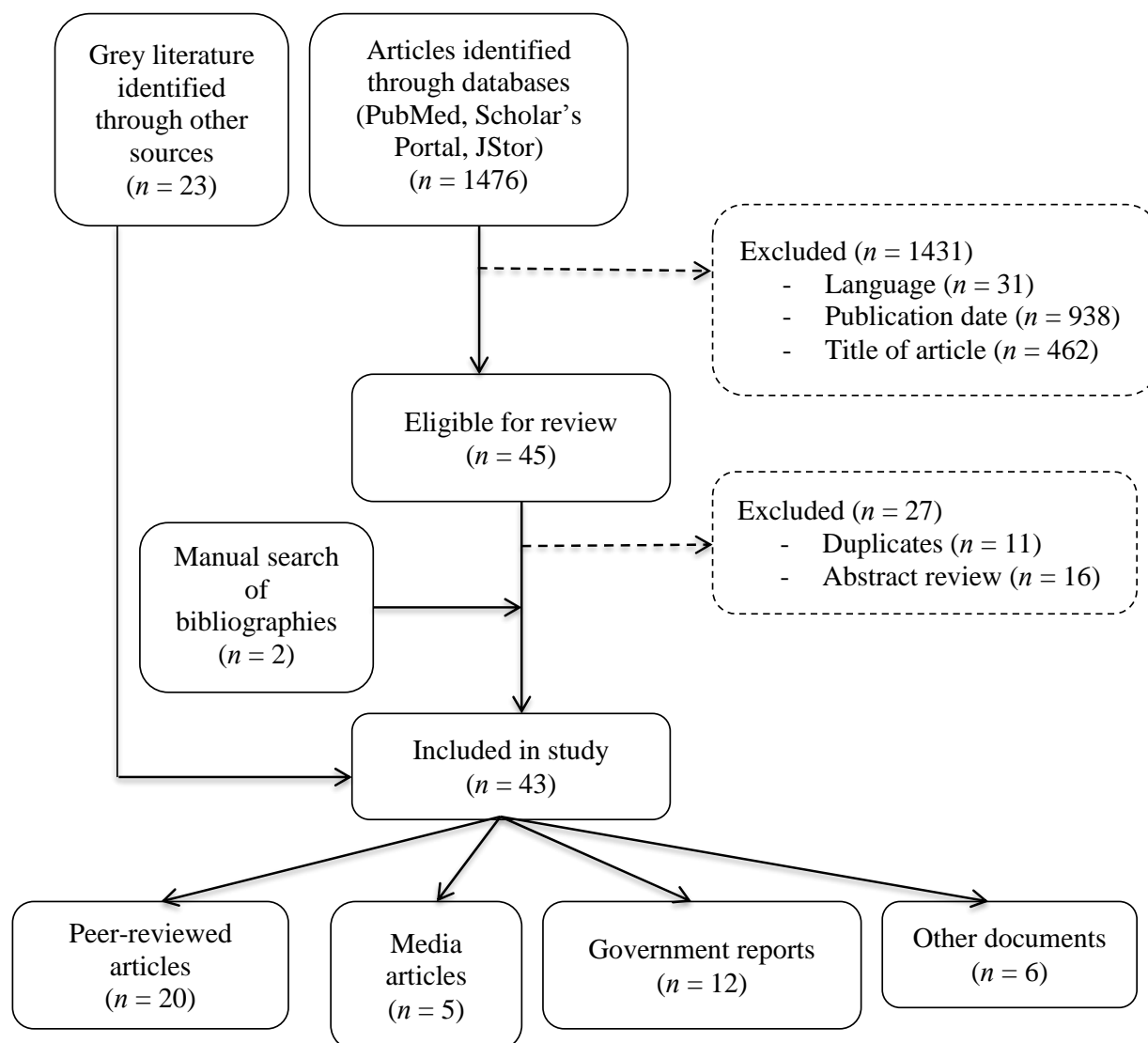
I used a narrative synthesis approach (Green, Johnson, & Adams, 2006) to explore the literature on sexual and reproductive health services in Canada's territories. This approach is less systematic and does not require a critique of each piece of literature chosen for inclusion (Green et al., 2006). As literature on sexual and reproductive health in the territories is scant, this method allowed and search and inclusion of a broader scope of literature, including grey literature. Furthermore, this literature review served as a starting point to gather background and contextual information before conducting further studies; narrative syntheses are useful in provoking thought and identifying gaps in knowledge in the literature (Green et al., 2006). I identified and examined articles reporting on a wide array of sexual and reproductive services, including research focusing on youth sexual health and education, sexually transmitted infections, maternal and child health, and abortion services. Throughout my search, I placed emphasis on facilitators and barriers that women face when accessing these health care services, and the consequent health indicators and experiences of women living in urban, rural, and remote areas of the territories. Reproductive justice aims to address the social injustices that hinder women's reproductive rights (Gilliam, Neustadt, & Gordon, 2009); through a reproductive justice lens I aimed to search the literature for women's experiences specifically.

I identified articles on online academic databases using keywords 'Nunavut', 'Northwest Territories', 'Yukon', 'Canadian territories', 'Aboriginal', 'sexual health', 'reproductive health', 'obstetric', 'abortion', and 'contraception' in various combinations. I included articles that centered on at least one sexual or reproductive health content area mentioned above, in addition to a focus on at least one population/region in the territories. I excluded articles if they were published before 2000, in order to obtain more current information, or if they were not written in

English. After applying exclusion criteria, I performed a manual screening of remaining articles titles to further eliminate articles that did not fit the inclusion criteria. I conducted an initial search for source material in early 2014 and repeated my search strategy in late 2015 to determine if any additional materials had been published.

My initial search in the electronic databases of PubMed, Scholar's Portal, and JStor yielded 34 peer-reviewed articles. I then manually searched the selected bibliographies and obtained two additional articles. After examining the abstracts, I selected articles for inclusion if deemed relevant to the objectives of this literature review ($n = 20$). In addition to peer-reviewed articles, I obtained government publications from federal and territorial websites to document up-to-date statistics, including Statistics Canada and Canadian Institute for Health Information ($n = 12$). Using a search on Google and LexisNexis, I also gathered articles and reports from the websites of national non-governmental organizations (NGOs) ($n = 6$) and media articles ($n = 5$) to broaden the scope of findings and search for documented stories of women's experiences. Manual review of the sources included in these materials did not yield additional articles or reports. The search strategy is presented in Figure 1.

Figure 1. Search strategy flow chart



I used a multi-step process to analyze the content (Evans & Fitzgerald, 2002). First, I read and reread all peer-reviewed literature collected in order to develop initial impressions and gauge what research and information is available through peer-reviewed sources. I developed an initial codebook based on my study objectives, and then added additional codes based on frequent content areas covered in the literature. I memoed throughout my initial review to document common areas of existing information on sexual health in the territories, as well as to identify

areas of information that were missing or incomplete. I collected grey literature through other sources in an attempt to fill the identified gaps in peer-reviewed research, and to include the most up-to-date sexual and reproductive health measures in my presentation of findings. After obtaining and reviewing all relevant literature, I used my codes and memos to identify how to appropriately categorize and present content areas in my review, and to synthesize and provide an interpretation and concrete recommendations based on my findings.

Results

Peer-reviewed literature incorporated in this review included quantitative and qualitative research studies as well as other literature reviews and analyses of secondary data. Studies pertained to the Canada-wide population with specific mention (although minimal) of populations in the territories, or focused on specific geographic regions or Aboriginal groups in the territories. The literature gathered centered on three main content areas related to sexual and reproductive health services: youth sexual health, maternal and infant health, and abortion services. Most peer-reviewed literature was quantitative or a review of secondary data. However there were a number of qualitative studies exploring youth, Aboriginal, or Aboriginal youth's sexual health knowledge and opinions ($n=4$). There were a number of articles focusing on obstetric evacuation policies in the territories, however none of them were qualitative. Additionally, there was minimal literature, and no qualitative studies, regarding abortion services in the territories. Government reports mainly provided statistics on sexual and reproductive health indicators. Media articles and reports produced by non-governmental organizations provided additional insight on practices not documented in peer-reviewed literature, such as Inuit custom adoption and abortion access.

Below I focus on the findings categorized into the three aforementioned content areas on youth sexual health, maternal and infant health, and abortion services. I further group these findings by sub-categories that I identified in the review.

Youth Sexual Health

Sexually transmitted infections. Of the three territories, the Northwest Territories and Nunavut experience higher rates of sexually transmitted infections compared to the provinces. Nunavut has the highest rate of chlamydia in Canada (3922.33 per 100,000), at more than 13 times the national average of 298.7 per 100,000 (Nunavut Department of Health and Social Services, 2012), while the Northwest Territories' rate of 2193.9 per 100,000 is more than seven times the national average (Public Health Agency of Canada, 2012). The rate of gonorrhoea in Nunavut is 1779.61 per 100,000, which is nearly 50 times the national average of 36.2 per 100,000 (Nunavut Department of Health and Social Services, 2012), and in the Northwest Territories the rate of 440.2 per 100,000 is more than 12 times the national average (PHAC, 2012). Syphilis has been an increasing concern in Nunavut over the last few years, with 94 cases reported in 2014 alone (Nunavut Department of Health, 2014). This places the syphilis rate in Nunavut at 50 times the national average of 5.8 cases per 100,000 (PHAC, 2012). The Northwest Territories and Yukon Territory are below national averages for syphilis (PHAC, 2012). Although higher rates were reported in previous years, Yukon's sexually transmitted infection measures fall closer to national averages in the most recent statistics (PHAC, 2012). Cases of reported infections tend to be highest among those aged 15 to 24 years. However, in all three territories the same age cohort reported higher rates of condom usage compared to the national average (Rotermann, 2012).

In a study of chlamydia screening practices among health care providers in Yukon Territory, physicians and community health nurses reported a number of barriers to initiating screening. Such barriers included patients' reluctance to discuss STIs due to confidentiality concerns, providers not having enough time in an appointment to discuss STIs with patients, and providers lacking up-to-date information on STIs (Machalek, Hanley, Kajiwara, Pasquali, & Stannard, 2013). The survey also found that reported chlamydia testing rates are lower among community health nurses (located in rural areas) than among physicians (predominantly located in Whitehorse, the urban capital). The study suggests that community health nurses have different asking and testing patterns than physicians; nurses may also be less inclined to assess STI risk and discuss testing if this is not the primary reason for the appointment (Machalek et al., 2013).

Teenage pregnancy. Compared to the Canadian average, Nunavut and Northwest Territories have significantly higher rates of teenage pregnancy (Statistics Canada, 2008). In 2005, the Canadian average rate of pregnancies (sum of live births, fetal loss, and induced abortions) for females under age 20 was 24.6 pregnancies per 1,000 females of the same age group. The rates in Nunavut and Northwest Territories were 125.5 and 59.6, respectively. Yukon's rate was closer to the Canadian average, at 26.7 (Statistics Canada, 2008). All three territories have higher rates of live births among females in the under 20 age category (Statistics Canada, 2012). The rate for mothers aged 15 to 19 years is 111.5 births per 1,000 females in Nunavut, compared to the Canadian average of 14.2. Northwest Territories and Yukon Territory both surpassed the nation's average at 34.3 and 23.3, respectively (Statistics Canada, 2012). The Canadian Maternity Experiences Survey found that women in the three territories reported the highest prevalence of unintended pregnancies, with respondents under 20 years of age being

more likely to experience an unintended pregnancy compared to respondents over 40 (Oulman, Kim, Yunis, & Tamim, 2015). Yukon Territory saw dramatic declines in rates of teenage pregnancy in the 1990s; Wackett (2002) assessed many factors that contributed to this decline in the territory. Yukon Health and Social Services implemented a number of initiatives, including a launch of media campaigns targeting youth sexual health, and increased provision of subsidized or free contraception and emergency contraception (Wackett, 2002).

Sexual education and health care access. In studies involving youth in the territories, participants suggest that they are lacking information about a number of sexual health topics and face barriers when accessing sexual and reproductive health services. A survey distributed to three high schools on Baffin Island in Nunavut identified gaps in knowledge pertaining to sexual health, with 23% of youth participants stating that they had not heard of emergency contraception, and 43% stating that they did not know where to get emergency contraception (Cole, 2004). The majority of respondents believed that their sexual health education was lacking and wanted to know more about topics including sexually transmitted infections and contraception options. Interviews of female youth in the Northwest Territories mirrored the findings in Nunavut; youth reported that their sexual health education is inadequate (Lys & Reading, 2012). The participants stated that they would prefer to receive information from adults rather than turning to the media or the Internet and they commonly mentioned the influence of alcohol as a factor in precipitating unprotected sex (Lys & Reading, 2012).

Youth outlined several persistent barriers to accessing sexual and reproductive health services. Confidentiality is a commonly raised concern when attempting to obtain information and/or resources for sexual and reproductive health (Lys & Reading, 2012). Added challenges arise in northern communities because of limited choices in clinics and pharmacies, provider

shortages and frequent turnover, and the likelihood of family or acquaintances working in the health sector in their community. The history of colonialism, particularly the trauma and abuse as a result of residential schools in the second half of the twentieth century, continue to factor into Aboriginal youth sexual health knowledge (Healey, 2014a). In qualitative studies exploring Inuit parents' perspectives on sexual health communication with their adolescent children, many parents emphasized the value of community elders as a resource to youth and the need for restoration of elder-youth relationships in order to promote sexual health discussion and education (Healey, 2014b). The residential school era and unresolved health issues continue to impact Inuit families' relationships, including parent-child dialogue about sexual health (Healey, 2014a). Steenbeck (2004) makes recommendations for Aboriginal youth sexual health education that focuses on engaging youth in the design and implementation of health promotion initiatives in order to more effectively combat high sexually transmitted infection rates. Youth engagement can be accomplished by emphasizing participatory action research, peer education, and strategies to develop self-advocacy skills. Initiatives that engage youth will empower individuals rather than using classic health promotion approaches that do not allow for learner input (Steenbeck, 2004).

Maternal and Infant Health

Birth Rates. Research on pregnancy and childbirth in Nunavut and the Northwest Territories reveal indicators that stray from national averages. Compared to the Canadian average of 54.6 pregnancies per 1,000 women, Nunavut has more than double the rate, with 120.3 pregnancies per 1,000 women and Northwest Territories has 85.6 pregnancies per 1,000 women (Statistics Canada, 2010). Yukon's rate falls in line with the Canadian average, at 54.5

pregnancies per 1,000 women. The pregnancy rate includes all live births, fetal losses, and induced abortions. These rates are likely to be underestimated, as collection of Aboriginal public health data may use substandard or inconsistent data sources and methodologies (Reading & Wien, 2009). Further, individual surveys that are restricted to particular Aboriginal populations, or populations living on versus off reserve, create fragmented data that may not comprehensively include all Aboriginal groups.

Delivery Practices. Remote populations in the three territories undergo a drastically different experience for labour and delivery in comparison to southern and urban populations. In a report of hospital births in Canada, almost all women living in rural areas in their territory of residence travelled more than two hours to deliver, including 99.5% of rural women in Yukon Territory, 84.1% of rural women in Nunavut, and 61.9% of rural women in Northwest Territories (Canadian Institute for Health Information, 2013).

The British North America Act (1867), followed by the Indian Act (1876), stipulated that health legislation was under provincial jurisdiction, but Aboriginal affairs were under federal authority, creating unclear guidelines as to organization and responsibility of Aboriginal health services (National Collaborating Centre for Aboriginal Health, 2011; Lawford & Giles, 2012a). Under federal authority, all women living in Northern and isolated geographic communities to travel, often great distances, to southern or regional centres for delivery (Browne & Fiske, 2001). The blanket policies, referred to as obstetrical evacuation, were implemented to improve pregnancy outcomes, as southern hospitals are better equipped to deal with complications during delivery (Healey & Meadows, 2007; Shaw, 2013). Travel costs and accommodation are covered for the woman under her territory's medical travel program; however, travel costs incurred by companions, children, and other supports are not covered (CIHI, 2013).

Childbearing is a profound experience that can impact future maternal-child attachment (Bryanton, Gagnon, Johnston, & Hatem, 2008). Positive birthing experiences are associated with a mother's increased competence and sense of mastery, whereas negative birthing experiences can evoke feelings of anger, guilt, and loss of control, and can place the mother at an increased risk for postpartum depression (Bryanton et al., 2008). When assessing predictors of women's perceptions of their childbirth experience, maintaining control over their behaviour, body, and health care is paramount for increased satisfaction and positive experiences (Bryanton et al., 2008). Lawford and Giles (2012b) assessed the evacuation policy for First Nations women specifically, stating that these policies were designed around a Euro-Canadian biomedical model, and therefore do not incorporate First Nations' epistemologies. Evacuated women experience labour and delivery with limited self-determination and in locations outside their land and communities, aspects that are fundamental to First Nations' meanings of health and wellness (Lawford & Giles, 2012b). The isolation from family, land, and community eliminates important contributors of psychological, emotional, and physical supports. The policy of requiring all women in rural and remote communities to travel to urban centres for delivery intends to lower obstetric risk, but fails to recognize that many women perceive leaving their community as a greater risk (Shaw, 2013). These stressors, including isolation, planning for childcare for other children, lack of choice of delivery location, and a lack of communication throughout their health care have some women referring to this mandatory process as "obstetric exile" (Healey & Meadows, 2007).

According to the Canadian Maternity Experiences Survey, mothers in Nunavut were more likely to report having limited information on pregnancy-related topics and less likely to report having a partner present during delivery (PHAC, 2009). Mothers in Nunavut rated their

overall satisfaction with maternity experiences lower than mothers from outside of Nunavut. Although evacuation is often not preferred by the expectant mother, funding a travel companion to accompany women would likely alleviate the feelings of isolation and lack of support that women currently face (Lawson & Giles, 2012). The Society of Obstetricians and Gynecologists of Canada suggests that in order to improve maternal health in Canada's North, the practice of flying mothers south must end, allowing women to deliver in their own communities (Payne, 2011). The establishment of midwife-run birthing centres could serve as a viable alternative for low-risk women, however the few existing centres struggle with staff retention (Moffitt & Vollman, 2006). Yukon Territory still does not recognize the profession of midwifery and consequently is the only territory with no association of midwives (Canadian Association of Midwives, 2015).

Infant Health. Despite these implemented delivery measures, the infant mortality rate in Nunavut remains high at 21.4 deaths per 1,000 live births, compared to the Canadian average of 4.8 deaths per 1000 live births (Statistics Canada, 2015b). Rates in Northwest Territories and Yukon Territory are lower than the national average, at 4.4 and 2.2, respectively.

Infant mortality rates vary depending on the age at and cause of death, with infant deaths in the neonatal period (birth to less than 28 days) indicating a lack of access to obstetric and neonatal care, and infant deaths in the postneonatal period (28 days to one year after birth) indicating inadequacies in social and/or environmental factors (Smylie et al., 2010). Unfortunately, there is a lack of consistency in reported infant mortality statistics in Aboriginal populations. With a range of cultures and populations, including First Nations, Inuit, Métis, Status Indians living off-reserve, and non-Status Indians, there is a need for a more standardized approach to collecting birth and death data across Aboriginal populations, especially in the

territories (Smylie et al., 2010). Improved reporting measures will aid in identifying and addressing the underlying social determinants of health that are contributing to higher infant mortality rates in Aboriginal populations (Smylie et al., 2010).

Custom Adoption. In Nunavut, it is a common tradition among the Inuit population for a family member to adopt a child that a mother is unable to care for, allowing the biological parents to remain in contact with their child (Cole, 2004; Rogers, 2014). Inuit custom adoption is not referred to as “giving away” a child, but as “making a gift” to the child and the new parents (Foot, 2008). In a survey of high school students on Baffin Island, 26% of Inuit respondents felt that custom adoption options made pregnancy “no big deal” (Cole, 2004, p. 271). Approximately 3,000 custom adoptions took place between 1999 and 2010, with the majority occurring during the newborn period (Rogers, 2014). Traditional Inuit adoption involved a simple verbal agreement and there is no legislation that deals directly with Inuit custom adoption (Rideout, 2000; Rogers, 2014). Stakeholders in Nunavut argue that a fine balance needs to be met between clearly defining practices and assuring comprehensive agreements between involved parties, while still maintaining the tradition of Inuit custom adoption as a family or community affair (Rideout, 2000).

Inuit infants have also been adopted by a number of families in southern Canada, mainly in the Atlantic provinces. Unlike other jurisdictions in Canada, Nunavut allows private adoptions because of its tradition of custom adoption. It is common for birth families to prefer to stay in contact with their biological child, ensuring that the child is taught about his or her Inuit culture (Foot, 2008).

Abortion Services

With only 15.9% of Canadian hospitals offering abortion services, the pattern in Canada as a whole has shifted to women obtaining services through freestanding clinics (Shaw, 2006). Although the majority of these providing hospitals are located in major cities within 150km of the U.S. border, the three Canadian territories only have hospital-based services, with one facility in Yukon, two facilities in Northwest Territories, and one facility in Nunavut (Canadians for Choice, 2012; Shaw, 2006). The facilities have gestational age limits ranging from 12 to 14 weeks. Territorial medical plans cover the cost of the procedure as well as the woman's in-territory or out-of-territory travel expenses to a region with a providing facility ("Abortion, Province by Province," 2010).

In 2014, Nunavut reported a total of 85 induced abortions by its sole hospital. Northwest Territories' hospitals reported 255 induced abortions, and the Yukon reported 102 (CIHI, 2015). In the same year, the total number of induced abortions reported by Canadian hospitals of women residing in Nunavut was 193. The Northwest Territories reported 208 total residents obtaining abortion services, and Yukon reported 121 (CIHI, 2015). Although hospital reporting is mandatory, data from private clinics are submitted to the CIHI on a voluntary basis (CIHI, 2015). Therefore, these numbers are likely underestimated and may not account for women from the territories who travel to private clinics in the provinces for care.

In a study of women's travel patterns across Canada to receive an abortion, respondents who self-identified as First Nations or Métis were nearly three times more likely than those who self-identified as white to have travelled over 100km to reach an abortion clinic (Sethna & Doull, 2013). Based on a questionnaire, this cohort also reported a more difficult journey as compared to self-identified white women. Reasons for difficulty included time-consuming and expensive travel to reach the clinic, as well as physical discomfort and emotional stress throughout the

journey. Abortion is an extremely common health care procedure in Canada, with one in three women obtaining an abortion during their reproductive lives (Norman, 2012). Termination of an unwanted pregnancy is a time sensitive health care service, yet not quite emergency care, thus the narrow time frame creates challenges for care in rural and remote areas.

Discussion

The literature included in this review highlighted that women living in the territories have experienced significant challenges and barriers to accessing comprehensive sexual and reproductive health services. These obstacles have contributed to poor reproductive health outcomes including high rates of sexually transmitted infections, negative birthing experiences, and high rates of infant mortality (Canadian Federation for Sexual Health, 2007). Of the three territories, these negative outcomes are most prominent in Nunavut.

The territories are home to the highest proportions of Aboriginal peoples in Canada, mainly First Nations, Métis, and Inuit, comprising 86.3% of Nunavut's population, 51.9% of the Northwest Territories' population, and 23.1% of Yukon Territory's population in 2011 (Statistics Canada, 2013). Regarding health care for Aboriginal populations specifically, current federal health policies are incongruent with aboriginal epistemologies and therefore are lacking in providing a holistic approach to health care (Lawford & Giles, 2012b). When implementing health care initiatives, consideration must be taken toward understanding and affirming traditional medicines and rituals, including knowledge held by female elders. Health needs to be understood with full incorporation of their unique social and cultural characteristics (Browne & Fiske, 2001). Canadian health legislation and policy rooted in colonialism continues to impact the health and well-being of Aboriginal populations, with current health services centring around

a Euro-Canadian biomedical model (Lawford & Giles, 2012b). In order to create health interventions that empower Aboriginal peoples, initiatives must recognize and validate their self-identity and cultural pride (Browne & Fiske, 2001), first and foremost by involving the individuals themselves in planning, implementing, and evaluating sexual health initiatives and policies going forward.

Establishing long-term relationships with health care professionals is important for quality of care; challenges to achieving and maintaining health in the territories is exacerbated by the overall shortages of health care professionals in northern Canada, as well as high rates of staff turnover (Browne & Fiske, 2001; Lys & Reading, 2012). These challenges highlight the need for a more collaborative, interdisciplinary approach to health care, with midwives, nurses, nurse practitioners, family doctors, and obstetricians working together to improve women's health (Payne, 2011).

Exploring the status of health in Canada's north is particularly challenging, as an overwhelming proportion of literature on sexual and reproductive health focuses on the provinces. With an estimated 75% of Canada's population living within 161km (100 miles) of the U.S border (National Geographic, 2014), health research in Canada tends to be focused to southern urban areas. The limited research on populations in the territories creates gaps in knowledge regarding women's experiences accessing health care, including more stigmatized topics in sexual and reproductive health care.

Across all aspects of the sexual and reproductive health literature analyzed for this review, there is an overwhelming lack of research documenting women's voices. With few hospitals and challenges retaining health care providers, women often travel lengthy distances to obtain health care, particularly for maternity and abortion services. There is a profound gap in

knowledge, however, regarding women's lived experiences travelling to and accessing these services. Regarding abortion care, with restricted choice in abortion-providing facilities in the territories, and low gestational age limits at those providing facilities, it is necessary to identify how these and other barriers shape the care being offered. The discrepancies between numbers of abortions performed in each territorial hospital, compared to numbers of women in each territory obtaining abortion services (CIHI, 2015), suggest that a proportion of women residing in the territories are travelling elsewhere to receive an abortion and they are likely travelling great distances. Women who access abortion services while residing in a province to attend school, but are still covered until their territorial health insurance, could also account for discrepancies. Qualitative research on women's experiences accessing sexual and reproductive health services would provide rich insight to help explain the current health measures, identify facilitators and barriers to accessing health care, and determine ways to improve services.

Limitations. Performing this literature review came with a number of challenges. Although the focus was to determine information about sexual and reproductive health in the three territories, a number of reported statistics specifically pertained to Aboriginal health. Although many residents in the territories are Aboriginal (Statistics Canada, 2013), Indigenous populations are not restricted to specific territorial boundaries. For example, the four main Inuit-inhabited regions in Canada are spread across Nunavut, the Northwest Territories, northern Quebec, and the northern coast of Labrador (Healey & Meadows, 2007). Thus, certain health territory-specific indicators reported may not be indicative of only that respective territory's current status of health. In addition, health indicators of one territory as a whole may not provide an accurate portrayal of the current state of health among individual citizens, because of the contrasts between urban populations (living within the territory's capital) and rural populations

(living outside of the territory's capital). Additional challenges arise when analyzing trends in data in the Northwest Territories and Nunavut because of the changes in boundaries in 1999 when Nunavut was created.

Conclusion

The Canadian territories suffer disproportionately across a number of sexual health indicators compared to the rest of the nation, demonstrating a possible lack of education, access, and availability of resources. There is a need for further research on women's experiences, preferences, and knowledge regarding the present services they have access to in their home territory, as well as their suggestions for improvements to health care. Sexual and reproductive health intersects with a number of domains contributing to poor health in populations in the territories; this warrants prioritizing health research and initiatives specifically geared to women's sexual and reproductive health services.

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CHAPTER 4: Article II: “They made me go through like weeks of appointments and everything”: Documenting women’s experiences seeking abortion care in Yukon Territory, Canada

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**“They made me go through like weeks of appointments and everything”:
Documenting women’s experiences seeking abortion care in Yukon Territory, Canada**

Abstract

Background: Abortion has been legal without restriction in Canada since 1988 and is recognized as a medically necessary service. However, research indicates that women still face numerous barriers to accessing care, challenges which are amplified for women living in rural, remote, and northern regions in Canada.

Objectives: This qualitative study aimed to document women’s experiences seeking and obtaining abortion services while residing in Yukon Territory, identify financial and personal costs, and explore avenues through which services could be improved.

Methods: We conducted 16 in-depth semi-structured phone interviews with women who accessed abortion services on/after January 1, 2005 while residing in the Yukon. We employed an iterative multi-phase analytic approach centering on content and themes, using both inductive and deductive techniques.

Results: With the Yukon’s sole facility offering first trimester abortions twice a month, women experienced difficulty navigating a fragmented process and long wait times. Women found the process of attending multiple pre-procedure appointments at multiple locations with multiple health care providers, all while enduring pregnancy symptoms and handling other life commitments, physically, financially, and emotionally taxing.

Conclusion: Efforts to streamline the process of obtaining an abortion and providing women with more information at the first point of contact would improve service access and quality. Mifepristone has the potential to improve access for rural and remote populations, reduce wait times, and alleviate privacy concerns, but only if the medication abortion regimen is affordable and available at a range of service delivery points and provision requirements are aligned with the global evidence.

Implications: By documenting women’s experiences, the identified barriers and outlined suggestions for improvement offer realistic avenues through which current abortion services in Yukon Territory can be modified in order to increase access. This study highlights future reproductive health care initiatives that warrant prioritization in Canada’s North.

Key words: Medication abortion, rural populations, mifepristone, qualitative research

1. Introduction

Induced abortion is an extremely common health care procedure in Canada, with an estimated one in three women obtaining an abortion during their reproductive lives [1]. Following the 1988 Supreme Court ruling to decriminalize abortion, service delivery patterns have shifted from being provided mainly in hospitals to mainly in freestanding clinics. Private clinics are exclusively located in urban centers, thus rural and remote communities offering abortion services provide care in hospitals [2-3].

Yukon Territory has a population of 33,897 spread across an area larger than California [4]. From 2012 through 2014, the territory's sole abortion providing facility reported the annual number of induced abortions as ranging from 102 to 145 [5-7]. However, the number of Yukon residents obtaining abortion care in Canadian hospitals was higher (121-170) during this same three year period [5-7]. Although some Yukon residents may be obtaining abortion care in the province or territory where they work or go to school, these differences also suggest that some women may be traveling to other provinces or territories for their abortion care. After obtaining a referral from a clinician, Yukon residents have access to first trimester aspiration/surgical abortion services through Whitehorse General Hospital and procedures are covered by territorial insurance [8]. Given the relatively low number of abortions performed each year, the service is only offered twice a month in Yukon's capital city [8]. Women with pregnancies beyond 12 weeks and six days' gestation must travel out of the Yukon for abortion care. Medication abortion is not readily available in Yukon Territory; methotrexate/misoprostol is available for women at less than seven weeks' gestation but few family physicians offer this option [8]. Mifepristone/misoprostol was only approved by Health Canada for early pregnancy termination in July 2015 and is expected to become available in Canada in the fall of 2016 [9].

Recent research suggests that Canadian women prefer clinic-based abortion care and that clinic-based services are both faster and more streamlined when compared to hospital-based services [4,10-11]. A national study found that some Canadian women bypassed nearby hospitals offering abortion services in order to obtain care in freestanding clinics [12]. However, women residing in Canada's North have limited options with respect to service delivery sites and may face unique barriers to accessing timely care in-territory.

We undertook a qualitative study to understand better women's experiences seeking and obtaining abortion care in the Yukon. Through in-depth interviews with abortion patients, we aimed to document women's experiences, explore the financial and personal costs associated with obtaining abortion care, and identify avenues by which services could be improved in the Yukon.

2. Methods

This project is part of a large-scale qualitative study dedicated to exploring Canadian women's abortion experiences. We have detailed the design of the Canada Abortion Study (CAS) in other publications [13-14].

2.1 Participant recruitment and data collection

We conducted in-depth semi-structured interviews with women between June 2015 and January 2016. We employed a multi-model recruitment strategy, posting study advertisements on listservs and online platforms, circulating study information through local organizations, and engaging with both traditional and social media [15]. Women were eligible if they had obtained an abortion on/after January 1, 2005, were a resident of Yukon Territory at the time of the

abortion, were aged 18 or older at the time of the interview, and were proficient in English or French. Interviews averaged one hour and took place over the phone/Skype and participants received a CAD40 gift card to amazon.ca.

Consistent with the overarching CAS, our interview guide contained questions about the participant's background, her reproductive health history, the circumstances surrounding the terminated pregnancy/pregnancies, her insights on future service improvements, and her knowledge of and opinions about mifepristone. We asked open-ended questions and probed participants' responses when appropriate. JC, a MSc student at the University of Ottawa, conducted all interviews after having received training from her supervisor (AF), a medical anthropologist and medical doctor with extensive abortion-related research experience. We audio-recorded interviews, with permission, which we later transcribed verbatim. JC took notes during and formally memoed immediately after each interview. Memoing served as a means to reflect on interviewer-participant interactions, identify emerging themes, and determine thematic saturation.

2.2 Analysis

We managed our data, which consisted of field notes, memos, and transcripts, with ATLAS.ti. We engaged in an iterative multi-phase analytic process centering on content and themes [16-17]. In the first phase we deductively developed a code book using *a priori* codes and categories based on the interview guide, study objectives, and findings from the larger study. In the second phase we employed inductive analytic techniques, adding additional codes and categories based on the data. This led to the third phase during which we identified themes and formed relationships between these themes and categories and codes. In the fourth phase, we

reviewed the identified patterns and themes for coherence, both within and between interviews. JC served as the primary coder and AF reviewed both the evolving codebook and coded transcripts. Group meetings, as well as discussions with the larger CAS team, guided our interpretation and we resolved disagreements through discussion.

2.3 Ethical considerations

We received ethics approval from the University of Ottawa's Research Ethics Board. Throughout this paper we use pseudonyms and have masked or redacted all personally identifying information. We showcase individual women's experiences through narrative vignettes and use illustrative quotes to highlight themes and ideas.

3. Results

3.1 Participant and abortion characteristics

We interviewed 16 women over the course of the study. Consistent with the demographics of Yukon Territory [4,18], most of our participants were from Whitehorse (n=14) and self-identified as white (n=9). At the time of the interview, our participants averaged 32 years of age and the majority were employed (n=13), married/partnered (n=13), and parenting at least one child (n=9).

We heard detailed information about 19 abortions, all of which were aspiration/surgical abortions that took place in-territory at Whitehorse General Hospital. One of these aspiration terminations took place after the woman's use of methotrexate/misoprostol was unsuccessful. The average gestational age at the time of decision and at termination were 5.5 weeks and 9.4 weeks, respectively. Women cited lack of financial and social support, being in an unstable

relationship, wanting to advance in their education or careers, and not wanting more children as primary reasons for choosing to terminate the pregnancy.

[Figure 1 here]

3.2 Obtaining an abortion in the Yukon is complicated and the process is not transparent

[The family doctor] didn't really provide me with information at the first appointment...I wasn't sure what to ask for 'cause I didn't know anyone who had gone through it and I wasn't really wanting to kind of tell anyone what was happening. (Danielle, 34)

As Heather's story illustrated, obtaining an abortion in Yukon Territory is a complicated process. For our participants an average of six appointments were required and involved a minimum of three different providers, including an initial referral. Most women were unaware of what obtaining an abortion would entail and those without a family physician had difficulty navigating where to go and who to contact. As Sofia, a 38 year-old woman who obtained her abortion in 2015, explained, "So it took me a little bit of searching around, you know, I called different people, different places, and eventually I got in touch with the sexual clinic." Even for participants that did have a family doctor, some reported difficulty getting an appointment in a timely manner, or receiving inadequate information about the overarching process. Alyssa, a 26 year-old who obtained her abortion in 2012, described her uncertainty, "Yeah they don't really lay it out clearly, like what's gonna happen, like you have no idea."

Although many women reported that obtaining a referral for the abortion from family physicians or others was challenging, women reflected very positively on the care that they received from abortion providers. They felt the consultation beforehand was comprehensive,

providing them with options counseling, support, information on the procedure, contraceptive counseling, and an opportunity to ask questions.

[The abortion provider] was very professional, you know, have you thought about your decision? Do you need to discuss it? You know, and I was like 'no not really'. And she was like okay great, talked me through the procedure and what I could expect, offered me follow-up care, but just in a very calm, professional manner, not pry-ey...just very professional throughout the whole thing. (Andrea, 29)

However, because the process requires multiple consultations with different health care providers, women risk interacting with anti-choice or unsupportive clinicians. After Alyssa learned she had an unintended pregnancy, she consulted her family doctor for an abortion referral and felt as though he treated her “like a slut.” He referred her for an ultrasound but at that appointment the technician did not heed her request to not show her the image and “they just like popped it up there, even though I told them I didn't want them to.” Alyssa reflected quite negatively on her entire experience as a result of receiving care that she believes was judgmental from multiple clinicians.

I'm so glad I made that decision, but I just wish my experience could have been better so that it wouldn't have affected me for so long like. It's not gonna be a walk in the park but it would be a lot better if people choose to support you instead of choosing to pat themselves on the back because of whatever belief they have.

Another participant waited over a month to get her ultrasound after her family doctor appointment. She suspects that the ultrasound department intentionally delayed her procedure; she was nearing the 12 week gestational age limit by the time her family doctor received the ultrasound results and was immediately scheduled for the next procedure date in-territory. She stated that her emotional recovery following the procedure was more difficult because she remained pregnant for seven weeks after making the decision to terminate.

When obtaining an ultrasound, seven participants described upsetting or distressing experiences because they saw the screen, heard a heartbeat, and/or the technician volunteered detailed information that they would have preferred not to know. Because pre-procedure appointments take place through multiple hospital departments and locations, abortion providers have limited control over these external encounters.

[Figure 2 here]

3.3 Multiple appointments, significant travel, and long wait times are financially and emotionally taxing and influence disclosure

And it's multiple appointments and all that stuff... [T]hat was the most challenging part, hiding all the appointments. (Michelle, 31)

Of the 19 abortion experiences shared, women found the waiting period, from the first point of contact to the time the procedure was performed, stressful or upsetting in 12 cases. Women reported wait times ranging from one week to seven weeks, with an average of 27 days. Like Michelle, many women discussed having to coordinate multiple appointments over a lengthy period of time, all while handling other life commitments and experiencing pregnancy symptoms. Some participants compared their experiences to those of women who obtained abortion care at freestanding clinics in southern urban cities.

[Having multiple appointments] was definitely on the more difficult side of things. I don't think I thought about it that way at the time, but I've since talked to female friends [from other parts of Canada] who've walked into clinics and had the procedure done in the same visit, and I'm just like what? They made me go through like weeks of appointments and everything. (Lauren, 29)

As outlined in Michelle's story, the multiple appointments were difficult to schedule and keep private. A number of our participants worried that because of the many appointments they would have to disclose the abortion to more people than they would have otherwise preferred. Participants consistently explained that Whitehorse is a car-centric town and public transportation is not readily available in surrounding residential areas. Finding transportation to appointments, especially for procedure itself, can also impact disclosure. Transportation challenges are further amplified for women living in remote communities, where there are few or no public transportation options available to travel to Whitehorse. Kristen, a 27 year-old, did not want anyone to know about her second abortion,

Yeah, I drove myself actually because I didn't want to tell my mom... And they said I needed somebody to pick me up, but I said I had somebody to pick me up but I didn't, I just, I drove myself home afterwards.

All of the procedures through Whitehorse General Hospital were covered by Yukon's territorial health insurance. Out-of-pocket expenses included taxi fares, IUDs inserted on the day of the procedure, medications (methotrexate/misoprostol) for one woman, and hotel and gas for the two participants travelling in from outside of Whitehorse, who were later reimbursed after submitting receipts. Indirect costs included missed work, missed classes at school, and childcare. Winona, who made multiple trips into Whitehorse from a remote community, stated that "[I]t's not easy, it's difficult travelling to Whitehorse... the process itself is frustrating."

[Figure 3 here]

3.4 A number of avenues exist for improving care

So if they could somehow even just bundle those appointments? Like so that they're all on the same day...and make them more like just convenient. (Heather, 29)

When asked how services could be improved, participants made suggestions to streamline the service and decrease the wait times. As Lauren opined, "Quicker service is obviously the big one...like fewer points of contact." Andrea experienced judgment when obtaining her referral from a locum doctor and stated that all clinicians "need to focus on choice and respect people's decisions." Like Erin, most participants, based on their own experiences, recommended that follow-up counseling be routinely offered, as they felt contact with health care providers was abruptly cut-off after the procedure. As Michelle suggested, "I think I would offer better, either counseling before or some counseling before and post. And I don't know if that's standard, but, yeah, there was just no, no follow-up". Women who accessed care through the new Yukon Sexual Health Clinic identified the need for expanded clinic hours and more providers offering care. As Karen explained, "So there's one nurse practitioner and [the physician], but that's not enough, like they need other people working and supporting women."

Most participants had not heard of mifepristone, but when JC explained a standard mifepristone/misoprostol regimen, the majority of women described this process as sounding "easier" and "simpler". Participants opined that they could have had a more timely, less invasive, and more private experience at home. All but one participant stated that she would feel comfortable receiving medication abortion care from a family doctor or nurse practitioner as long as the clinician was adequately trained and qualified; many said that they would prefer it.

4. Discussion

Rural, remote, and northern regions of Canada face challenges with both limited health care facilities and providers, creating fragmented care, and increased wait times for many health

care services. However, the hoops that women have to jump through to access abortion care in the Yukon create additional barriers. Women risk receiving judgment from an anti-choice provider and must navigate and coordinate appointments for a service that is rarely discussed in public. With one providing facility, few physicians offering medication abortion, and a limited gestational age window, women have limited options when obtaining an abortion in-territory.

The fragmented services left most of our participants unsatisfied, stressed, and/or upset with the lack of information, multiple appointments, and lengthy wait times. When first meeting with a clinician to obtain a referral for the procedure, women may benefit from a discussion of medications and other strategies to relieve symptoms of nausea, vomiting, and fatigue while they are awaiting the procedure. Furthermore, creating a more streamlined process that requires fewer visits to different health service providers at different sites on different days could reduce the waiting period, which would benefit women physically and emotionally.

With the shortage of family physicians in the territory, participants faced challenges initiating the abortion referral process. Literature demonstrates that a small proportion of women rely on assistance from their general practitioner in reaching a decision to terminate a pregnancy [19-20]. Allowing women to self-refer to access abortion services in Yukon Territory could ease the process, prevent delays in care, and reduce the risk that women will encounter an anti-choice or judgmental clinician. Giving abortion care in the Yukon a “medical home”, ideally a dedicated space within the hospital, would also allow for woman-centered care from a team of service providers for every part of the process. Yukon’s current abortion providers have less control over both women’s experiences with other clinicians within the community and less control over the logistical constraints of coordinating timely pre-procedure and procedure appointments. Offering the option of a post-procedure telephone call could provide women with the follow-up support

they identified as lacking and offer an opportunity for referral to additional counseling resources, if desired [21].

Health Canada approved the combination drug Mifegymiso® (mifepristone/misoprostol) in July 2015. Our participants expressed considerable interest in medication abortion and reacted positively to the possibility of being able to obtain this care from a range of providers. However, Health Canada limited provision to physicians and only through 49 days' gestation [9]. These restrictions are not aligned with the global evidence that shows that mifepristone/misoprostol can be provided safely by a range of clinicians through 63-70 days' gestation [22-25]. Health Canada's restrictions limit the potential for mifepristone to increase abortion access in rural and remote areas that are primarily staffed by community health nurses. Creative and innovative models – including collaborative prescribing agreements and telemedicine provision [26-27] – will need to be explored in order for the introduction of mifepristone to address existing barriers.

4.1 Limitations

As this is a qualitative study with a relatively small sample size, our results were not intended to be representative or generalizable. Because interviews took place over the phone/Skype, women without access to these technologies were unable to participate. Most participants resided in Whitehorse at the time of their abortion and all of our participants were English speaking. Future research would benefit from capturing the perspectives of women residing outside of the capital city and of language minority populations.

4.2 Conclusion

Women in the Yukon face a number of barriers to accessing timely abortion care. Creating a more streamlined and transparent process, offering abortion a “medical home”, and allowing women to self-refer could alleviate existing barriers. The introduction of mifepristone promises to offer women a choice with respect to abortion procedure and also has the potential to reduce geographic disparities and wait times and enhance privacy. Developing and evaluating creative service delivery models, including telemedicine provision, appears warranted. Our results may offer insights into ways in which services could be improved in other areas of Canada’s North and for rural and remote populations.

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Figure 1: Heather's story

Heather was living in Whitehorse with her husband when she became pregnant in 2013. In her late 20s, Heather and her husband decided that although they wanted children one day, this was not the right time for them. Their living situation and finances were not yet stable and Heather was still looking for permanent employment after finishing her degree.

Heather's family doctor extended clinic hours to fit her in for an appointment immediately to set up the abortion referral. Heather was scheduled to have the abortion three weeks after this appointment. She had an ultrasound and blood work at Whitehorse General Hospital. She was not working at the time, and drove herself to all of the pre-procedure appointments. "[T]here's so many points in this process where, if I didn't have a vehicle, if I didn't have a family doctor, if, you know, I had had a job, that I would have been pretty stuck." She was experiencing fatigue, nausea, and vomiting throughout the waiting period, and consequently found it difficult to keep her situation private. Heather also worried that in the process of having all of these appointments other people would find out she was having an abortion.

The day before the procedure she had a consultation with the abortion provider, which she described as informative and supportive. She also had a brief and basic pre-operative appointment with the nurses at the hospital. On the day of the procedure, Heather raised concerns about privacy; because abortion services are only offered every other week she worried that hospital staff knew that all of the women were getting abortions. The procedure went smoothly and her husband drove her to and from the hospital that day. Heather would have considered taking mifepristone, had it been available, in order to obtain her abortion sooner and in a more private context.

Figure 2: Michelle's story

Michelle is in her early 30s living in Whitehorse with her partner and her young children. She had an IUD inserted prior to becoming pregnant, as she was not planning on having any more kids. She was very upset when she initially found out she was pregnant again in 2015. She chose not to tell her partner; she felt her partner would not support her decision to get an abortion. She was able to schedule an appointment with a family doctor within a few days and learned she was about four weeks' gestation.

Michelle found the scheduling and consequent wait times upsetting and hiding the appointments from her family was challenging. She was informed that she would not be able to get an ultrasound in time for the next abortion service day and Michelle was scheduled to be out of town on the following procedure date, thus she was going to have to wait for over a month to get the abortion. She considered flying to Vancouver or Calgary; she was worried about keeping her pregnancy secret and scared that she would begin to have the same mood swings and depression that she experienced in her previous pregnancies. She could not believe that the ultrasound was holding up her abortion and after multiple phone conversations with various administrative personnel, she got accepted onto a cancellation list and was ultimately able to get the ultrasound in time for the next procedure date.

At the consultation appointment with the abortion provider the day before her procedure, Michelle was shocked to find out that the medication option (methotrexate/misoprostol) was not offered to her and that she would have to be sedated for the surgical procedure and could not drive herself home. These details were not provided to her at her first point of contact. She ended up walking home from the hospital after being discharged.

Figure 3: Erin's story

Erin is a single woman in her mid-30s. She obtained an abortion in 2015 while living in Whitehorse. Although she took Plan B® after intercourse she became pregnant and immediately sought medical care. Her friend told her about the new Sexual Health Clinic in Whitehorse and she was able to see the nurse practitioner within a week. Her first appointment took place on the day abortion procedures were being offered at Whitehorse General Hospital and the procedure date two weeks later had been cancelled, therefore it would be at least four weeks until she could have the procedure.

The nurse practitioner explained the methotrexate/misoprostol regimen as a more timely option. Erin was not interested because she has had a history of difficult periods and was worried because it could take up to three weeks to complete the abortion process. But when she learned that she would only be able to have an aspiration abortion six weeks after her initial appointment, she opted for the medication route. She experienced severe nausea, pain, and cramping and managed these symptoms while working her full time job. After multiple visits to the hospital for blood work and follow-up visits to the clinic, clinicians determined that the medication abortion failed. After pleading with administrative medical staff, she was able to get on the schedule for an aspiration procedure four weeks after initially seeing the nurse practitioner. Because of all of the appointments, Erin felt she had to disclose to her boss that she was having an abortion. Her disclosure was met with judgment.

Erin spoke highly of her interactions with the abortion provider and the nurses at the hospital and had an IUD inserted on the day of the procedure. She stated that it was unfortunate that she saw so many staff and patients at the hospital that she knew. Erin characterized the process of obtaining the abortion as difficult overall; she felt there were so many steps involved and initially continuing the pregnancy actually seems easier in comparison. Erin had a follow-up visit with the abortion provider and discussed how she was having trouble bouncing back emotionally after the procedure. She later had an appointment at the Sexual Health Clinic and was referred to another counselor, which she found helpful.

CHAPTER 5: Article III: “There’s a lot of hoops that the women have to jump through to get to us”: Dynamics shaping abortion care in the Yukon

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ABSTRACT

Background: Although abortion has been decriminalized in Canada since 1988 and is covered as a medically necessary service through territorial health insurance schemes, anecdotal evidence suggests women in Canada’s north face significant barriers to accessing care. With a population of less than 34,000 spread across an area that is larger than California, geographic remoteness impacts health care access and quality in the Yukon.

Objectives: We aimed to explore the dynamics shaping access to abortion care in Yukon Territory, provide an opportunity for women and key informants to share their experiences, and identify possible avenues for improving service delivery.

Design: We conducted 16 semi-structured phone interviews with women who had an abortion while residing in Yukon on/after January 1, 2005 and 11 semi-structured phone interviews with key informants who have experience in reproductive and sexual health care in the territory. We analyzed both study components for content and themes using deductive and inductive techniques.

Results: Women face a number of structural, systems, and institutional barriers to accessing abortion services in the Yukon. Physician referral requirements, the need for several pre-procedure appointments, and the absence of a central location to obtain services make it difficult for women to navigate the territory-specific system. Challenges are further amplified if a woman is not residing in Whitehorse, the only location in Yukon Territory with an abortion providing facility.

Conclusions: Simplifying existing requirements for obtaining an abortion in the Yukon would ease the process for women seeking care and would be welcomed by providers. The recent registration of mifepristone could expand access to services.

Keywords: Canada, mifepristone, reproductive health, pregnancy termination

INTRODUCTION

Located in the northwest of Canada, Yukon Territory's land mass of 474,712 square kilometres contains a population of only 33,897 (1). Seventy-six percent of the population resides in Whitehorse, Yukon's capital. The remaining residents are spread across small communities, with health centres staffed primarily by community health nurses (2). When travelling to Whitehorse to access medical services from remote communities, costs for transportation and accommodation are reimbursed through medical insurance (3). Yukon's population is comprised of 23.1% Aboriginal peoples; registered Aboriginal peoples are covered under Non-Insured Health Benefits (NIHB), under the First Nations and Inuit Health Branch of the federal government, for most of their health care services, whereas territorial health insurance covers non-Aboriginal residents (4).

The geographic remoteness of northern populations creates barriers to accessing comprehensive health services, including sexual and reproductive health care. Since the decriminalization of abortion in 1988, Canada has witnessed a service delivery shift from hospitals to freestanding clinics. In 2014, nearly 60% of all abortions were performed in freestanding clinics and less than 16% of Canadian hospitals offered abortion care (5). However, private clinics are exclusively located in urban centres in Canada (6) and there are no freestanding clinics in Canada's three territories. In the Yukon, Whitehorse General Hospital is the sole abortion providing facility. Physician referral is required and the procedure is performed through 12 weeks' gestation (2).

Hospital-based abortion procedures may present challenges for both women and clinicians. For women accessing care, obtaining a physician referral can be problematic for women who do not have a family physician, are concerned about privacy, or encounter an anti-

choice doctor (7). Further, hospital-based procedures typically require multiple appointments over multiple days, a process that can be burdensome for patients. For clinicians, providing abortion care in hospital facilities in rural and remote areas is often complicated by scheduling and logistical issues, the attitudes of anti-choice co-workers and administrators, and overall isolation (6,7).

Our study aimed to document women's experiences obtaining abortion care and explore their perspectives on how services could be improved in Yukon Territory. We also aimed to explore key stakeholders' perspectives on the dynamics shaping access to abortion services in the Yukon and ways in which services could be improved.

METHODS

Our qualitative study is comprised of two components: in-depth interviews with women who obtained abortion care while residing in the Yukon and interviews with key informants working in the field of sexual and reproductive health in the region. JC, a MSc student at the University of Ottawa, conducted all interviews for both study phases between June 2015 and January 2016, after being trained by AF, a medical anthropologist and medical doctor with considerable experience in abortion-related research.

Data collection: In-depth interviews with women

We used a multi-modal recruitment strategy to recruit participants. Women were eligible to participate if they had had an abortion in the last ten years while residing in the Yukon, were over 18 at the time of the interview, were proficient in English or French, and had access to a telephone/Skype. Refer to Cano & Foster (2016) (8) for a detailed discussion of this study component, including recruitment strategies and semi-structured interview guide content.

Data collection: Key informant interviews

We recruited a purposive sample of key informants using publicly available contact information and professional affiliation. We also asked early participants to refer us to others. Using a semi-structured interview guide developed specifically for this study, we asked respondents about their professional backgrounds, experiences in sexual and reproductive health in the Yukon, insights on facilitators and barriers shaping access to abortion care, and suggestions for improving services. We conducted all interviews, which ranged from 30 to 60 minutes, over the phone.

Analysis

We audio-recorded all interviews, with permission, which we later transcribed verbatim. JC took notes during the interviews and formally memoed immediately afterward. The memoing process allowed us to reflect on interview-participant interactions, identify emerging themes, and establish thematic saturation for the first study component.

We employed an iterative multi-phase analytic process which centred on content and themes (9,10). We used ATLAS.ti to manage our data which consisted of transcripts, memos, and notes. In the first phase, we developed an initial code book using pre-determined codes and categories based on the interview guide and study objectives. In the second phase, we used inductive techniques to add codes and categories based on the data. In the third phase, we used assigned codes and categories to identify themes and form relationships between ideas. We analysed each component of the study separately and in the final analytic phase we integrated the findings, paying specific attention to concordant and discordant themes. Regular team meetings guided our analysis and we resolved disagreements through discussion.

Ethical considerations

We received research ethics approval from the University of Ottawa's Research Ethics Board (File#H-08-12-08 and File#03-15-25). Because we were not physically present in the Yukon, we were not required to obtain a Scientific Research License. In this paper we have masked or redacted all personally identifying information and have assigned pseudonyms to participants.

RESULTS

Participant characteristics

We conducted 16 in-depth interviews with women and 11 key informant interviews. Our 16 participants identified as Caucasian (n=9), First Nations, Métis, or Aboriginal (n=3), and a range of other races and ethnicities (n=4). Our participants were age 20 to 42 at the time of the interview and all but two of resided in Whitehorse at the time of the abortion. Our 16 participants reported on 19 abortions obtained in the Yukon over the previous decade. Our key informants included physicians, nurses, representatives from Anglophone, Francophone, and First Nations health organizations, and other decision-makers involved in sexual and reproductive health care initiatives in Yukon Territory.

Service fragmentation and provider shortages create difficulties to navigate the service

It was just the being sent from one person to the other thing that was shitty, but the actual interactions with people were good. (Erin, 34)

Overall, participants reflected positively on the care they received and the abortion providers with whom they interacted. However, our participants reported that the process of obtaining an abortion was complicated and involved multiple visits to different providers and facilities. Key informants described the standard process for obtaining an abortion in the Yukon as requiring an initial referral, at least one clinical visit for blood work and an ultrasound, a consultation with the abortion provider, a pre-operative appointment at the hospital in Whitehorse, and ultimately the hospital-based procedure itself. Women's experiences were consistent with this process; our participants reported an average of six visits. As Michelle explained,

[It] was like three different clinics. So there's medical imaging at the hospital, then there's...the clinic that provides the service, and there was my medical clinic. So this is [me] fielding phone calls from three different people.

Women were generally unaware that the overall process would require so many appointments and consistently referred to their care as fragmented. As one clinician explained, “There’s a lot of hoops that the women have to jump through to get to us.” For many of the women we spoke with, obtaining multiple appointments from different providers in different facilities resulted in significant delays in care. On average, women were able to obtain their abortion 27 days after making the decision and initiating the process. In some cases, delays appeared to result from the lack of coordination of care which created misunderstandings.

The challenges with fragmented care are exacerbated by the overall shortage of health care providers in the Yukon. Indeed, many women and key informants emphasized the need for more service providers of all types. The initial physician referral requirement creates barriers for women who do not have a family physician; key informants explained that they were seeing a growing number of abortion referrals coming from the emergency department. One physician discussed these challenges; “Whitehorse is struggling with people not having a family doctor, so the only access points are one walk-in clinic and the emerg, and now the sexual health clinic which is good.” This was echoed by Sofia who explained, “Like you know when you don’t have a family doctor, you just go to the different clinic and they do one part and they refer, but there is no person following my whole clinic story.” Jamie reflected on the hardships women would face without a family doctor:

I think of people who don't have a doctor here like what do they do? Do they go to a walk-in or emerg?...Because I have a doctor I can go to the office and you know cry in their office...or have somewhere to call, like I can't imagine if I didn't have a doctor.

A pharmacist also reflected on the ways in which the shortage of providers impacts access to services,

It's hard for people to get doctors so they tend to just make do with either the birth control method they've always used, which may not be appropriate for them anymore, or there may be more effective things that are available to them, but, if they are just seeing a walk-in doctor, those typically aren't the kind of conversations you have with a walk-in doctor, so, I think the main thing we need to focus on here is filling the gaps in our health care system and making sure that everyone, regardless of the day of the week, can get the health care that they need.

Hospital-based service provision complicates patient privacy

Then the next day then you go to the hospital and it's like Abortion [weekday] – everyone who's there is getting an abortion here. Everyone's names, you hear all their medical details, 'cause you're all in little rooms next to each other, like I recognized at least two or three people. (Alyssa, 26)

With a population of just over 26,000 (1) Whitehorse is considered a small town.

Women and key informants consistently reported that patients had high likelihood of running into acquaintances when seeking services, a dynamic that is not unique to abortion care.

However, the structure of hospital-based abortion care raised specific concerns regarding privacy and confidentiality. Notably, because abortion care is only provided on specific days each month women explained that they worried about seeing people they knew, including other abortion patients. Women also raised concerns about having all abortion patients in one waiting area and discussing their situation and medical history behind curtains rather than in private rooms. As explained by Heather, “I could hear all that stuff right, which is also not optimal, and like, everyone knew why you were there right, everyone who was in this area was all getting abortions.”

For women living in communities outside of Whitehorse, obtaining a referral for an abortion requires either a visit to the local nursing station or travel to Whitehorse. Privacy

concerns are exacerbated in these communities with small populations, as explained by a clinician,

There may be concerns for women out of town about confidentiality at their health centre. So they might not feel comfortable going to their health centre, or feel that they would want to come into town to get their referral, so can then create time, be a time barrier.

Given the multitude of appointments, women often have to make multiple trips from their community or stay in Whitehorse for several days. As a result, our two participants from outside of the Whitehorse area expressed challenges with finding transportation and concerns with keeping the abortion secret. As Danielle explained:

I booked hotel rooms, 'cause I could have stayed with someone [in Whitehorse] that I knew, but...I didn't really want a lot of people to know and so I just knew that I could just pay for everything and submit receipts and I'd get it all back.

However, women who lack the financial ability to front the costs of travel and accommodation and await reimbursement and women who do not have cars have far less flexibility in determining with whom to share their decision. As a women's representative remarked, "There's not greyhound bus or anything like that that goes from the communities into Whitehorse. So women, if they don't have their own vehicle have, somehow have to arrange a ride."

Few post-abortion counselling and support services exist for women in the Yukon

If there could be...a special counsellor just meant for that particular procedure, even at the hospital, even just someone just to talk to for a few minutes after the procedure in a private room, I think [that] would help. Or even if there's some kind of follow-up service then that would be like a huge bonus. (Alyssa, 26)

The majority of the women in our study suggested that some sort of follow-up care should be routinely offered after the procedure. Participants explained that they felt well-informed about the physical aspects of the abortion process. However, some women reported

that emotional supports were lacking and that after the procedure their contact with health service providers was abruptly cut off. Key informants expressed the challenges with the current “bare bones” abortion service, and the need for a more collaborative, comprehensive and streamlined service for women in the territory. One clinician articulated the current circumstances:

So we don't have a clear streamlined counselling availability. Women have to go find somebody if they need it afterwards which is not ideal. Like ideally there could be someone available to her onsite, right? Or that they just know they can go to right away if they've never been to one of the counselling places before. It's a barrier, it's a barrier to go to a new building, we all know that.

Five of our participants sought counselling after their abortion; four of them scheduled the sessions themselves or had a pre-existing relationship with a counsellor and one was referred for counselling during a follow-up appointment with the abortion provider. Three other women reported that they would have probably benefitted from post-abortion support, but did not access services. As Jamie explained, “I think like at the time I probably would have been like oh I don't need that but, yeah I think, because I really struggled afterwards I think it would have been nice to have somewhere to talk that's specific to [the abortion].”

Enthusiasm exists for the prospect of introducing mifepristone in the Yukon

Before I even went to the doctor someone had told me about the pill option, and right away I thought oh my god that would be so much better, then you don't have to go in the hospital, people don't have to see you there. (Jamie, 39)

Most of the women in our study were unfamiliar with mifepristone at the time of the interview, a finding that is not surprising given that the medication is not yet available in Canada. However, when we provided participants with information about a standard mifepristone/misoprostol protocol, 12 of the 16 participants reacted positively to this abortion

option being offered in the Yukon. Women consistently reported that the best features included the ability to avoid a hospital-based procedure and instrumentation, increased privacy, and decreased wait times. As Karen opined, “I just think you can also then be at home, the comfort of your home and not feel like holstered in these little enclosures.” Most women also reported that they would be comfortable receiving abortion care from a family doctor or nurse practitioner.

Key informants were overwhelmingly pleased with Health Canada’s recent approval of mifepristone, noting its clinical superiority to methotrexate/misoprostol both in terms of efficacy and time to completion. However, health care providers also expressed concerns that the cost would be prohibitive and women would not receive appropriate follow-up care. One clinician discussed considerations with providing the current available medication abortion in rural communities:

The biggest thing with any of the medical terminations is that women have to be pretty reliable to not get lost to follow-up. Because if it doesn’t work they have to go through with a surgical abortion, and so they can’t kind of go off the grid, kind of fall off the map. So it has to be the right woman that it would work for, and they still have to have an ultrasound, and they still have to have the ability to access medical care should they need to. So it tends to not be offered out in the communities.

As a practical matter, key informants also reported that the introduction of mifepristone may not alleviate barriers for women living in remote communities as community health nurses would not be able to dispense the medication, women would still have to travel into Whitehorse for an ultrasound, and the medical support needed to address complications is not yet available. However, both key informants and women repeatedly expressed an overall sentiment of optimism and resiliency, captured by the following statement by a nurse practitioner:

[T]here’s a real commitment to figuring out, and it’s kind of that Northern spirit of, well let’s just make it work. If this is broken let’s grab some duct tape and try this and do that, it’s that kind of, making something fit for life up in the North versus following sort of southern models that don’t always work as well.

DISCUSSION

In July 2015, Health Canada approved Mifegymiso® (mifepristone and misoprostol) for early pregnancy termination (11). Incorporation of the gold standard medication abortion method into the Canadian health system has the potential to significantly decrease geographic barriers to access. If offered by a range of providers at different service delivery points, mifepristone/misoprostol also promises to reduce the need for hospital-based provision of abortion care, decrease wait times, and increase privacy. Our findings suggest that there is enthusiasm about this option among both women and key stakeholders.

However, in contrast with the global body of evidence and the recommendations of the World Health Organization (12), Health Canada only approved Mifegymiso® for use through 49 days' gestation, for provision by physicians, and following a required ultrasound confirmation to exclude ectopic pregnancy and confirm gestational age (11,13). These restrictions are not aligned with evidence-based practices (12,14,15) and mute the potential of mifepristone/misoprostol to address the access barriers experienced by rural and remote populations. Supporting efforts to extend the gestational age limit, expand the pool of qualified providers that can offer the regimen, and develop high quality telemedicine services will be important for improving abortion access in the Yukon. Establishing feasible and appropriate follow-up infrastructure for different areas of the territory will be an important component of implementation. A study in California suggests that offering women options with regard to follow-up, either an in-person visit or telephone assessments, could reduce the percentage of patients lost to follow-up by allowing women to choose their preferred method (16).

Yet, even in the absence of enhanced medication abortion provision, women in Yukon Territory need transparent and streamlined abortion services. Allowing women to self-refer

eliminates the barrier of finding a physician to initiate the process, and giving abortion services in the territory a “medical home” would also aid in coordinating fragmented care. Dedicating a space within the hospital specifically for abortion services would create one central location for all appointments.

With persistent challenges of physician shortages in the Yukon, there is a need for expanded sexual and reproductive health services. The opening of the Sexual Health Clinic in Whitehorse in October 2014 marked an important step in expanding access to high quality services, including providing pap tests, contraceptive counselling, and information about and referrals for abortion care (17), thereby helping women in the Yukon navigate a complex system. Moving forward, this clinic has the potential to provide more comprehensive care, including incorporating post-abortion support services into current offerings and connecting women with other resources, such as Backline, that provide women in Canada with non-judgmental, non-directive phone based support.

Limitations

As is true of all qualitative research, our study was not intended to yield representative or generalizable results. Because we conducted phone/Skype interviews, women who lack access these technologies were unable to participate. Further, we did not have any Francophone participants. Consequently, the perspectives of this group, as well as other language-minority populations, are not included. The overwhelming majority of women in our study resided in the Whitehorse area at the time of their abortion. Many of the barriers we identified are likely even more significant for women living in smaller and/or more remote communities. Finally, women

reported on abortion experiences that took place over the last decade thus more recent changes in service delivery may not be reflective in their accounts.

Conclusions

With a number of barriers identified, strategies need to be implemented that cater to rural and remote populations. Facilitating efforts to streamline appointments, providing clear information to women, and creating a dedicated space for services to be offered would ease the process and prevent delays in care. The recent registration of mifepristone could serve to alleviate a number of barriers but the approved regimen limits this potential. Aligning the future provision of mifepristone/misoprostol with evidence-based guidelines, expanding provision to a range of qualified clinicians, and considering models of telemedicine, appear warranted.

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Chapter 6: Discussion

In this chapter I provide a discussion of the findings from my study, integrating findings from all three manuscripts. I also discuss of the role of reproductive justice in my research, followed by an outline of the significance of the findings. I provide an overview of my community dissemination project in April 2016 as well as recommendations informed by both the study findings and discussions with local stakeholders during the dissemination trip. Next, I discuss future work planned to share the study findings in the most effective ways. I conclude with a reflection of my own positionality and reflexivity as a researcher, strengths and limitations of the study, contributions from members throughout every step of this project, and concluding thoughts.

6.1 Integration of findings

The three articles in this thesis outline the overarching challenges to offering accessible, comprehensive, and timely medical care in the Yukon. Abortion services are offered through hospital-based care in Yukon Territory, as there is a small number of women accessing services relative to urban centres that have adequate numbers of patients daily to provide services through a separate freestanding clinic. With abortion services only being offered in the first trimester in the Yukon, women must access care in a timely manner in order to prevent having to leave the territory to obtain care. Providers in the Yukon are family physicians with advanced scope, rather than OB/GYNs, and have set this gestational limit as a safe measure with highly minimal risk that will allow them to keep their skill set up-to-date. With the small number of women obtaining care, the even smaller proportion of women who would be seeking second trimester abortion care would not allow them to keep their skill set in confidently and safely providing later term

abortion services. Furthermore, with the absence of OB/GYN support for providing induced abortion services in the territory, these aforementioned reasons justify the gestational limit currently remaining at 12 weeks 6 days’.

Without a dedicated space offering services, there is also not a central location that women can call to self-refer for their abortion. All abortion referrals must be provided in writing by a physician or a community health nurse; in some cases representatives from women’s organizations are able to make the referral if a woman presents to them. While the medical office assistant (MOA) in one of the abortion provider’s family practice books the surgical procedures through the hospital, this is not his or her primary role. Requiring a referral also puts the responsibility on other health care providers in the community to set up the woman’s blood work and ultrasound requisitions before initially meeting with the abortion provider.

Many women, even some with a family physician, had trouble navigating the process of appointments. Women faced challenges not only in obtaining the initial referral, but also receiving adequate information on what visits and consultations were required, and when and where those visits would take place. Women who were trying to keep their procedure private had difficulty scheduling appointments around other life commitments including school, work, and childcare. Getting all pre-procedure appointments completed, in combination with the procedure only being offered every other week, led to lengthy wait times that many participants were dissatisfied and upset with. Some women identified that obtaining the abortion later in their pregnancy than they would have liked may have contributed to the emotional difficulties they experienced after the procedure. Other women expressed the discomfort they experienced with physical pregnancy symptoms throughout the waiting period. Although women living in Whitehorse were not concerned with transportation to each appointment if they owned a car,

some experienced difficulties getting to and from the hospital on the day of the procedure, as they were not allowed to drive after being sedated.

Overwhelmingly, participants reacted positively to the idea of mifepristone being made available in the territory. Women opined that opting for a medication abortion sounded like a “simpler” route and could have alleviated a number of the barriers identified above, including lessening wait times and number of appointments, avoiding a surgical procedure with sedation, and increasing privacy. While key informants were pleased with Health Canada’s approval of Mifegymiso®, they expressed logistical and practical concerns about the out-of-pocket cost and the follow-up infrastructure. They also stated that it would most likely not alleviate geographic constraints to care for women in rural and remote communities under Health Canada’s current restrictions for provision.

Results from all three articles demonstrate the differences in health care access between women living in Whitehorse and women living in communities outside of Whitehorse. Barriers to accessing sexual and reproductive health services that were identified among women living in the territory’s capital are likely amplified for women living outside of the city. When assessing territory-wide reproductive health measures, such as teenage pregnancy rates and sexually transmitted infection rates, it is difficult to ascertain whether these indicators are more representative of populations living in urban or rural communities in Yukon.

6.2 Reproductive Justice

6.2.1 Definition and brief history of reproductive justice

In order to comprehensively explore sexual and reproductive health care service delivery, a discussion of the reproductive justice framework is warranted. Reproductive justice (RJ) is

rooted in a history of slavery, civil rights, and coercion pertaining to contraception and sterilization (Gilliam et al., 2009). RJ addresses reproductive rights within a social context, placing emphasis on historically marginalized populations. A reproductive rights framework centers on ensuring everyone has access to sexual and reproductive health care services including contraception and abortion, and that everyone has the freedom to make reproductive choices (Gilliam et al., 2009). RJ takes a broader scope than reproductive rights by acknowledging that a woman cannot exercise her reproductive rights with barriers such as lack of resources, lack of access to services, inequalities, disrespect over her reproductive decisions, and other injustices, preventing autonomy over reproductive health decisions (Christler, 2014). RJ aims to empower women who have been subject to reproductive coercion and discrimination, such as poor women, women of colour, and incarcerated women. Empowering these diverse communities of women requires identifying, acknowledging, and addressing injustices in reproductive rights on the basis of historical, social, and economic factors influencing these marginalized populations (Gilliam et al., 2009).

6.2.2 Reproductive justice and research

As an academic researcher, I can advocate, raise awareness and promote education through a RJ framework, with the goal of ultimately reducing or eliminating social and economic barriers to sexual and reproductive health services (Guilliam et al., 2009). My study focuses on women living in rural, remote, and northern regions, and aims to incorporate perspectives of cultural or language minorities. Through this framework I aim to use my research to promote equality among all women, historically marginalized or not, ensuring they have complete freedom over their reproductive choices and health status. My qualitative research study aimed to

identify facilitators and barriers to abortion care so that access can be improved; engaging with local stakeholders on my dissemination trip outlined below served to expand the implications of my research and identify specific and practical recommendations for future sexual and reproductive health care priorities. I plan on disseminating my study findings in socially relevant and effective ways so as to evoke improvements in reproductive health care quality and access in Yukon Territory.

6.2.3 Reproductive justice in Yukon Territory

Although abortion has been legal without restriction in Canada since 1988 (Kaposy, 2010), reproductive justice addresses the inequalities in access for women living in rural and remote regions. As demonstrated above, women in Yukon Territory face a number of barriers to accessing a fragmented health care service. While the surgical procedure is covered by territorial health insurance, women face indirect costs for missed work, missed school, and childcare due to the large number of appointments required leading up to the procedure. Participants outlined direct costs that include taxi fares and contraception if they do not have private insurance coverage. First Nations women do not have to pay for contraceptive methods as they are covered under Non-Insured Health Benefits (NIHB) (Health Canada, 2016). Women travelling into Whitehorse from rural and remote communities in the territory must front the costs for travel and accommodation, and must leave their community for multiple days. First Nations women funded under NIHB submit travel and accommodation receipts for reimbursement in a similar manner to non-First Nations women, including funding travel for medical or non-medical escorts if a health care provider determines it to be necessary (Yukon Health and Social Services, 2015). Direct costs for First Nations women are coordinated and determined on a case-by-case basis through

the woman's local health centre; arrangements are made if a woman cannot front the costs. Coordinating transportation to and a lengthy stay in Whitehorse may impact a woman's decisions of disclosure.

While privacy concerns undoubtedly arise when obtaining health care services in a small town, the added stigma and shame that is historically attached to abortion exacerbate women's experiences obtaining care. The requirement of a physician referral increases the likelihood of a woman encountering an anti-choice or unsupportive clinician, rather than obtaining care from a dedicated reproductive health care provider at the first point of contact. The stigma related to abortion care in comparison to other health care services may complicate the process of attending multiple appointments over a lengthy period of time for women that would prefer to keep their situation private. Furthermore, many participants identified the need for follow-up care; without professional counselling and support resources routinely offered after the procedure, women may not have the opportunity to speak about their experience if they do not feel comfortable sharing with non-professional supports in their lives.

The hoops that women living in Yukon must jump through in order to obtain a medical necessary service are an issue of reproductive justice. With the existing constraints of accessing care at one providing facility in the entire territory that offers first trimester abortion services twice a month, "reproductive rights remain, but reproductive justice is diminished" (Christler, 2014, p. 207) for women in the territory. With the fragmented, multi-step process, key informants describe the service as "bare bones". The service faces challenges to offering comprehensive services with the low number abortions performed in territory annually, however improvements can be made in a way that is still practical and realistic for this northern territory. Yukon women need access to a dedicated abortion facility, offering a well-informed and

streamlined service, staffed with an interdisciplinary team offering all aspects of pre and post care in a woman-centered approach. Women throughout the territory deserve access to high quality abortion medication, with provision aligning with the most current evidence-based practice.

6.3 Significance and implications of findings

6.3.1 Community engagement and dissemination trip

As action research values collaboration with nonresearcher participants (Small, 1995), I incorporated a community engagement and dissemination trip into my project. In April 2016 I travelled to Whitehorse, Yukon Territory to meet with my key informants and other relevant stakeholders. The key informants that I spoke with during recruitment and data collection were enthusiastic about the study and eager to hear about my findings. During this visit, I coordinated meetings and presentations with stakeholders in the community who are involved in sexual and reproductive health care and women's initiatives in Yukon. During my stay I met with both abortion providers, a reproductive health group, a number of family doctors who provide obstetrical care, an OB/GYN, and a government representative from Yukon Health and Social Services. At each of these meetings I distributed an executive summary of the study findings to all interested stakeholders. This key informant report can be found as Appendix B.

The abortion providers were receptive to my findings and recommendations. We discussed feasible improvements to the service going forward including adding a follow-up phone call to care for women who consent; this service could likely be offered by staff through the Yukon Sexual Health Clinic. The providers expressed the need for their own ultrasound machine, allowing them to perform a point-of-care ultrasound to aid in streamlining the service,

however this would be a large financial investment. The providers also informed me that they will soon be improving their data intake software and receiving assistance from a data analyst in order to collect more accurate statistics on the service.

The reproductive health group, consisting of clinicians, representatives from women's groups, and government representatives, were involved in the preparation and implementation of the Yukon Sexual Health Clinic; these committee members have been long time advocates for improvements to abortion care in the Yukon. The government grant that is currently funding the Yukon Sexual Health Clinic in Whitehorse will be reassessed in 2017. During this committee meeting we discussed strategies to further disseminate the study findings as well as future priorities for the committee's agenda going forward. Sharing our study findings with policy stakeholders in Yukon will reinforce the demonstrated need for a clinic of this nature, notably a resource that provides low-cost contraceptives, pap tests, options counselling, and abortion referrals for women without a family doctor.

I also had the opportunity to present at a Continuing Medical Education meeting that a number of the local family physicians, who also provide obstetrical care, attended. One of Whitehorse's three OB/GYNs was also in attendance. I provided a brief overview of my study and the main findings. This was a great opportunity for the physicians to ask questions and hear perspectives from women who present to their family physicians for abortion referrals.

Lastly, I met with a representative from the Health and Social Services sector of the Government of Yukon. We discussed the implementation of mifepristone in the territory, including the need for insurance coverage of the medication, as the out-of-pocket cost will be a major barrier to use for many women who may prefer to have a medical abortion over a surgical/aspiration abortion. It is still unclear whether various health insurance schemes will

cover all or a portion of the cost of mifepristone. It is possible that cost will vary depending on women's health insurance coverage (territorial medical insurance, private insurance, or NIHB for status Aboriginal peoples). The government representative was pleased to use my study as recent evidence to refer to going forward. All of the stakeholders that I spoke with are keen to see the future publications from our study, which will aid in informing their future initiatives.

6.3.2 Dissemination activities and future work

In addition to my community engagement and dissemination trip, I intend to disseminate my findings through multiple avenues, including submitting to peer-reviewed journals, presenting at academic conferences, and engaging with sexual and reproductive health organizations and media outlets. Consistent with the action research framework, I will disseminate my results through appropriate, relevant, and effective mediums with the aims of directly benefitting sexual and reproductive health care services in Yukon Territory. Guillam and colleagues (2009) suggest that academic researchers working under a reproductive justice framework can partner with advocacy organizations with similar agendas to develop shared policy messages, allowing study findings to reach farther distances and other sectors. Just as I engaged with local and national reproductive health advocacy organizations when recruiting for this study, I will engage with these organizations for dissemination activities.

I was accepted to present my thesis findings at two conferences this spring. In April 2016 I attended the National Abortion Federation (NAF)'s 40th Annual Meeting in Austin, Texas. NAF is the professional organization of abortion providers and researchers in Canada, United States, Mexico City, and Columbia (National Abortion Federation, 2015a). I presented in-depth interview findings from CAS at the Canadian Abortion Providers' Annual Meeting along with

Dr. Foster and Kathryn LaRoche, the CAS study coordinator. I also presented a poster of my findings from both phases of the study. In May 2016 I presented a poster at the Women's Xchange Spring Event in Toronto, Ontario. I engaged with stakeholders in women's health, providing a background on the context of abortion provision in the country to those who were not familiar, and describing the findings in Yukon Territory, emphasizing the added challenges in abortion provision for populations outside of southern urban centres.

Canada's annual March for Life took place across the country on May 12, 2016; pro-life and anti-choice advocates gather across Canada to protest against abortion services. This rally is also an opportunity for pro-choice advocates to engage with media agencies to discuss access barriers to the service. This year myself, Dr. Foster, and a number of other abortion researchers and sexual health agencies in the Ottawa area collaborated to make ourselves available to the media to provide a pro-choice perspective. Furthermore, my study was referenced in an article in *Yukon News*, a local newspaper, as part of the coverage on the March for Life rally in Whitehorse. This article brought to light the need to improve services in the territory.

Lastly, I will be preparing a separate report to distribute to my participants who expressed interest in receiving a copy of study findings. Below I provide a discussion on concrete recommendations to abortion service delivery in Yukon Territory as a product of the study findings and meetings with stakeholders.

6.4 Recommendations

6.4.1 Exploring models of telemedicine

Models of telemedicine, also known as telehealth, offer a unique strategy for health care service delivery for rural and remote populations. Telemedicine uses information technologies to

link patients to a range of health care providers and services from a distance through communication (Romanow, 2002). As the implementation of mifepristone in Canada is still in the preliminary stages, meetings with stakeholders did not include discussion of telemedicine strategies with regards to service delivery of medication abortion and other sexual and reproductive health services. However, with the potential that this method provides in a geographically vast country, further discussion is warranted. The Commission on the Future of Health Care in Canada, also known as the Romanow Report, discusses that telehealth applications not only have the ability to reduce hardships for the patient, but can also provide professional and continuing education opportunities for clinicians, and can aid in reducing the burden on Yukon Territory's medical travel plan (Romanow, 2002). Yukon's total medical travel costs rose from \$4.9 million in 2004 to \$8.5 million in 2008 (Office of the Auditor General of Canada, 2011), outlining a need to consider creative strategies to target this rise in costs. The Yukon TeleHealth Network currently links 14 Yukon communities with telehealth workstations, offering programs such as diabetes education and addictions counselling. Using telehealth could link women in rural communities to a health care provider via teleconference, for the purposes of options counselling and abortion referrals when faced with an unplanned pregnancy. Expanding reproductive health services into the scope of telemedicine in Yukon, where feasible, would offer women with a more private and convenient option instead of interacting with their local community health nurse or travelling to Whitehorse.

As demonstrated in Chapters four and five, women in the Yukon may prefer medication abortion to aspiration/surgical abortion if the former is available to them. Literature demonstrates that medication abortion can be successfully provided through telemedicine. This avenue could be particularly important in increasing access to Mifegymiso® for women living outside of

Whitehorse, and could still offer provision by a physician as per Health Canada's requirement. A study in Iowa found that three quarters of women who visited a clinic and consulted a physician via teleconference were satisfied with their experience, and there were no significant differences in adverse side effects when compared to women who saw a physician in-person (Grossman et al., 2011). Although women may still have to travel into Whitehorse for a dating ultrasound to confirm the gestation of the pregnancy, mifepristone could still shorten the length of stay in Whitehorse and the number of appointments and/or trips required. A study in British Columbia assessing medical abortion via teleconference used serial quantitative hCG tests instead of an ultrasound to confirm the pregnancy and the completion of the abortion (Wiebe, 2013). Assessing models of medical abortion that do not require a dating ultrasound would offer further accessibility for women living in rural and remote areas.

6.4.2 The importance of collaborative care

Since opening in fall 2014, the Yukon Sexual Health Clinic has been an important avenue for increasing access to sexual and reproductive health care services in the territory. The Sexual Health Clinic, along with a second Women's Midlife Health Clinic focusing on menopause care, is funded for three years through a Collaborative Care Initiative grant supplied by the Government of Yukon (Government of Yukon, 2014). This territorial grant demonstrated the government's priority to move towards a more collaborative approach to health care service delivery; stakeholders involved in developing the proposal for the Sexual Health Clinic stated that incorporating a nurse practitioner into the clinic design made them competitive candidates when applying for the grant.

Yukon Territory was the last jurisdiction to pass legislation allowing licensure of nurse practitioners (Yukon Registered Nurses Association, 2016). Legislation was passed in November 2012, and as of 2013, there were four nurse practitioners registered in the territory (Canadian Nurses Association, 2013). Allowing nurse practitioners to work their full scope of practice in the territory can aid in alleviating current strains on the health care system, increasing efficiency for patients to access primary care. The Romanow Report outlined the issue of physician shortages and lack of equal distribution across the country, along with the challenges of creating financial incentives and educational opportunities to alleviate these shortages (Romanow, 2002). The report emphasized that exploring collaborative approaches to health service delivery could be a more promising solution, making recommendations to expand training opportunities for a range of rural health care providers in rural and remote settings (Romanow, 2002). Implementing collaborative initiatives will maximize benefits from the skills of an interdisciplinary team of health care professionals. The Yukon Sexual Health Clinic has received great uptake in its first year under the lead of a nurse practitioner and just added on one additional nurse practitioner in April 2016 in order to expand clinic hours (Yukon Sexual Health Clinic, 2016). This new clinic would be an appropriate avenue for the territory to offer more comprehensive sexual and reproductive health services through an interdisciplinary team of health care professionals. The clinic could expand hours and offer services such as sexual education seminars and post abortion support.

6.4.3 Follow-up services

Although participants obtained their abortions for numerous reasons, had a variety of different support systems, and experienced an array of different emotions throughout the process

and after the procedure, the majority of women identified a need for follow-up care, or at least for services to be routinely offered. The National Abortion Federation outlines informed consent and counselling procedures in its clinical guidelines (National Abortion Federation, 2015b). The guidelines stipulate that each patient must be fully informed of the procedure, have an opportunity to address their questions and concerns, and be provided with sufficient information and resources regarding contraception and aftercare. The patient must sign documentation affirming “that she understands the procedure and its alternatives, the potential risks and benefits, and that her decision is voluntary” (National Abortion Federation, 2015b, p. 2). While the pre-procedure counselling for abortion care is quite standard across the country, and Yukon participants described the consultation as informative, professional, and supportive, there is less standardization with post-abortion support.

A study by Kimport and colleagues (2012) assessing phone-based post-abortion support found that some women appreciate and need a space outside of politics to discuss their abortion experience. This service should be available to women on a voluntary basis, and not mandated, given that women experience a range of emotions following their abortion, and many do not feel the need to reach out for support beyond their personal networks. Furthermore, in order to offer women more comprehensive abortion care, abortion service providers could collaborate with talk lines dedicated to pregnancy and abortion support, such as Backline, by including resource information in a pamphlet to send home with women after their procedure. A phone service for follow-up care would be a practical and feasible service for women in the Yukon, as it provides them with emotional support, but does not involve scheduling yet another appointment. Yukon women should still be able to connect with local in-person counselling services if needed and desired, however offering resources for non-biased, non-judgmental phone-based support should

be another routinely offered form of post-abortion care. Wiebe and Hamidizadeh (2011) found that women who opted to receive a follow-up phone call after their abortion found the call helpful, even though very few participants experienced serious emotional difficulties. The follow-up phone service with a counsellor was found to be a very feasible service to incorporate into care. As discussed during my in-person meetings in Whitehorse, stakeholders agree that this could be a feasible addition to abortion care in the territory. With a second nurse practitioner recently added to the Sexual Health Clinic, there is flexibility to expand the range of services that the clinic can provide.

6.5 Positionality and Reflexivity of the Researcher

Before beginning data collection, I underwent extensive training in conducting qualitative interviews, both through didactic and hands-on experience. In my first year coursework, I completed a qualitative methods module instructed by Dr. Foster. During this module we reviewed literature that provided techniques on designing and conducting qualitative studies. We performed in-class exercises and completed assignments that allowed us to identify strengths and weaknesses in our interview skills, and to remain conscious of our influences as a researcher during interviews. I also participated in a two-day qualitative methods workshop to further develop skills in drafting in-depth interview guides, conducting interviews, and coding content. Furthermore, for my directed study in the first semester of this program, I trained and assisted in conducting interviews for the Canada Abortion Study. I first observed our lead study coordinator conducting interviews and then conducted my own interviews with assistance from my colleague. We discussed my strengths and weaknesses and I received guidance from my supervisor and more experienced colleagues before beginning to conduct interviews on my own.

After completion of these means of training and preparation as a qualitative researcher, I began recruitment and data collection for my own thesis. Through previous experience as a Crisis Line Responder with the Ottawa Distress Centre, and my training and guidance on CAS interviews from Dr. Foster and the CAS study coordinator, I have been commended on my calm tone and my ability to match how the interviewee is feeling/reacting. With these interview skills I created a respectful and comforting environment during phone interviews that allowed the participant to share the details of her experience, and provide further elaboration when probed.

As a qualitative researcher, I must be aware of my own values and attitudes and their association with my research field. Reflexivity involves “taking a critical look inward and reflecting on one’s own lived reality and experiences” (Hesse-Biber, 2007, p.22). It requires me to take my personal experiences into account to determine how my social background and assumptions may influence the research process. I acknowledge my values as a feminist in conducting this research, and my passion for improving women’s equality and women’s reproductive justice. I also acknowledge my lack of experience living in Canada’s north, and thus the importance of ensuring the participant is the expert in the phenomenon I am researching. As I analyze content and form themes, my beliefs, background, and emotions influence knowledge construction (Hesse-Biber, 2007); practicing reflexivity allows me to acknowledge my subjectivity in this process. Through introspection I can reflect on my identity, knowledge, and assumptions, and provide transparency to the reader regarding these influences throughout data collection and analysis.

Action research rejects positivist concepts emphasizing that the researcher should remain value free, and instead encourages acknowledgement of the influences of positionality. As a qualitative researcher, I remained aware of my influences throughout data collection and

analysis. After each interview, I formally memoed as a way to reflect on my influences and subjectivity on the interview. By remaining aware of my positionality, I made sure to clarify participant responses during in-depth interviews, in order to understand the meaning behind more ambiguous responses, rather than forming meaning based on my own assumptions (Britton, 1995). I transcribed all of my interviews, which also served as a way to reflect on my influences during the interview, such as remaining aware of the use of leading questions and how they can affect a participant's response (Britton, 1995). Taking all of these considerations into account during data collection and analysis enhanced the credibility and transferability of my results.

One example I came across in initial memoing and reflection when I began conducting my key informant interviews was my assumptions of northern populations and persistent challenges with health care. My agenda initially aimed to identify challenges health care providers face in contrast to health care delivery in the South. Through reflection I modified my wording of questions in order to document key informants' views without influence from my assumptive wording. Through reflection and modification, I realized that exploring avenues for improvement involves constructing unique solutions for the Yukon rather than implementing southern models of care in the territory.

6.6 Strengths and Limitations

This study has a number of limitations, but was also designed and conducted in a way to minimize these limitations. This study was not designed as a case study, although this method is common in qualitative health research (Hyett, Kenny & Dickson-Swift, 2014). As this study was part of a large scale national qualitative study of in-depth interviews with women, a territory-

specific case study was not consistent with the original design and methods of the overarching national study, nor was it necessary to address the outlined research objectives.

Interviews were conducted via phone/Skype, therefore participants who did not have access to these technologies would be unable to participate. For the first phase of the study with women, although interviews could be conducted in English or French, we did not have any Francophone participants. Thus, the experiences of this population and other language minorities were not documented. I did, however, purposively sample key informants from francophone organizations. Through these participants, I was able to explore two of my objectives: exploring insights on facilitators and barriers francophone women face when accessing sexual and reproductive health services, and exploring avenues for improving health services for this minority population in the Yukon. Although 23.1% of Yukon's population is Aboriginal (Statistics Canada, 2013), only three of my participants self-identified as Aboriginal, or partially Aboriginal. Once again, however, I purposively sampled key informants who had experience working in the health care sector with First Nations women, allowing me to document added insights on health care services for this population. The overwhelming majority of our participants resided in Whitehorse at the time of their abortion(s), and none of the participants obtained their abortion(s) outside of the territory. Barriers identified are likely more significant for women travelling into Whitehorse from smaller and/or more remote communities in the territory, and for women who must leave the territory if they are over the 12 week gestational limit. With the low annual numbers of Yukon women obtaining abortion services, participants could participate if they had an abortion in the last ten years. Some participants spoke of experiences that occurred many years ago, thus stories recalled may be missing relevant details and/or may not adequately portray more recent changes in service delivery. However, the

overwhelming majority of experiences occurred more recently, with only three participants obtaining abortions prior to 2011. Finally, as is true of all qualitative research, the small sample size of participants was not intended to be representative or produce generalizable findings, however the study was designed and conducted with rigor so as to produce import beyond the participant.

6.7 Statement of Contribution

I completed this study in partial fulfillment of the requirements for this degree, a Master's of Science in Interdisciplinary Health Sciences. As the Principle Investigator (PI), I designed study instruments for the key informant portion of the study, prepared and submitted a *de novo* REB application for the key informant phase, and prepared and submitted grant applications for funding. I coordinated recruitment efforts, conducted and transcribed all interviews, led the analysis and development of the three manuscripts, and coordinated local dissemination activities for my community engagement trip in Whitehorse.

This project would not have been possible without the significant contributions from others. Most importantly, my supervisor, Dr. Angel Foster, has guided me through the entire research process. She has been heavily involved throughout my data collection, analysis, and writing. Regular meetings with Dr. Foster guided the development of my thesis proposal, study instruments, REB application, grant applications, recruitment and data collection, analysis, preparation of manuscripts, and coordination of my dissemination activities. She reviewed my memos and transcripts, and we discussed codes, categories, and emergent themes throughout the analytic process.

As this study is embedded in a larger Canada Abortion Study, and I began my Master's after the nation-wide study was fully ongoing, there are a number of people that have contributed substantially to this project. As the Senior Investigator (SI) of the overall Canada Abortion Study, Dr. Foster led the design and development of initial study instruments and the REB application for the in-depth interviews with women, which I used as the base for CAS Yukon. The study coordinator for CAS, Kathryn LaRoche, guided me in my initial training with CAS recruitment and interviews. Other members of the CAS study team assisted in reflection and debriefing after interviews, as well as discussion during the analytic process.

Many of my key informant participants stepped forward to assist in the coordination of meetings and presentations for my community engagement and dissemination trip in Whitehorse. Local clinicians and community representatives were welcoming and hospitable throughout my stay in Whitehorse.

6.8 Conclusions

In Canada, one in three women will have an abortion over the course of their reproductive lives (Norman, 2012). Although abortion has been available in Canada without restriction since 1988, women do not have equal access to this medically necessary service (Kaposy, 2010). Women in Yukon Territory face added barriers to accessing comprehensive sexual and reproductive health services due to the unique challenges to health care service delivery in rural, remote, and northern populations. The study findings highlight the high quality abortion care offered by the providers in Yukon, but the fragmented, multi-step process that women are required to navigate in order to access the service. Women expressed concerns of privacy, lack of information, wait times, and lack of follow-up support when obtaining care.

Identified barriers are further exacerbated for women who do not have a family doctor, and women living outside of Whitehorse.

Women deserve a streamlined, transparent service provided by supportive and professional health care providers at every point of contact. Women deserve access to high quality evidence-based provision of medication abortion, offered at a range of service delivery points. While I am not proposing that a southern model of abortion care be implemented in the territory, I am advocating that there are avenues to explore that would be practical, feasible, and instrumental in improving access to and quality of abortion services in Yukon Territory.

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APPENDIX A: Map of Yukon Territory



Geology.com. (2016). *Yukon Territory May*. Retrieved from <http://geology.com/canada/yukon-territory.shtml>

APPENDIX B: Executive summary of findings for key informants

**Documenting women's experiences obtaining abortion care while
residing in Yukon Territory**

Executive Summary

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Executive Summary

Background

Although abortion has been decriminalized in Canada since 1988 and is covered as a medically necessary service through territorial health insurance schemes, anecdotal evidence suggests women in Canada's north face significant barriers to accessing care. With a population of less than 34,000 spread across an area larger than California, geographic remoteness impacts health care access and quality in Yukon Territory.

Study aims and objectives

This study aimed to explore the dynamics shaping access to abortion care in Yukon Territory and provide an opportunity for women to share their experiences and insights on possible improvements to care. This study also examines key informants' perspectives on facilitators and barriers to access and avenues for improving service delivery.

Methods

Between June 2015 and January 2016, we conducted 16 in-depth semi-structured phone interviews with women who have had an abortion, and 11 phone interviews with key informants working in the field of sexual and reproductive health in the region. Women were eligible to participate if they: (1) were aged 18 or older; (2) had an abortion on/after January 1, 2005; (3) resided in Yukon at time of their abortion; and (4) were proficient in English or French. We employed a multi-phase analytic process which centered on content and themes, using inductive and deductive techniques. We received research ethics approval from the University of Ottawa's Research Ethics Board (File#H-08-12-08 and File#03-15-25).

Findings

Participant characteristics

Of the 16 in-depth interviews conducted with women, we documented a total of 19 abortion experiences in the ten years prior to the interviews. Participants were aged 20 to 42 at the time of the interview. Women identified as Caucasian ($n=9$), First Nations, Métis, or Aboriginal ($n=3$), and a range of other races and ethnicities ($n=4$). All but 2 participants resided in Whitehorse at time of their abortion(s). We conducted 11 key informant interviews with physicians, nurses, and stakeholders from Anglophone, Francophone, and First Nations women's health organizations.

Service fragmentation is difficult to navigate

Overall, women reflected positively on the care they received and the abortion providers with whom they interacted. However participants found the process of attending multiple consultations and visits with numerous health care providers at various locations difficult. Women and key informants outlined a consistent process of six required visits. Women who did not have a family doctor had trouble finding information on the service initially. The average wait time from first point of contact to the day of procedure was 27 days.

It was just the being sent from one person to the other thing that was shitty, but the actual interactions with people were good. (34 years old, abortion in 2015)

Privacy concerns

Women expressed concerns about seeing acquaintances at the hospital, either staff or other women getting abortions, and were generally dissatisfied with pre-procedure care taking place behind curtains. Privacy concerns are further exacerbated for women living in communities outside of Whitehorse, who have to obtain a referral at their local health center, and must coordinate travel to Whitehorse for multiple days.

Then the next day then you go to the hospital and it's like Abortion [weekday] – everyone who's there is getting an abortion here. Everyone's names, you hear all their medical details, 'cause you're all in little rooms next to each other, like I recognized at least two or three people. (26 years old, abortion in 2012)

Post-abortion counselling and support services

Participants explained that they felt well-informed about the physical aspects of the abortion process. However some women reported that emotional supports were lacking; contact with health service providers was abruptly cut off after the procedure. Five participants sought counselling afterwards and 3 other participants reported that they would have probably benefitted from post-abortion support, but did not access services.

I think like at the time I probably would have been like oh I don't need that but, yeah I think, because I really struggled afterwards I think it would have been nice to have somewhere to talk that's specific to [the abortion]. (39 years old, abortion in 2015)

Enthusiasm for mifepristone

When we provided participants with information about a standard mifepristone/misoprostol protocol, 12 of the 16 participants reacted positively to this alternative option being offered in the Yukon. Women stated they would feel comfortable receiving abortion care from a family doctor or nurse practitioner. Key informants were pleased with Health Canada's recent approval of mifepristone, but expressed concerns surrounding cost, follow-up infrastructure, and that it may not alleviate barriers for women living in remote communities due to the requirements of physician-only provision and ultrasound confirmation.

I just think you can also then be at home, the comfort of your home and not feel like holstered in these little enclosures. (42 years old, abortion in 2012)

Discussion and recommendations

The study findings showcase the high quality abortion care offered by the providers in Yukon Territory, but also the fragmented, multi-step process that creates barriers to timely access. Women expressed concerns regarding lack of information, scheduling, wait times, and privacy when navigating and accessing abortion care. Challenges are further exacerbated for women who do not have a family physician or who reside in communities outside of Whitehorse.

Health Canada's restrictions on Mifegymiso® (physician-only provision, mandatory ultrasound, and 49 days' gestational limit) are not aligned with evidence-based practice. Supporting efforts to extend the gestational age limit, expand the pool of qualified providers that can offer the regimen, and develop high quality telemedicine services and follow-up infrastructure will be important for improving abortion access in the Yukon.

Women need a transparent and streamlined abortion service. Allowing women to self-refer and giving abortion services in the territory a "medical home" would aid in coordinating the fragmented care. Routinely offering women information on voluntary follow-up resources (such as Backline) would ensure more comprehensive care. The Yukon Sexual Health Clinic marked an important step in expanding access to sexual and reproductive health services in the territory, and residents would benefit from an expansion in hours and a more interdisciplinary team offering care.

[T]here's a real commitment to figuring out, and it's kind of that Northern spirit of, well let's just make it work. If this is broken let's grab some duct tape and try this and do that, it's that kind of, making something fit for life up in the North versus following sort of southern models that don't always work as well. (Key informant)