Exploring the Journey of Mifepristone in Canada and Australia

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Abstract

Mifepristone, also known by its drug development name RU486, is an anti-progestin that is part of the gold standard regimen of medication abortion. This medication is taken orally to induce an abortion through 70 days after the first day of the pregnant person's last menstrual period. When mifepristone is used in conjunction with misoprostol, a prostaglandin analog that induces uterine contractions and causes cervical softening, the regimen results in a complete abortion about 98% of the time. France first registered mifepristone for use as an early abortifacient in 1988. Mifepristone has subsequently been introduced in more than 60 countries and used by over 40 million women worldwide. The promise of mifepristone to expand access to abortion care stems from the fact that it can be safely provided by a variety of clinicians, including family doctors and nurse practitioners, in a wider variety of settings than instrumentation abortion procedures. In addition, the regimen is safe, effective, cost-effective, and highly acceptable to patients. Canada and Australia are two countries that have recently made mifepristone available after drawn-out drug approval processes. In Canada, mifepristone was registered in 2015 and became available in 2017; in Australia, mifepristone was approved for commercial import in 2012. This thesis uses qualitative methods to explore how the introduction of mifepristone has impacted the service delivery landscape of abortion care in Canada and Australia, with a specific focus on patient experiences. In addition, this thesis examines how different regulatory settings and barriers condition access to abortion care and aims to generate policy-relevant insights for improving access to medication abortion.

Résumé

Mifépristone, ou RU486, est une antagoniste des récepteurs à la progestérone et elle est comprise dans le régime pour l'interruption volontaire de la grossesse (IVG) médicale. Ce médicament se prend oralement afin d'induire une IVG jusqu'au 70^{e} jour depuis les dernières règles. Lorsque la mifépristone est prise en combinaison avec le misoprostol, une prostaglandine synthétique qui provoque des contractions et la maturation du col de l'utérus, ce régime a un taux de succès de 98%. La France a enregistré la mifépristone comme médicament abortif en 1988. Depuis ce temps, la mifépristone a été introduite dans plus de 60 pays, et utilisée par plus de 40 millions de femmes globalement. La mifépristone peut avoir un impact considérable sur l'accessibilité de l'IVG puisqu'elle peut être distribuée par plusieurs cliniciens, incluant les médecins de familles et les infirmières praticiennes, avec une plus grande capacité que les IVG instrumentales. De plus, ce régime est sécuritaire, efficace, a un bon rapport coût-efficacité, et très bien supporté par les patients. Le Canada et l'Australie sont deux pays qui ont récemment autorisé la distribution de la mifépristone, suivant un délai considérable du processus d'approbation. Au Canada, la mifépristone a été enregistré en 2015, et rendue disponible en 2017; en Australie, mifépristone a été approuvée pour l'importation commerciale en 2012. Cette thèse emploie des méthodes de recherche qualitatives afin d'explorer comment l'introduction de la mifépristone a eu un impact sur la prestation de services de l'IVG au Canada et en Australie, avec un accent sur les expériences des patientes. De plus, cette thèse examine comment les différentes régulations et obstacles conditionnent l'accès aux IVG et vise à générer des connaissances sur les politiques pour améliorer l'accès à l'IVG médicale.

Acknowledgements

I am immensely grateful for all of the support and guidance I have received throughout my graduate training at both the University of Ottawa and Macquarie University. While writing a dissertation is an individual task, I would never have been able to accomplish it without the time, help, and effort of many people.

Chiefly, I am deeply indebted to my dissertation supervisor at the University of Ottawa, Dr. Angel M. Foster. I first started working with Dr. Foster during my undergraduate degree and she has been instrumental in defining my career and the path of my research. I have learned so much about scholarship and mentorship from her, and I will never be able to adequately express my appreciation for the time and energy she invested in me to help me reach my personal and professional goals. Dr. Foster offered steadfast support throughout my entire program and I am profoundly grateful to have had the opportunity to learn from her and work alongside her. As I complete this degree and move onto the next stage of my career, I will forever be thankful to Dr. Foster for taking a chance on me when I was 20 years old and knew very little about – but was deeply committed to – conducting research about reproductive health in Canada. I would not be where I am today without her.

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I gratefully acknowledge the funding I received towards my doctoral studies from the Canadian Institutes of Health Research, the Society of Family Planning, the Women's College Hospital, and the Department of Anthropology at Macquarie University, and various conference travel grants from the University of Ottawa.

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I owe a heartfelt thank you to my friends and colleagues – and so many colleagues who have become dear friends – throughout this process. It has been a privilege to learn with and from people who are so passionate about their work, rigorous in their research, and generous

with their time. I feel fortunate to have always been surrounded by such a tremendous group of people.

I am grateful to my partner Brian who has, from day one, been unequivocally supportive of my work, dreams, and future plans. I am immensely thankful for his understanding and all the days he believed in me more than I believed in myself.

Lastly, I would like to thank all of my participants who shared their stories with me as a part of the various research projects that comprise this dissertation. Without them, none of this work would have been possible.

Preface

I completed this project in partial fulfillment of the requirements of a Cotutelle Doctor of Philosophy in Population Health at the University of Ottawa, Canada and Anthropology at Macquarie University, Australia. A Cotutelle doctoral program is a collaboration between two universities. I was jointly supervised by a thesis supervisor at each institution, and spent a minimum of 12 months attending each university.

Ethical Considerations

The data collected as a part of Chapters 4, 5, and 6 were covered under a previous application to the University of Ottawa Health Sciences and Science Research Ethics Review Board (File #S-04-18-551, Appendix A). I submitted a de novo application for my key informant interviews (included in Chapter 3) to the uOttawa Social Sciences and Humanities Research Ethics Board (File #03-18-11, Appendix B). I also submitted a *de novo* application to the Human Research Ethics Committee at Macquarie University for all of the data that I collected while in Australia (file #3491, Appendix C).

Statement of Contribution

This dissertation contains eight manuscripts. At the time of submission, four manuscripts have been accepted for publication. This includes Chapter 3, which has been published as a chapter in the peer-reviewed volume *Abortion, politics, and the pill that promised to change everything: the global journey of mifepristone* by Palgrave MacMillan. Chapters 4 and 7 have been published in the journal *Contraception*, and Chapter 5 has been published in the open-access journal *FACETS*.

An additional two manuscripts are currently under review. Chapter 9 is currently under review at the journal *Contraception*, and Chapter 6 is under review at *Women's Health Issues*. Chapter 8 has been accepted at the Australian journal *Public Health Research and Practice*; Chapter 10 is formatted for the journal *Medical Anthropology Quarterly* and we plan to submit it for review soon.

In conjunction with my supervisors, I conceptualized the study design and designed the study instruments. I conducted the primary data collection in both Canada and Australia and carried out data analysis for all components of the project.

Some of the interviews used in Chapter 5 and 6 were previously conducted as a part of my supervisor's project, the Canada Abortion Study. I was the Study Coordinator of this national qualitative study and was directly involved in data collection. I conducted an independent analysis of the data and integrated it with the data that I had collected specifically for this thesis.

I also led the drafting of all eight manuscripts. My supervisor(s) reviewed and contributed to the qualitative data analysis, contributed to and approved the submitted manuscripts, and supervised me through all components of this project.

My graduate research was supported by the Canadian Institutes for Health Research (2017-2019), an Ontario Graduate Scholarship (2017), the Society of Family Planning (2017-2018), the Women's College Hospital of Toronto (2017), various travel grants at the University of Ottawa, and the Department of Anthropology at Macquarie University (2019). The conclusions and opinions expressed in this dissertations are those of the authors and do not necessarily represent the views of the organizations with which the authors are affiliated or the funders.

Statement of Originality

This thesis is being submitted to Macquarie University and the University of Ottawa in accordance with the Cotutelle agreement dated 8 June 2018. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

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ACT	Australian Capital Territory
ARCC	Abortion Rights Coalition of Canada
CADTH	Canadian Agency for Drugs and Technologies in Health
CARAL	Canadian Association for the Repeal of the Abortion Law
CAPS-CPCA	Canadian Abortion Providers Support – Communauté de pratique Canadienne sur l'avortement
CAS	Canada Abortion Study
CME	Continuing Medical Education
FNIM	First Nations, Inuit, and Métis
GP	General practitioner
GTA	Greater Toronto Area
LBGTQ+	Lesbian, gay, bisexual, trans, and queer
LMP	Last menstrual period
NAF	National Abortion Federation
NGO	Non-governmental organization
NP	Nurse practitioner
NDP	New Democratic Party
NSW	New South Wales
OBOC	Our Bodies, Our Choices
PBS	Pharmaceutical Benefits Scheme
PTAS	Patient Transfer Assistance Scheme
RJ	Reproductive justice
SNDS	Supplement to a new drug submission

SOGC	The Society of Obstetricians and Gynaecologists of Canada
SRHR	Sexual and reproductive health and rights
TAC	Therapeutic Abortion Committee
THS	Tasmanian Health Service
TGA	Therapeutic Goods Administration
US	United States
WHO	World Health Organization

Chapter 1:

General Introduction

General Introduction

Abortion is one of the most common medical experiences worldwide, with approximately 25% of pregnancies ending in an induced abortion (Singh et al., 2018). Between 2010 and 2014, this meant that an estimated 56 million abortions occurred globally each year (Singh et al., 2018). Despite the fact that 45% of abortions that occur annually are considered to be unsafe, abortion is not inherently dangerous (Singh et al., 2018). Extensive research has documented the safety of abortion for both physical and mental health (Major et al., 2009; Paul et al., 2002; Raymond & Grimes, 2012; Steinberg et al., 2014). Instead, the continued stigmatization and politicization of abortion has created uneven access to the procedure globally and resulted in the proliferation of unsafe methods and practices to terminate a pregnancy. Indeed, there is ample evidence to demonstrate that policies intended to restrict access to abortion are only successful in restricting access to safe abortion care (Sedgh et al., 2012; Shah & Ahman, 2009).

First trimester abortion care, which accounts for the vast majority of procedures, can safely and effectively be provided in primary care settings (Amico et al., 2018). Yet, despite this evidence, in many countries around the world, the majority of abortions take place in freestanding clinics (Baird, 2017; Jones & Jerman, 2013; Norman, 2012). This model of care emerged in response to efforts of both abortion advocates and opponents, and the abortion clinic has become a sort of institution in its own right (Joffe, 2009; Kimport et al., 2012).

In the most pragmatic sense, the advent of the freestanding clinic was a necessity, as many hospitals and other health care settings refused to provide abortion care (Kimport et al., 2012). The specialized nature of freestanding clinics also means that they can often offer care to patients at a reduced cost and providers are able to maintain surgical competency more easily (Limacher et al., 2006).

Despite these considerations, the model presents a paradox with regards to security and stigma. Patients at a freestanding clinic have increased assurance that staff are supportive of abortion rights. Similarly, staff at the clinic experience a comparable assurance from their colleagues and patients. Yet, these sites are also more vulnerable to anti-abortion picketing, protests, and violence because they are easy to identify. While the majority of reported anti-abortion violence has occurred in the United States, there have also been documented instances in Canada, Australia, and New Zealand (ALRANZ Abortion Rights Aotearoa, 2011; Douglas & de Costa, 2015; Grimes et al., 1991; LeBourdais, 1995). Some jurisdictions have introduced so-called "bubble zone" or "safe access zone" laws in response to ongoing anti-abortion picketing and harassment (Kaposy, 2010).

Beyond issues of security, the clinic model also has broader implications for the ways that we talk about and conceptualize abortion. While the model emerged as a response to stigma and violence, the success of the freestanding clinic means that abortion continues to be siloed from other kinds of routine health care. Kumar and colleagues argue that this contributes to "social norms that treat the practice of abortion and the women who have them has deviant and non-normative" (Kumar et al., 2009, p. 634)

From a health equity perspective, the clinic model is insufficient. Abortion clinics tend to be located in major metropolitan areas, and barriers to access are often amplified for young, rural, and low-income abortion seekers (Jones & Jerman, 2013; Olukoya et al., 2001; Sethna & Doull, 2007). Providing care in a select number of centralized locations means that those seeking abortion care are often required to travel long distances, which can increase both direct and indirect financial costs (Jones & Jerman, 2013; Sethna & Doull, 2007, 2013). There is also a social cost for abortion seekers associated with having centralized services, as they may have to

access care outside of their communities, navigate issues of disclosure, and have major concerns about privacy (Foster et al., 2017). Studies from around the world have consistently found that many women would prefer to have their abortion in a primary care setting (Vogel et al., 2016; Weitz & Cockrill, 2010; Yanow, 2013).

For these reasons, medication abortion has been lauded as having great potential to disrupt the way in which abortion care has historically been delivered, and in turn, increase access. Medication abortion is a set of pills that can be used to safely and effectively terminate a pregnancy up to 70 days' gestation (Sanhueza Smith et al., 2014). The recommended regimen from the World Health Organization (WHO) consists of two types of pills: one called mifepristone and another called misoprostol (World Health Organization, 2012). Taken together, the regimen is safe, effective, highly acceptable to abortion patients, and can easily be incorporated into primary care (Foster et al., 2015).

However, globally mifepristone has been burdened with over-regulation, which has significantly muted its potential (Erdman et al., 2008; Raymond et al., 2017). This thesis aimed to explore the journey of mifepristone in Canada and Australia, which are two countries that have recently registered the medication. This general introduction chapter begins with a brief overview of the history of mifepristone and the medication abortion regimen. Next, I give general context about abortion care in Canada and Australia, before outlining the dissertation's specific objectives and structure. The chapter concludes by detailing the conceptual framework used to inform the overall project.

A Note About Language

Using Inclusive Language When Discussing Abortion

While abortion has historically been discussed as a "women's issue", people of all gender identities have abortions (Light et al., 2018; Sutton & Borland, 2018). As a part of a growing movement, The Planned Parenthood Federation of America and the US-based National Network of Abortion Funds have officially adopted inclusive language in their materials and work. Other organizations like the National Abortion Federation and the Abortion Rights Coalition of Canada have stated that using inclusive language is something they are working towards (Bidal, 2019).

Resistance to the use of inclusive language within reproductive health and abortion care usually stems from two key arguments. First, the majority of people who have abortions are women. Second, policies and regulations intended to restrict access to abortion are deeply intertwined with sexism and misogyny. While both of these statements are true, I do not believe that either is sufficient to reject the use of inclusive language. We can recognize that cis-women are the target of anti-abortion restrictions and simultaneously acknowledge that people across the gender spectrum are harmed by them. Further, trans- and gender non-binary people experience unique health disparities (Institute of Medicine, 2011). Using language that obscures the fact that people from across the gender spectrum need – and get – abortions may exacerbate these inequities.

As a result, none of my recruitment materials included gendered language, and there were no eligibility criteria based on gender identity. I asked study participants about their pronouns and a number of my participants did not identify as women. In this thesis, I have attempted to avoid using gendered language by referring to pregnant people, abortion seekers, and abortion patients. Still, the majority of literature that has been written about abortion to-date has used the

term “women”. This is especially true for research that has been conducted in the fields of public health and clinical medicine. Because of this, when I refer to specific literature, I use the terminology that the original authors used.

Further, I acknowledge that “abortion patients”, the term I use most often to refer to people who have had an abortion throughout this dissertation, is not without its own controversies. The term “patient” – which originates from the Latin “patiens” meaning to undergo, suffer, or bear (Neuberger, 1999) – is inherently passive. It also perpetuates the biomedicalization of abortion care, which is incongruous with a feminist approach to health care. Indeed, the term “patients” may be stigmatizing in its own right and frames people as being primarily defined in relationship to an authoritative healthcare provider (Kleinman, 1980). A continued critique of the word patient is that it is best suited for a model of health care that is primarily focused on the diagnosis of an illness and its consequent management, rather than illness prevention or health maintenance (Shevell, 2009; Neuberger, 1999). Although framing abortion as a kind of disease management is not commonly discussed within the field of reproductive health and rights, it subtly and unsubtly informs popular understandings of female reproduction. This point was driven home for me when a participant in a research interview explained to me that, “My pregnancy was a disease and the abortion was the cure that I needed.”

The use of medicalized language within abortion care also presents a number of specific considerations. Abortion rights advocates have put forth a sustained effort to categorize abortion as health care in order to imbue the procedure with legitimacy. Arguing that abortion is necessary health care has been employed as a fundamental framework for activism and legal reform in Australia, Canada, and internationally (Kaposy, 2009; Kaposy, 2010; Keogh et al.,

2017). At the same time, concerns for "patient safety" are commonly used to justify abortion restrictions (Jerman et al., 2017).

In discussing the language of medical anthropology and clinical practice, Dr. Arthur Kleinman, a psychiatrist and anthropologist, (1989) argued that "…clinicians (and researchers, too) need to unpack their own interpretive schemes, which are portmanteaus filled with personal and cultural biases" (p. 53). Rather than discontinue use of the word "patient" altogether, Kleinman urges us to be thoughtful and reflective in our usage of this term. A scoping review of preferred terms for labelling individuals accessing health care found that health care recipients tended to prefer the term "patient" to "client" (Costa et al., 2019).

The language of abortion is an evolving issue that warrants ongoing discussion and dialogue. Throughout this thesis I have attempted to balance inclusivity with medical accuracy and clarity and precision when writing. I am hopeful that the terminology we use within our field will continue to evolve and move towards an inclusive framework.

Interrogating the "Gold Standard"

Throughout this thesis, I use the term "gold standard" to refer to the mifepristone/misoprostol medication abortion regimen. This is a common phrasing within the disciplines of public health and medical sciences, and the expression can be used to refer to a kind of test, study design, or medication regimen that is the best available in a given situation (Jones & Podolsky, 2015). The gold standard is the current standard in the field that other tests, procedures, or methods should be measured against (Claassen, 2005). Importantly, "[the] gold standard is not the perfect test but merely the best available test" (Versi, 1992, p. 187). Although there are different regimens of medication abortion available, the considerable evidence base

supporting the safety and efficacy of mifepristone/misoprostol means that the WHO recommends this regimen for early medication abortion above others (World Health Organization, 2018).

The metaphor "gold standard" is one that clinicians and medical researchers borrowed from economists who historically used gold as a monetary standard (Jones & Podolsky, 2015). The basic unit of currency was a stated quantity of gold, to which different currencies were compared against for international trading (Jones & Podolsky, 2015). Since the term "gold standard" was originally introduced into the medical lexicon with its current meaning in 1979, its use in medical, clinical, and public health publications has proliferated (Claassen, 2005). The term has even been translated and is used frequently outside of English-language publications (Claassen, 2005).

This is not to imply that the expression has been used without criticism. In 1992, Dr. P. Finbarr Duggan penned a letter to the editor of the *British Medical Journal* urging that the term be abolished (Duggan, 1992). He argued that gold standards are never reached and that "the phrase smacks of dogma [and] its use should be discontinued in medical science" (p. 1569). Duggan's letter did not have the intended effect, and despite the fact that financiers no longer use the term, the use of the phrase has only gained in popularity in medicine.

Although I use the term "gold standard" in this dissertation, I am cognizant of its limitations and idiosyncrasies. Indeed, the gold standard has nothing to do with either elements or minerals. The pervasive interpretation that gold is symbolic of the best option, or first place, such as with the Olympic Games, where the first place finisher is awarded a gold medal (rather than silver or bronze) means that people who use the term "gold standard" often "think the term denotes the best standard in the world" (Claassen, 2005, p. 1121) rather than a standard to be tested against. The term also raises broader questions, such as: which factors are taken into

account when deciding a gold standard, and who gets to declare what a gold standard is, that are beyond the scope of this thesis.

A Brief History of Mifepristone

In 1976, Dr. Étienne-Émile Baulieu was studying the role of progesterone receptors in the uterus during pregnancy. Inspired by this work and the findings of Dr. Arpad Csapo, who had proved that progesterone was crucial to the development of a pregnancy, he became dedicated to developing an anti-progesterone to be used as an abortifacient (Baulieu & Rosenblum, 1991). On the importance of creating medication abortion, Baulieu explained, "For centuries, abortion has been not only a morally difficult event for women, but also a physically painful and often dangerous procedure. A medical means for pregnancy termination should diminish this threat to women's health and, in turn, allow them to maintain their dignity" (Baulieu, 1993, p. 72).

Still, resistance to so-called "fertility control" – including contraception and abortion – was prevalent, and so it was difficult to convince a pharmaceutical company to dedicate resources solely to creating an anti-progesterone abortifacient. In a workaround, Baulieu openly dedicated himself to the development of a different but related compound: an anti-glucocorticosteroid. This was less controversial and, as Baulieu described, "useful … in looking for an antiprogesterone" (Baulieu & Rosenblum, 1991, p. 71).

In 1980, mifepristone, or RU-486, was the 38,486th compound synthesized by the French pharmaceutical company Roussel Uclaf (Baulieu & Rosenblum, 1991). While it was the chemist Georges Teutsch who ultimately synthesized the compound, it is Baulieu who has become synonymous with RU-486 based on his role in the drug's development (Baulieu & Rosenblum,

1991; Campbell, 2018). Mifepristone is both an anti-glucocorticosteroid and an anti-progesterone.

The first clinical trials with mifepristone took place in Cantonal Hospital in Geneva, Switzerland in 1982 (Herrmann et al., 1982). Baulieu selected his friend, Dr. Walter Herrmann, to run the trials; Hermann administered RU-486 to 11 women who were between six and eight weeks pregnant at the time. After four days, nine of the 11 women had complete abortions. The two women who had incomplete abortions had aspiration procedures without additional complications. Baulieu recalled his excited conversations with Hermann about the outcomes of the clinical trials by saying, "No one had ever heard of a nontoxic substance, taken orally, that could induce a safe abortion" (Baulieu & Rosenblum, 1991, pp. 85–86). In order to increase the efficacy of RU-486, Hermann and Baulieu determined that an additional dose of a prostaglandin could help the process in the case of incomplete expulsion.

France first registered mifepristone under the trade name Mifegyne® in September 1988 (Baulieu & Rosenblum, 1991). In response to anti-abortion protests, Roussel-Uclaf suspended the distribution of the drug on October 26th of the same year. Two days later, the French government ordered the pharmaceutical company to continue the distribution of Mifegyne®, with the Minister of Health Claude Évin stating, "I could not permit the abortion debate to deprive women of a product that represents medical progress. From the moment Government approval for the drug was granted, RU-486 became the moral property of women, not just the property of a drug company" (Woodroffe, 1992, p. 77)

Mifepristone was originally prescribed in France with an injectable prostaglandin called sulprostone. In 1991, Baulieu and his colleague Dr. Elisabeth Aubény began clinical trials of mifepristone with misoprostol, a prostaglandin that would prove to be better tolerated than

sulprostone (Aubeny & Baulieu, 1991). Misoprostol was commonly used in the treatment of stomach ulcers and was both inexpensive and widely available. Additionally, it came in pill form and was shelf stable.

Today, mifepristone and misoprostol is considered the gold standard of medication abortion (World Health Organization, 2012). First, mifepristone is used to end the pregnancy; as an anti-progesterone, mifepristone breaks down the embryo's bond to the uterine wall. Then, 24 to 48 hours later, misoprostol is taken to induce uterine contractions. Taken together in the first 70 days of pregnancy, this regimen results in a complete abortion between 95% and 98% of the time (Chen & Creinin, 2015; Gatter et al., 2015). In the cases when the regimen does not result in a complete abortion, evidence has demonstrated that patients are able to identify when it is necessary to seek follow up care (Aiken et al., 2017; Chen & Creinin, 2015). Serious complications are extremely rare (Chen & Creinin, 2015).

The dosing, timing, and route of administration of the regimen has been refined over time, but the overall process remains the same (Newhall & Winikoff, 2000). As of 2019, mifepristone was registered in 73 countries worldwide and tens of millions of pregnancies have been terminated using this method (Gynuity Health Projects, 2019; Winikoff & Sheldon, 2012).

From the beginning, Baulieu understood the revolutionary potential of mifepristone. We now have extensive evidence to show that the drug can safely be provided by a variety of health service providers, including family doctors and advanced practice clinicians, in a variety of settings (Yanow, 2013). The regimen can also be used in low resource settings and less developed countries (Elul et al., 2001). Novel service delivery strategies for medication abortion, including telemedicine, have emerged, so that patients are not required to have a face-to-face interaction with a clinician or travel in order to obtain care (Grossman & Grindlay, 2017;

Raymond et al., 2016). Beyond this, the abortion pill has been praised for having the ability to demedicalize the process and put abortion "back in women's hands" (Jelinska & Yanow, 2018, p. 86). Online medication abortion services like Women on Web, Women Help Women, and Aid Access have continued to push for a less medicalized abortion service, as patients complete an online consultation and, if eligible, are mailed medication abortion pills directly (Aiken et al., 2016).

Abortion in Canada

Before the introduction of the *Criminal Law Amendment Act* in 1969, abortion in Canada was illegal in all circumstances and there were thousands of casualties each year due to unsafe abortion. Between 1969 and 1988, in order for an abortion to be considered lawful, a three member Therapeutic Abortion Committee (TAC) had to approve the procedure based on the criteria that continuing with the pregnancy would endanger the woman's life or health. The law limited legal care to procedures performed in hospitals and made abortion clinics illegal across the country (Kaposy, 2010).

Accessing care in the era of the TACs was highly variable as each TAC interpreted the criteria for a lawful abortion quite differently (Kaposy, 2010). Women with higher socio-economic status and greater social mobility were better able to navigate the system; for those who were low-income and faced other barriers to accessing health care in general, safe abortion care remained largely out of reach.

Dr. Henry Morgentaler purposely defied the law and beginning in 1969 he provided abortion care out of his clinic in Montreal, Quebec. In 1973, he publicly stated that he had performed over 5,000 safe abortions at his clinic, implying that a hospital setting was not a

requisite for safe care (Marshall & Mclaren, 2013). His clinic was raided by police and he was charged with performing illegal abortions three times between 1973 and 1975 (Shaw & Norman, 2019). Each time, he presented the "defence of necessity" and argued that the abortions he performed were necessary for the life and health of his patients (Dunphy, 1996). Each time, he was acquitted and then continued to perform safe abortions in his clinic (MacKinnon, 2013). By 1976, the Justice Minister of Quebec, Marc-André Bedard, stated that because juries continued to acquit Morgentaler, the federal abortion laws were unenforceable. The province refused to prosecute abortions performed by qualified medical personnel, even if they were violating federal laws (Dunphy, 1996).

While Morgentaler was, in many ways, the face of the abortion rights movement in Canada, he was not the entirety of it. Patients and advocates alike were campaigning, rallying, and gathering signatures on petitions (Marshall & Mclaren, 2013). Indeed, testimony from some of his abortion patients at his trials was considered critical in the jury acquitting Morgentaler of the charges (Dunphy, 1996). In 1974, the Canadian Association for the Repeal of the Abortion Law (CARAL) was founded. There were provincial and local chapters of CARAL, and the group raised money to help pay for Morgentaler's legal fees (Marshall & Mclaren, 2013).

Once Quebec had agreed not to continue to prosecute Morgentaler, he opened up two additional abortion clinics: one in Winnipeg, Manitoba, and one in Toronto, Ontario. He knew that by continuing to defy the federal law in provinces outside of Quebec, the case would eventually be forced to go to the Supreme Court of Canada.

Morgentaler's legal battles culminated in the historic 1988 *R v. Morgentaler* decision, which decriminalized abortion across Canada. Since 1988, there have been no federal restrictions

on the procedure. Canada is unique in this regard as it is the only country in the Global North without any restrictions (Shaw & Norman, 2019).

Abortion in Canada After Decriminalization

Instead of a criminal offense, abortion in Canada is regulated as a health care procedure under the *Canada Health Act*. The *Act* is a piece of 1984 federal legislation that governs the nation's publicly funded health care insurance; it serves two primary purposes (Health Canada, 2019a). First, it outlines which services are covered under Canada's single-payer health care system. Services that are covered are considered to be "medically necessary" (Health Canada, 2019a). Second, the Act establishes five criteria that provinces and territories must abide by when providing health care services in order to receive funding from the federal government (Health Canada, 2019a). These criteria include public administration, comprehensiveness, universality, portability, and accessibility (Health Canada, 2019a).

As a procedure that the government has deemed to be a medically necessary service, the vast majority of the approximately 100,000 abortions that take place across Canada each year are publicly funded and abortion seekers do not usually incur a direct out-of-pocket cost for the procedure (Abortion Rights Coalition of Canada, 2017; Kaposy, 2009). However, this is not to say that abortion is neither politicized nor stigmatized in Canada. Indeed, the fact that New Brunswick continues to violate the *Canada Health Act* by refusing to fund clinic-based abortion care, and goes unchecked in doing so, is indicative of this (Foster et al., 2017). A number of jurisdictions across Canada have implemented safe access zone laws in order to protect abortion clinics, patients, and providers from harassment and picketing (Kaposy, 2010). However, the public discussion of abortion in Canada is distinct from the much more volatile discourse that

takes place in the neighbouring United States. As an example, in 2008, Dr. Henry Morgentaler was awarded the prestigious Order of Canada for his contribution to the country (Alphonso & Curry, 2008).

Still, access to abortion care across Canada remains uneven and has been described as a "patchwork quilt with many holes" (Eggertson, 2001, p. 164). As a remnant of the Therapeutic Abortion Committees, in the early 1990s, the majority of abortions took place in hospital-based facilities (Ferris et al., 1998). Further, nearly half of all general hospitals provided abortion care (Ferris et al., 1998). By the late 2000s, this trend had flipped; fewer hospitals were providing abortions and the majority of first trimester procedures took place in clinics (Kaposy, 2010; Norman, 2012). The number of hospitals that provide abortion care across Canada has continued to decline (LaRoche & Foster, 2017).

As is typical with a specialized model of care, abortion clinics in Canada are concentrated in urban areas. For example, in 2016, there were 12 abortion clinics operating in the country's largest and most populous province, Ontario (Abortion Rights Coalition of Canada, 2016). Half of these clinics were located in the city of Toronto, while eight were in the Greater Toronto Area (GTA) (Abortion Rights Coalition of Canada, 2016). The bulk of abortion clinics in Canada are located within 250 kilometres of the Canada-US border (Abortion Rights Coalition of Canada, 2016; Kaposy, 2010). Research has demonstrated that Canadian abortion seekers often have to travel long distances to access clinic-based care (Sethna & Doull, 2007, 2013). There are significant differences in the availability of abortion services both across and within provinces, with a pronounced rural and urban divide. In addition, wait times are a serious concern in some places, and have been shown to exceed six weeks (Foster et al., 2013).

Many of the access issues inherent with a centralized model of care made the potential of mifepristone seem especially salient to revolutionize the landscape of abortion care in Canada. However, up until 2017, medication abortion – with methotrexate and misoprostol, a less effective regimen that has less acceptability to patients – was only available in a small selection of clinics in British Columbia and Alberta. Mifepristone was not registered in the country and therefore completely unavailable (Erdman et al., 2008).

Abortion in Australia

In Australia, unlike in Canada, there has been no federal ruling on abortion. Instead, liberalization and decriminalization have been advanced one jurisdiction at a time through legislative reform (de Costa & Douglas, 2015). Up until the late 1960s, abortion was illegal in all circumstances and governed by the *1861 Offences Against the Person Act* of the United Kingdom. The Act outlawed the use of drugs or instruments to procure an abortion and criminalized both abortion seekers and providers (de Costa & Douglas, 2015).

Spurred on by state-specific Abortion Law Reform Associations, feminist activism, and broader social change, the liberalization of abortion in Australia formally began in 1969. The South Australian Parliament issued amendments to the criminal code and outlined specific circumstances, due to concerns about "maternal health" or "foetal disability", under which an abortion could be considered lawful in the state (Mulligan & Heath, 2016). These amendments mandated hospital provision of abortion care and also imposed a requirement that anyone having an abortion in the state had to be residing there for at least two months at the time of receiving care (Mulligan & Heath, 2016).

The same year, the Supreme Court of Victoria issued the landmark *R v. Davidson* case (*R v Davidson*, 1969). The case represented the first legal precedent for abortion law in Australia, and was delivered by Justice Menhennitt, which is why the ruling is most commonly known as the Menhennitt ruling. The Court found that an abortion could be considered lawful if the provider held a reasonable belief that the procedure was both "necessary" and "proportionate" (*R v Davidson*, 1969). The case specified that an abortion was lawful if terminating the pregnancy was necessary to prevent serious harm to the woman's life or physical or mental health (*R v Davidson*, 1969). The proportionate part of the ruling referred to the fact that abortion had to be perceived to be proportional with the danger that terminating the pregnancy would avert (*R v Davidson*, 1969). The Menhennitt ruling was influential in setting legal precedents in the states of New South Wales (in the 1971 *R v. Wald*) and Queensland (in the 1986 *R v. Bayliss & Cullen*) and was applied in Tasmania and Western Australia without ever actually being prosecuted (Baird, 2017; Warhurst & Merrill, 1982).

The country's first freestanding abortion clinic, the Fertility Control Clinic, opened in East Melbourne, Victoria in 1972 (Wainer, 2008). By the late 1970s, abortion was liberally available across Australia, yet state-by-state efforts towards decriminalization persist at the time of writing (Baird, 2017; de Costa et al., 2013). As of early 2020, Western Australia and South Australia were the only two jurisdictions that continue to have criminal laws related to procuring an abortion.

However, as piecemeal decriminalization efforts have moved forward across Australia, charges related to an "unqualified person" performing or helping someone to procure an abortion remain a criminal offense in most states (de Costa et al., 2015). As medication abortion becomes more widely available, and the line between patient and provider becomes increasingly blurred,

it is unclear how Australian states that criminalize "unqualified providers" may respond to this. For example, in Western Australia, *Section 199* stipulates that the offense of "unlawful abortion" can only be committed by someone performing an abortion (de Costa et al., 2015) and "the woman herself is not subject to any legal sanction" (p. 106). However, there has been a proliferation of demedicalized service delivery strategies, such as the aforementioned Women on Web and Women Help Women.

These services were created to provide abortion care to pregnant people in settings where safe and legal abortion is unavailable, and as such they do not ship medications to either Canada or Australia. Yet, the existence of these services speaks to a broader trend of an expansion of the ways that abortion – and specifically medication abortion – can be provided. There is also an increase in medication abortion pills available for sale online that can be self-sourced by abortion seekers outside of the formal health care system (Owens & Burke, 2014).

There have been notable cases of people being prosecuted for having, or attempting to procure, an unlawful abortion. In 2009, Tegan Simone Leach and Sergie Brennan, a couple from Cairns, were charged in Queensland for procuring a miscarriage, attempting to procure a miscarriage, and supplying drugs to procure an abortion (Nancarrow & Howells, 2010). The couple had asked Mr. Brennan's sister to bring misoprostol – a drug that can be used as an abortifacient and is widely available in Australia – into the country from Ukraine so that Ms. Leach could have a medication abortion at home (Nancarrow & Howells, 2010). The charges went forward in a three-day trial and the couple emphatically stated that they were "not ready" to have a child (Sexton-McGrath, 2010). Leach and Brennan were both eventually found not guilty on all counts (Nancarrow & Howells, 2010). However, the case prompted two Cairns doctors to stop providing medication abortion for fear that their patients would also be targeted (Calligeros,

2009). More doctors followed suit and the withdrawal of public services prompted the state government to re-examine *Section 282* of the criminal code in 2009 (Baird, 2015).

In 2016, a 12 year-old girl from Queensland, known only as Q in order to protect her identity, had to go before the state Supreme Court in order to receive permission to terminate her pregnancy (Higgins, 2016). She had previously tried to obtain care at the Rockhampton public hospital, but because of the way that abortion was listed on the criminal code at the time, hospital executives were concerned about potential legal ramifications. As Q was under 14, it was unclear from a legal perspective whether or not she was able to give informed consent. Q was ultimately able to obtain her abortion, but the legal process delayed care by a month (Robertson, 2016). Further, Justice Duncan McMeekin ruled in the case that a typical 12-year old was "unable to give informed consent" which many argued set a dangerous precedent for adolescents trying to obtain care (Robertson, 2016).

Since the end of 2018, abortion has been removed from the criminal code in Queensland and the changes garnered significant momentum for similar reform in New South Wales later in 2019 (Douglas & de Costa, 2016; Han, 2019). Still, the legislative differences between Australian states and territories are but one way in which geography conditions access to care across the country.

The Provision of Abortion Care in Australia

The majority of abortion care in Australia is provided by private providers in clinic settings, except in South Australia and the Northern Territory where abortion is available in public hospitals (Baird, 2017). The United Kingdom-based sexual and reproductive health care charity, Marie Stopes International, started providing privatized abortion care in clinics in

Australia in 2000 (Baird, 2017). Approximately one third of the abortions that take place in Australia annually are now provided through Marie Stopes clinics (Baird, 2017).

Instrumentation procedures have been eligible for Medicare rebates since 1975 (de Costa et al., 2015). However, this does not cover the entire out-of-pocket fee for abortion patients; for first trimester procedures, the rebate amounts to approximately half of the cost for those obtaining care in private clinics (Baird, 2017).

For 20 years there were special conditions surrounding the importation of mifepristone which effectively banned the medication in Australia (Baird, 2015; Petersen, 2010). These conditions were amended in 2006 but still did not allow for the general importation of the drug. Instead, the changes to the legislation allowed individual physicians to go through a time-consuming process to become Authorised Prescribers through the Therapeutic Goods Administration (TGA) (Baird, 2015). A group of physicians in South Australia banded together to avail themselves of the Authorised Prescribers scheme and provide medication abortion with mifepristone. However, with these restrictions, the regimen was only available in hospital settings and was not incorporated into primary care. Unsurprisingly, uptake was slow and the regimen was not widely available outside of South Australia (Baird, 2015).

In 2012, MS Health, a subsidiary of Marie Stopes, an international private abortion provider, completed the costly application to the TGA to import and distribute the drug more broadly. Although the application was approved, the TGA also imposed an expensive risk management scheme and implemented a number of non-evidence based restrictions surrounding the medication (Baird, 2015; de Costa & Douglas, 2015).

Research has demonstrated that amidst shifting legal and regulatory environments, there are a variety of both legal and non-legal barriers to accessing abortion care in Australia (de

Moel-Mandel & Shelley, 2017). Similar to the Canadian context, regional and rural populations in the geographically vast Australia face particular barriers to accessing healthcare, including abortion (de Moel-Mandel et al., 2019; Doran & Hornibrook, 2016). Yet, prior to this study, no research has focused specifically on how medication abortion may – or may not – influence access to abortion care in Australia.

The Current Study

Taken together, Canada and Australia represent interesting comparison settings to examine the introduction of mifepristone. Although there are key policy and regulatory differences between the two countries, both countries have recently registered the medication. The recentness with which mifepristone has become available means that there is a dearth of research that has focused exclusively on the experiences of those accessing the mifepristone regimen in these settings.

The restrictions put in place by Health Canada following mifepristone's approval were modelled after the Australian approval process (CADTH, 2015; Campbell, 2018) yet each country has dealt with these regulations in different ways. Additionally, both countries have a large landmass with a comparatively small, dispersed population, as well as a long history of providing abortion care in freestanding clinics (Baird, 2017; Norman et al., 2016). The wide geographic area of each country makes centralized abortion care difficult for many to access and in each country access is highly varied and closely tied to geography.

From a social perspective, both Canadians and Australians have similar views on the acceptability of abortion. The global market research and consulting firm Ipsos has found that Canadians and Australians are on par with each other in terms of the overall opinion that

abortion should be permitted (Simpson, 2017). While there continue to be instances of anti-abortion activism in both Canada and Australia, the majority of the population in each country regards abortion as a healthcare issue (Baird, 2017; Norman & Downie, 2017). In different ways, which will be elaborated on throughout this thesis, innovative models for health service delivery of medication abortion have emerged in each context.

Theoretical Framework

This study has been conceived as action research. It explicitly incorporates principles of feminist scholarship, sexual and reproductive health and rights, and a health equity framework. Consistent with the underlying principles of these frameworks and the methods described in Chapter 2, this project is situated within an interpretivist paradigm.

Interpretivism is rooted in the German intellectual traditions of hermeneutics and phenomenology (Blaikie, 2004). It emerged as a direct critique of positivism, which is premised on the tenets of objectivity and observation. While positivism purports that only objective and observable facts form the basis of science, interpretivism holds that the goals of the cultural and social sciences are distinct from the goals of the natural sciences. Drs. Max Weber and Alfred Schütz sought to establish "an objective science of the subjective with the aim of producing verifiable knowledge of the meanings that constitute the social world" (Blaikie, 2004, p. 509). In particular, Weber, a German sociologist, elevated the importance of *Verstehen,* meaning to "grasp or understand the meaning of social phenomena", and argued that this was the goal of social sciences (Schwandt, 1998, p. 118).

Interpretivism rejects the assumption that human behaviour is predictable in the same way that the natural world is, and instead aims to produce contextualized meaning within a

socially constructed reality (Mathison, 2005). It argues that in order to study social phenomena, it is necessary to have an understanding of the social worlds that people inhabit (Mathison, 2005). A key component of the interpretivist paradigm is that the investigator and investigation are inextricably linked, and as such, memoing and constant reflection served as integral part of the research process for this project (Birks et al., 2008). I discuss this in more depth in Chapter 2.

Specifically, this project draws on Dr. Norman Denzin's approach of interpretive interactionism (Denzin, 2001). This approach brings together personal experiences, history, and structural systems in an interpretive process that focuses on "problematic interactions". Denzin uses this term to refer to "interactional sequences that give primary meaning to subjects' lives," (Denzin, 2001, p. 32). He argues that these key problematic interactions alter how people see themselves and define their relationships with others, because these instances prompt social interactions with a wide variety of people, including broader social systems. By focusing on these significant, transformative events, interpretive interactionism differentiates itself from other kinds of interpretivist approaches (Denzin, 2001). Throughout this thesis, the problematic event that I focus on is participants' experiences with pregnancy and how they interpret and manage this event. In short, interpretive interactionism centers on the complex interrelationship between "private lives and public responses to personal troubles" (Denzin, 2001, p. 2). It also focuses on a critical appraisal of how individuals connect their lived experiences to the cultural representations of those experiences (Denzin, 2001; Schwandt, 1998).

Another key characteristic of this approach is that it is premised on the assumption that every human being is a universal singular (Sartre, 1981 as cited in Denzin, 2001). Essentially, every person is like every other person but also like no other person. This means that every participant and participant's story should be studied as a single instance of broader social

experiences, trends, and processes. Interpretivist interactionism strives to connect personal histories to broader social histories. The researcher's role within this process is to serve as an interpreter.

Additionally, Denzin's approach explicitly incorporates perspectives from cultural and feminist studies and argues that the interactions of both the inquirer and the respondent need to be read and understood through an intersectional lens (Schwandt, 1998).

Action Research.

Action research serves as the theoretical foundation for this project. Dr. Kurt Lewin, a social psychologist, is often referred to as the originator of this framework in 1934 (Adelman, 1993). As a form of action-oriented research, action research is specifically concerned with producing research that has social relevance and can address practical concerns (Small, 1995). This can take the form of solving a specific problem or informing practice. As Lewin himself concluded, "No action without research; no research without action" (Adelman, 1993, p. 8)

Importantly, a key characteristic of action research is that it involves an inclusive, collaborative approach. As noted by Gilmore, Krantz, and Ramirez, "there is a dual commitment in action research to study a system and concurrently to collaborate with members of the system in changing it in what is together regarded as a desirable direction" (Gilmore et al., 1986, p. 161).

This project coincided with the introduction of mifepristone in Canada, and the overarching study aims were defined in consultation with key stakeholders. The practical concerns that I aim to address with this project emerged from conversations with abortion providers and reproductive health advocates in Canada. The project is designed to empower participants, acquire knowledge, and affect social change. Specifically, this project is derived

from and structured as *practical action research*, meaning that it is intended to address a specific problem while also informing larger issues.

As is characteristic of action research in general, our design embraced the planning, acting, observing, and reflecting cycle, which was ongoing throughout the life of the project. For a diagram of the action research cycle, please see Figure 1. It is important to note that the cycle was continuous and repeated numerous times throughout the project. Finally, I believe that the knowledge generated through this project will have import beyond the local context and thus we prioritized disseminating our results and lessons learned to multi-disciplinary audiences.

Feminist Health Research.

This project is further informed by critical feminist scholarship and perspectives on health. Applications of feminist research can vary widely; rather than being a necessarily prescriptive approach, this theoretical framework uses insight from feminist theory to broadly challenge the androcentric bias that has characterized much of early research. Walter (1995) posited that feminist research is located in an interrogative space and that its overarching goal should "ask questions about how differences in power and knowledge have been constructed over time as gender" (p. 272). However, it is inaccurate to say that feminist inquiry is only concerned with matters of gender. Just as feminists have criticized various fields, methods, and assumptions as being overly preoccupied with a white male perspective, feminism and feminist approaches have also been criticized for lacking intersectionality and focusing almost exclusively on the experiences of upper to middle class white women (Walter, 1995). This is also a salient critique of a lot of the work and research that is done in the field of sexual health and rights (Gilliam et al., 2009).

A number of scholars and researchers have argued that the advancement of intersectionality theory is one of the most important theoretical contributions that women's studies and feminist research have made (McCall, 2005). The term "intersectionality" was originally added to the lexicon by legal scholar and one of the founders of critical race theory, Kimberlé Crenshaw (Crenshaw, 1989). In her early articulations of intersectionality, Crenshaw (1989) explored how Black women in the United States occupy the distinct yet overlapping kinds of subordination of race, sex, and gender. She later expanded on this idea and defined three dimensions of intersectionality, including: structural intersectionality, political intersectionality, and representational intersectionality (Crenshaw, 1991).

Intersectionality acknowledges the interactions between different forms (or axes) of oppression and discrimination (Crenshaw, 1991). An intersectional approach considers the multiple identity categories that each of us belong to, such as gender, sex, race, ability, sexual orientation, and class, and the ways that these axes interact on multiple levels. A foundational tenet of this framework is that these contexts cannot be pulled apart and examined separately (Nash, 2008). While intersectionality was originally conceived to contend with individual axes of subordination, more recent scholarship has emphasized the need to integrate contextual cues and a transnational perspective (Anthias, 2012; Henne & Troshynski 2013; Patil 2013).

In an intersectional approach, our indivisible identities influence the entire research process, from the conception of the project to data collection and dissemination. Further, in acknowledging the importance of intersectionality, we cannot focus solely on the identities of research participants. Rather, we need to actively reflect and engage with the researcher's identity and how it interacts with the research process, which has long been characteristic of anthropological approaches to ethnographic research. Specifically, the post-modernist turn in

anthropology is linked with the evolving intersectional framework and its corresponding theory. The turn gave rise to a "new ethnography" that was concerned with how the discipline may perpetuate or maintain notions of Western hegemony (Wolf, 1992; Scheper-Hughes, 1993). "Postmodernist anthropologists … wish to call attention to the constructed nature of cultural accounts" (Mascia-Lees et al., 1989, p. 9).

Weber and Castellow (2014) argue that in contrast to the traditional biomedical approach, critical feminist research: "prioritizes social justice over knowledge accumulation, encourages researchers to engage with subjectivity, reflexivity and collaboration with those being researched; emphasizes a holistic representation of meaning in individual lives and institutional arrangements in the social context; encourages multimethod approaches; explores power relations of dominance and subordination between groups at macro- and micro levels; explicates the interconnected nature of inequities and inequalities at macro-systemic and micro-individual levels; and, aims to produce interventions that are designed to change broad systems of inequity and inequality, including those outside of the health care system" (p. 438).

The differences in this perspective to a traditional biomedical approach are the strengths of an intersectional feminist approach and we have explicitly incorporated these goals into this project from the initial planning stages. Specifically, with this project I prioritized patient voices and explored preferences for patient care. As well, examining legislative restrictions has implications for better understanding abortion stigma on both a micro- and macro- level.

Stratified Reproduction and Reproductive Governance.

A disciplinary shift to forefront the interplay between power and reproduction represents another critical turning point in feminist anthropology and the study of abortion (Ginsburg, 1989;

Ginsburg & Rapp, 1995). The acknowledgement that reproductive experiences can be "analysed as sources of power as well as subordination" (Ginsburg & Rapp, 1991, p. 312) has influenced my understanding of intersectionality and underpins my thinking and analyses throughout this dissertation.

Indeed, Crenshaw's work expanded upon – and named – dynamics captured in other key work that has also been critical in influencing feminist health research and feminist anthropology, as well as my own study of sexual health and rights. In the early 1980s, Drs. Floya Anthias and Nira Yuval-Davis problematized the notion of "sisterhood", or the implicit feminist assumption that "there exists a commonality of interests and/or goals amongst all women" (Anthias & Yuval-Davis, 1983, p. 62). They asserted that including ethnic and class contexts in feminist analyses was a necessity, and their work notably influenced feminist anthropological thinking and discourse (Henne, 2018). In 1986, Shellee Colen wrote about "stratified reproduction" in her classic study of West Indian childcare workers and their employers in New York City (Colen, 1986; Colen, 1995). Drs. Faye Ginsburg and Rayna Rapp (1995) went on to define stratified reproduction as "the power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered" (p. 3).

The fact that policy and legislation are mechanisms through which this power is frequently exerted has particular salience for this dissertation which focuses on how law and policy condition patients' abortion experiences and access to care. As a forthright example, when we view the laws that criminalize abortion across Australia through the lens of stratified reproduction, it is evident that certain circumstances for seeking abortion are deemed acceptable while others are not (de Costa et al., 2015). This dichotomy is baked into the law itself by requiring abortion seekers to meet certain criteria in order to have an abortion that is deemed

lawful. This is, quite clearly, one way through which some categories of people can be empowered or disempowered through the abortion seeking experience (Beynon-Jones, 2012; Beynon-Jones, 2013).

I also understand and interpret the global overregulation of mifepristone through the framework of stratified reproduction. Evidence has consistently demonstrated that restricting access to abortion does not lower the abortion rate (Berer, 2004). Rather, it creates a stark division between those who have the means (which may be social, financial, and/or logistical) to navigate the barriers to obtain safe care, and those for whom the barriers are insurmountable and are forced to seek unsafe abortions or carry unwanted pregnancies to term (Berer, 2004; Harris et al., 2014; Upadhyay et al., 2015). While advocating for evidence-based policy has long been a useful strategy for abortion rights activists seeking to expand access to care, stratified reproduction highlights the shortcomings of being overly focused on policy and urges us to instead consider the range of forces that influence access to health care. It forefronts our understanding that policy is not a neutral intervention.

Drs. Lynn Morgan and Elizabeth Roberts extended the stratified reproduction framework to explicitly invoke this tension in what they refer to as "reproductive governance" (Morgan & Roberts, 2012). Specifically, define reproductive governance as "the mechanisms through which different historical configurations of actors – such as state, religious, and international financial institutions, NGOs [non-governmental organizations], and social movements – use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviours and population practices" (p. 243). Reproductive governance provides theoretical backing and language for examining how

reproduction has been deployed at the centre of various religious, economic, and demographic agendas (Morgan, 2019).

Sexual and Reproductive Health and Rights and Health Equity.

Feminist scholarship has been integral in the development of the sexual and reproductive health and rights (SRHR) framework that further informs this project. The sexual health and rights movement traces its origins to the International Conference on Population and Development (ICPD) in Cairo in 1994 (Hempel, 1996). At this conference, a notable shift occurred in the field: while the focus was once on providing family planning services to meet certain demographic targets, the final Programme of Action from the ICPD emphasized improving the individual's quality of life (Chandra-Mouli et al., 2015; Shaw, 2006). The 1994 ICPD set out a bold and comprehensive definition of reproductive health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes" (United Nations, 1995).

The programme acknowledged the need to explicitly incorporate a human-rights framework in the understanding of reproductive health issues. In most cases, SRHR prioritizes policy and legislative reform as a mechanism through which to achieve these goals. In conceptualizing sexual and reproductive rights as a human right, this project centers on three broad categories of reproductive rights, as defined by Erdman and Cook (as cited in Hardee et al., 2014):

1. The right to reproductive self-determination (right to bodily integrity and security of person and the rights of couples and individuals to decide freely and responsibly the number and spacing of their children).

2. The right to sexual and reproductive health services, information, and education (including right to the highest attainable standard of health).
3. The right to equality and nondiscrimination (right to make decisions concerning reproduction free of discrimination, coercion, and violence).

This dissertation also draws on a health equity framework which implies that everyone should have the opportunity to achieve their full health potential. Health inequalities are used to refer to differences in health status or outcomes between groups. In contrast, health inequities refer to these differences between groups that are avoidable, unfair, and unjust (Braveman, 2014). Health inequities can be addressed with the redistribution of health resources and effective policies and interventions.

Specific Objectives

The overarching study aims for this project were defined in consultation with key stakeholders in Canada. While the Australian component of this dissertation was initially conceived as a comparative piece that would be of interest to Canadian stakeholders, the research agenda evolved based on conversations with Australian advocates and reproductive health scholars. The approach and framework responded to questions posted by local advocacy groups that were a part of the decriminalization campaign in New South Wales and I worked with stakeholders in Tasmania to investigate questions that were of particular relevance to their ongoing work.

With a specific focus on Canada and Australia, this study aimed to:

1. Document the experiences of abortion patients using mifepristone and misoprostol to terminate a pregnancy;
2. Explore the feasibility and acceptability of different health service delivery models from the perspective of abortion patients;
3. Describe the ways that the introduction of mifepristone has impacted the landscape of abortion care;
4. Explain the ways that policies and regulations condition access to abortion care;

5. Generate insights for ways that services could be improved.

Thesis Structure

This thesis takes the form of "thesis by article" and is divided into 11 chapters. In Chapter 1, I have provided essential context and justification for our specific research aims. In Chapter 2, I describe the overall methodological approach, as well as the particular research methods and analytic strategies used throughout this dissertation.

The middle section of this thesis comprises eight manuscripts, which were at various stages of submission, review, and publication at the time I submitted my dissertation. The thesis is organized by country and begins with the work that focused on mifepristone in Canada before turning to a series of articles that focus on medication abortion in Australia.

Chapter 3 is a peer-reviewed book chapter in the volume *Abortion, politics, and the pill that promised the change everything: The global journey of mifepristone* edited by Angel M. Foster and L. L. Wynn. This book is forthcoming and will be published by Palgrave Macmillan. In this chapter, I draw on a literature review, media audit, and key informant interviews, to describe the historical context leading up to the registration of mifepristone in Canada, including the Health Canada review process.

Chapter 4 has been published at the peer-reviewed journal *Contraception* (LaRoche & Foster, 2020). This piece draws on qualitative, in-depth interviews that I completed with 64 people from across Canada who used mifepristone and misoprostol to have an abortion. In the article, we document participants' general reflections on using mifepristone and misoprostol and explore how the shifting regulation of mifepristone in Canada impacted access to the drug. In this paper, we also provide concrete recommendations for how abortion patients think services and information could be improved across Canada.

Chapter 5 is a qualitative case study that has been published in the open-access, peer-reviewed journal *FACETS* (LaRoche, Labeca-Gordon, & Foster, 2020). In this chapter, we analyzed in-depth interviews with people who obtained an abortion in Ottawa, Canada's capital city, before and after the introduction of mifepristone. We assessed the ways that medication abortion has changed the health service delivery landscape of abortion care in Ottawa and provide recommendations for policy makers and service providers.

Chapter 6 is formatted for *Women's Health Issues* (as of August 2020 the article was under review). This manuscript draws on data from the *Canada Abortion Study* and is an in-depth exploration of a group that make up a large subset of abortion patients: mothers. Based on the specific needs, recommendations, and preferences that this population expressed about the abortion care that they received, mifepristone is a particularly resonant option. Taken together, these papers form a holistic, extensive investigation into the promise and impact of mifepristone in Canada.

Chapter 7 has been published in the peer-reviewed journal *Contraception* (LaRoche, Wynn, & Foster, 2020). This paper serves as an Australian companion piece to Chapter 4. In this paper, we drew on interviews with 22 Australians who had accessed medication abortion. We discuss their experiences deciding to use and accessing mifepristone and include recommendations for policy makers and clinicians.

Chapter 8 has been accepted at the Australian journal *Public Health Research and Practice*. In this chapter, we discuss the ways that the legal status of abortion between states across Australia impacted patient experiences and perceptions of accessing care. This paper was an emergent finding from the data collected as a part of Chapter 7 and we wrote this paper to

respond to the (at the time) ongoing legal battles for the decriminalization of abortion in New South Wales.

Chapter 9 is formatted for *Contraception* (as of August 2020 the article was under review). In this chapter, we draw on interviews that I conducted with abortion patients in Australia's island state of Tasmania to describe the shifting landscape of care in the state. This paper illuminates the ways that mifepristone has influenced access to abortion care in the Tasmania and broader changes in the delivery of abortion.

Chapter 10 is formatted for the journal *Medical Anthropology Quarterly*. In this paper, I draw on field work that I conducted in Tasmania, which is a combination of in-depth interviews with abortion patients, key informant interviews, and participant observation, to explore the competitive framing processes of abortion in the state. I detail how abortion has simultaneously silenced and mobilized different stakeholders, and I explore the implications that these framings have for abortion seekers.

The thesis concludes with a general discussion in Chapter 11. I begin with a summary and synthesis of the articles. Next, I discuss the implications of this body of work overall before discussing limitations and next steps for future research.

Chapter 2:

Methodology

Methodology

This is a qualitative thesis that uses a number of different methods to explore how the introduction of mifepristone has impacted the service delivery landscape of abortion care in Canada and Australia, with a specific focus on the experiences of abortion seekers. I begin this chapter with an overview and justification of qualitative methods and then include my statement of positionality and descriptions of how I engaged in reflexivity throughout the research process. Next, I include a detailed description of the methods and analytic strategies that I used in this thesis. As this is a binational project with original data collection in both Canada and Australia, I have organized the discussion of the methods around the country they were conducted in.

Qualitative Methods

The overarching research questions for this project were identified as gaps in the current evidence base through a thorough review of the literature and defined in consultation with key stakeholders. After identifying the broad questions that we wanted to explore with this thesis, it was quickly apparent that qualitative methods were the most appropriate data-gathering tool for these areas of inquiry.

There is no singular "qualitative method". Rather, qualitative methods encompass a variety of approaches that can be used to understand and explore the feelings, values, and perceptions that underlie behaviour (Denzin & Lincoln, 2018). They also provide an excellent mechanism through which to generate insights about previously unexplored phenomena (Flick, 2014). One of the key strengths of qualitative research is that it provides unique insight into issues from the participant's perspective and therefore is essential to creating policy recommendations and interventions that are truly patient-centred (Abelson, 2019).

Although mifepristone is not a new technology and its safety and efficacy are well established, this medication has only recently become available in both Canada and Australia. The majority of literature available on medication abortion is clinical science that employs quantitative methods (Grossman & Grindlay, 2017; Guilbert et al., 2016; Hyland et al., 2018). There is a dearth of literature that focuses on the experiences of those accessing and using medication abortion in these settings (Goldstone et al., 2012; Vogel et al., 2016). We used a multi-methods approach in order to generate rich and detailed insights about patients' experiences finding and accessing abortion care in different settings. We also wanted to gain an understanding of how social, geographic, economic, and regulatory barriers condition access to care. With this in mind, we selected in-depth interviews as our primary data collection method.

Criteria Used to Evaluate Qualitative Research

While public health and health sciences scholarship has seen qualitative methods increasing in popularity, the limitations and goals of qualitative research remain poorly understood by many in these fields. Qualitative research, by design, does not produce results that are representative or generalizable. Rather, qualitative methods endeavour to provide us with a rich, detailed, and contextualized understanding of a particular phenomenon (Lincoln & Guba, 1985).

There is a degree of debate among methodologists about whether reliability and validity are appropriate – or useful – ways evaluate qualitative research (Lecompte & Goetz, 1982; Rolfe, 2006; Sandelowski, 1993). Some have advocated for expanded definitions of these terms that are applicable to qualitative methods. However, consistent with a broader body of literature, I

believe that these terms are inherently rooted in a positivist paradigm and are therefore incompatible with a qualitative approach.

Instead, with this project, we drew on Lincoln and Guba's well established evaluative criteria and aimed to produce research that is credible and trustworthy (Lincoln & Guba, 1985). Lincoln and Guba initially proposed the four criteria of credibility, transferability, dependability, and confirmability as essential to establishing trustworthy research, and they also argued that trustworthiness is critical to evaluating a study's worth. In 1994, they added a fifth criterion of authenticity (Guba & Lincoln, 1994).

Credible research means that the researcher has accurately and appropriately reported on the phenomenon under investigation; it is concerned with the degree to which we can be confident in the 'truth' of the findings (Lincoln & Guba, 1985). Trustworthy research means that the researcher's conclusions are supported by the research findings. In order for research to be rigorous, the appropriate research tools need to be used to meet the stated objectives of investigation (Cope, 2014; Davies & Dodd, 2002).

We have used a number of techniques to increase the overall rigor, credibility, and trustworthiness of the research carried out as a part of this thesis (Lincoln & Guba, 1985). Namely, we have a well-defined research question and aims, a consistent and appropriate methodology, and we have included quotes and thick description (Geertz, 1973), including narrative vignettes, when reporting on our findings. We have also used multiple methods and engaged with the experiences and perceptions of different stakeholders in order to strengthen our recommendations based on our findings.

The term "thick description" can be used to describe both a process and an output. As a process, thick description involves "paying attention to contextual detail in observing and

interpreting social meaning when conducting qualitative research" (Dawson, 2010, p. 942). When we write a thick description, we endeavour to describe not only the immediate phenomena of interest, but to portray and take into account the contextual and experiential cues that give meaning to an event or action.

Many researchers cite the anthropologist Dr. Clifford Geertz as the originator of thick description (Hammersley, 2008; Ponterotto, 2006), although Geertz himself reported that he borrowed this phrase from the work of the British philosopher Gilbert Ryle (Geertz, 1973). Ponterotto (2006) proposed five key components of what constitutes a thick description:

1. "Thick description" involves accurately describing and interpreting social actions within the appropriate context in which the social action took place.
2. "Thick description" captures the thoughts, emotions, and web of social interaction among observed participants in their operating context.
3. A central feature to interpreting social actions entails assigning motivations and intentions for the said social actions.
4. The context for, and the specifics of, the social action are so well described that the reader experiences a sense of verisimilitude as they read the researcher's account.
5. "Thick description" of social actions promotes "thick interpretation" of these actions, which lead to "thick meaning" of the findings that resonate with readers.

Another debate among methodologists is the extent to which qualitative data can or should be quantified, or presented in numerical form (Maxwell, 2010; Sandelowski, 2001). It is standard practice to use qualifiers such as "many", "most", and "several" to describe findings (Maxwell, 2010; Sandelowski & Leeman, 2012). This is the convention that we have followed, for several reasons. First, describing qualitative data using percentages or numbers is often incongruent with the smaller sample size associated with these methods. Describing qualitative data in this way may also give the impression that qualitative research is generalizable (Sandelowski, 2001). Second, researcher judgment is necessary in qualitative data analysis and the number of times that a particular phenomenon is reported on is not necessarily indicative of

its importance (Braun & Clarke, 2006; Flick, 2014). Indeed, an event or feeling can be reported by a minority of participants but still hold great importance for the overall study aims.

In general, we do not quantify our findings. However, there are times that we present numbers in our findings. For example, when discussing wait times and the cost participants paid for procedures, we felt that providing ranges and averages for these phenomena was key contextual information.

Positionality and Reflexivity

Qualitative methods explicitly acknowledge the role of the researcher in the collection and production of data (Denzin & Lincoln, 2018; Dowling, 2006). Positionality refers to the identity, experiences, and perceptions of the researcher, including the social and political context that have shaped and influenced her development. Reflexivity refers to the active process of reflecting on one's positionality and the ways in which this contributes to the data collection process and research relationship (Dowling, 2006; Gergen & Gergen, 2000).

Finlay proposes five lenses for the interviewer as starting points that can enable thoughtful and systematic reflection (Finlay, 2014). Specifically, she refers to (p. 318):

1. strategic reflexivity as a lens focused on the methodological and epistemological aspects of a project;
2. contextual-discursive reflexivity as a way to examine situational and sociocultural elements involved in the research process;
3. embodied reflexivity as a way to reflect on the researcher's embodied felt sense and the research relationship between interviewer and interviewee;
4. relational reflexivity as a way to examine the intersubjective, interpersonal realm; and
5. ethical reflexivity as monitoring the processual aspects and power dynamics in the research relationship and process.

I used these lenses as starting guides for my own reflexive process. Importantly, reflexivity is an ongoing process that occurs throughout the entire life of the project and is much

more than simply listing a list of the researcher's various identities and training. As is standard practice in social sciences, I begin this section with a formal positionality statement. I also describe my reflexivity process and include some of my reflections from throughout the project.

Statement of Positionality

I am a white, queer, able-bodied, Canadian woman who is pursuing a Cotutelle PhD in population health and anthropology. Broadly, I consider myself to be a public health social scientist, as I have formal training in feminist and gender studies, public and population health, and medical anthropology. These perspectives influence the way I approach scholarship as I am deeply committed to an equity framework.

I have been involved with qualitative research and primary data collection for approximately eight years at the time of writing. Over the course of this time, I have received training in qualitative research, data analysis, and interviewing. This training has been both formal and informal, including one-on-one training directly from my supervisor, completing coursework, and through seeking out additional methodological training opportunities through workshops and readings. Further, I have been directly involved in training emerging researchers in qualitative methods. I have done this through individualized, one-on-one training, as well as contributing to the development of research methods training workshops. I have taught about research methods in both the faculties of Health Sciences and Social Sciences at the University of Ottawa.

I believe that access to safe abortion is both a public health benefit and fundamental human right, and I approach my work with the key belief that women, trans folks, and gender

non-binary people are capable of making informed decisions about their own health, bodies, and lives.

Reflections on reproductive health, rights, and justice.

While reproductive health, reproductive rights, and reproductive justice may sound alike, these are three distinctive frameworks that approach similar issues with different perspectives and goals. Still, these frameworks are often conflated.

As a framework, reproductive health is the most narrowly defined and takes a micro-view by chiefly focusing on individual outcomes. Reproductive health projects aim to address problems associated with the accessibility of services and the individual care provided (Ross & Solinger, 2017). Reproductive rights expands on this viewpoint by acknowledging that individuals have a right to make free and informed decisions about their reproduction and that these decisions should be free of discrimination, coercion, and violence (Gilliam et al., 2009). Reproductive rights is also a philosophy that prioritizes a legal right to the highest standard of sexual and reproductive health and shifts the focus from individuals to incorporate the role of laws and policies on health outcomes (Hardee et al., 2014). Reproductive health and rights are often discussed together, and combined into a framework called sexual and reproductive health and rights (SRHR).

Reproductive justice (RJ) emerged as a critique of the mainstream abortion debate, as it argued that premising the movement on "choice" was both insufficient and a misnomer. Central to this framework was the acknowledgement that there were circumstances in people's lives and realities that meant they could not make a choice in the first place (Ross & Solinger, 2017). The RJ framework was created by Black women in the United States and it employs a macro lens to

argue that individuals, families, and communities are linked (Chrisler, 2014). Using an intersectional approach, the RJ framework is not a synonym for "pro-choice" and it explicitly foregrounds the leadership and visions of women of colour. This framework also responds to the assertion that the reproductive rights movement has been preoccupied with the experiences of upper and middle class white women. In contrast to reproductive rights, which defines the key problem as restrictive laws and policies, reproductive justice defines the problem as reproductive oppression (Ross, 2017)

While I have been aware of reproductive justice, both as a movement and as a conceptual framework, for many years, I have spent more time in the past year engaging with and reflecting on this scholarship. In the autumn of 2019, I was a visiting scholar at Emory University in Atlanta, Georgia in the United States. Atlanta is considered to be the birthplace of the reproductive justice movement in North America (Ross, 2017). I attended lectures by some of the Founding Mothers of Reproductive Justice, networked with and learned from RJ scholars and advocates, and also went to the world's largest RJ-specific conference called "Let's Talk About Sex."

In my thesis proposal for this project, I wrote about RJ as a theoretical underpinning for this project. However, as I have engaged more deeply with the foundations, intentions, and meaning of reproductive justice, I no longer feel that I can claim that this dissertation is rooted in an RJ framework. Doing so would be disingenuous and would do a disservice to those who are truly operating within this framework. Instead, this project is influenced by reproductive health and rights, and I see myself as working towards a reproductive justice framework in my future work. While RJ undoubtedly influences my thinking and analysis of the data, the goals of this project fit quite squarely within a reproductive health and rights perspective.

Reflexivity Process.

I used memoing throughout the research process as a formal reflexivity exercise. I also engaged in less formal discussions with my supervisors, peers, and colleagues. There are no rules for memoing with regards to format, grammar, or style; rather, a memo provides an opportunity to document thoughts and ideas, draw preliminary connections between ideas, and generally reflect on the research process (Sandelowski & Leeman, 2012). I memoed throughout the entire life of my dissertation project, beginning with the initial conception of the research aims. I continue to memo as I move forward with a dissemination strategy and knowledge translation activities. I memo in a variety of different formats, including on paper with a notebook, on scrap pieces of paper, and in the Notes application on my phone. Occasionally, I record voice memos to myself as a way to talk through ideas. Despite the varying formats of my memos, I store and organize them in a consistent way so that I can review them. I do not go back and edit my previous memos, but I do annotate them as my thinking on the issue evolves and new ideas emerge.

Memoing has been an important part of my academic and methodological training in public health and the social sciences, and I refer to it as "memoing" because this is how I was initially introduced to, and how I personally conceptualize, the practice. However, as I have received additional training in anthropology, I recognize the connections between what I call "memos" and what most anthropologists would call "fieldnotes". Indeed, fieldnotes are a ubiquitous aspect of anthropological practice and writing, yet are they not often discussed explicitly. Many anthropologists make a connection between fieldnotes and their professional identity (Jackson, 1990), yet Lederman (1990) notes that "fieldnotes remain largely obscured from view, even among practitioners. They are a 'muted' medium …" (p. 72).

However, much like memos, fieldnotes offer a space for documentation, observation, and reflection. There is a great degree of variation as to what anthropologists consider, and refer to, as fieldnotes (Jackson, 1990). Still, Sanjek (1990) described a general process that many anthropologists follow in the creation of their fieldnotes. He notes that fieldnotes begin with field perception, and that rough, in the moment, abbreviated jottings – or "scratch notes" – are often used to document observations or details that may later be forgotten. Sanjek then describes a process through which scratch notes are transformed into fieldnotes. Importantly, he notes "[the] scratch-notes-to-descriptive-fieldnotes writing act must be timely, before the scratch notes get 'cold'" (Sanjek, 1990, p. 97). The components that undergird this practice, including observation, documentation, and a process of timely refinement, are all present in my process of taking notes during data collection (for example, during an interview), memoing shortly after the encounter, and then annotating my memos at as my understanding of a phenomenon and analytic process progresses.

Admittedly, part of my hesitation to use the word "fieldnotes" to describe my own written observations stems from a disciplinary uncertainty about whether much of my work was in fact fieldwork. What is considered the field, and do telephone interviews constitute a form of fieldwork? Although textual and cyber- and online-ethnographies have become more widely used in anthropology (Boellstorff, 2008; Eichhorn, 2010; Ginsburg, Abu-Lughod, & Larkin, 2002; Wilson & Peterson, 2002), there is undoubtedly a "legacy of the field" (Clifford, 1997, p. 88) in which field work and ethnography is assumed to include physical displacement, an unfamiliar setting, and face-to-face interaction. This is an evolving issue and that many anthropologists have pushed back on Clifford's (1997) assertion that "[a] research practice defined by 'shifting locations,' without the prescription of physical displacement, extended face-

to-face encounter, could, after all, describe the work of a literary critic, attentive, as many are today, to the politics and cultural contexts of different textual readings" (p. 88).

Lederman (1990) writes that when discussing fieldnotes, her "focus is less on the contexts in which notes are written down than how they are read and used" (p. 74). She goes on to say that the act of taking fieldnotes "…need not involve any traveling at all: it sometimes involves simply a shifting of attention and of sociable connection within one's own habitual milieus. From this perspective 'the field' is not so much a place as it is a particular relation between oneself and others, involving a difficult combination of commitment and disengagement, relationship and separation" (p. 88). Although I agree with Lederman's assessment, the terms "field work" and "fieldnotes" are used much less commonly in public health spheres and I continue to feel an uneasiness with embracing these terms in relation to my work and process.

Research assistants contributed to my project by completing a bulk of the transcriptions. This was incredibly helpful due to the sheer volume of data I collected, but transcription would usually provide a key opportunity to further reflect on the interview content and dynamics. Because of this, I still took the time to listen back to most of the audio recordings. When I listened back to the interviews, it gave me an opportunity to reflect not only on the content, but also on my interviewing skills. I considered the interaction the same way that I would if I was listening to a recording of another interviewer that I was training. I took notes during these exercises and made notes to myself about what I wanted to improve or change in the next interviews I would conduct.

Much of the data for this thesis was collected over the telephone, which creates an interesting scenario to reflect on how my positionality influenced the research relationship.

Undoubtedly, my voice gives some contextual clues to participants about my age and (perhaps) gender, but many other aspects of my identify could not be easily inferred over the phone. My status as a PhD candidate while conducting the research gives some preliminary clues about my educational attainment and socio-economic status. Yet, because many of my research participants were not able to see me during our interviews, it is difficult to ascertain how they may have perceived or imagined me. Some have proposed this as an advantage of using the telephone as a medium for conducting interviews (Vogl, 2013). Still, reviewing the interview audio files and reflecting on the way that I reacted to participants, the way that they reacted to me, and examining my own assumptions and thought process was a critical part of this project.

When I conducted interviews in Australia, I was immediately identifiable as – to some degree – an outsider. Even though Australia is a diverse country, my accent provided participants with a major clue that I was not raised in the country. This was a different dynamic than what was at play during my interviews with Canadian residents, but I do not believe it hindered my ability as an interviewer.

In a number of ways, I think that I was able to use my outsider status to my advantage. I used it as an opportunity to build rapport with participants and in my experience, Australians have favourable views towards Canadians. (This was true of my experiences more broadly living and travelling across Australia, and not just my interactions with interviewees). In many cases, my accent served as a conversation starter and many participants pre-emptively offered additional explanations about geographic locations, the inner workings of the health system, and certain social and cultural trends that I might not otherwise have known about. Participants seemed eager to offer me this additional clarification. At the same time, I always made an effort – through my use of language – to demonstrate a degree of cultural fluency that gave me both an

insider and outsider status. For example, in Canada, we use the term “pharmacy” to describe a drug store, while in Australia it is much more common to use the word “chemist”. We offered participants in Australia a $40 gift card to the grocery chain Woolworths, but it is more often referred to as Woolies.

I tried to navigate regional variations of speech and slang thoughtfully because I was wary of giving an impression that I was trying too hard. So much of casual speech in Australia depends on shortened forms of words, which sometimes seemed unprofessional or overly casual when compared to the standard I am used to in North America. Still, with interviews, it is critical to develop a sense of rapport and trust with participants. During my time in Tasmania, which is rarely (if ever) referred to by its full name by those in-state, the use of slang and shortened forms seemed especially relevant to rapport building. I quickly learned to refer to Tassie (Tasmania) and Launie (Launceston).

An example of strategic reflexivity that I engaged with during this process has to do with the research tools and materials that I had originally created for this project. They used the term “on-island”. For example, I wanted to find out about the experiences of those accessing care “on-island.” On one of my first nights in Hobart I had a meeting with a key stakeholder and when I ised this term, I was met with a somewhat perplexed expression. I was quickly corrected that it would be better to say “in state” for what I was trying to convey and this is the language that I used moving forward.

Methods Related to Studying Mifepristone in Canada

My primary institution for this dissertation is the University of Ottawa in Ottawa, Canada. At uOttawa, I am affiliated with the Faculty of Health Sciences, School of

Interdisciplinary Health Sciences. The data collected as a part of this thesis was covered under several different research ethics applications.

Per the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS-2), the literature review and media audit did not require ethical approval because it did not involve human subjects. The interviews with Canadian Mifegymiso® users and the data collected as a part of the Canadian Abortion Study were covered under a previous application that my supervisor had submitted to the University of Ottawa Health Sciences and Science Research Ethics Review Board (file #S-04-18-551). I submitted a *de novo* application for my key informant interviews to the uOttawa Social Sciences and Humanities Research Ethics Board (file #03-18-11).

Literature Review and Media Audit

This project began with a literature review, including peer-reviewed and grey literature, and a media audit of coverage of mifepristone in Canadian news sources. In conjunction with a document analysis, this was combined with interviews with Canadian key informants (methods described below) to produce the first chapter of this thesis. This chapter explores the history of mifepristone in Canada and takes a close look at what the factors that contributed to mifepristone's delayed introduction in the country when compared with the rest of the world. While there is a rich literature about the history of abortion in Canada, the majority of this has focused on the era prior to decriminalization (Ackerman, 2012; Browne & Sullivan, 2005).

Mifepristone has only recently been registered – and even more recently, become available – in Canada (Dunn & Brooks, 2018). The drug's introduction coincided with the beginning of my doctoral studies. While this presented a timely opportunity to document the

introduction of Mifegymiso® across the country in real time, it also meant that peer-reviewed literature on the topic was quite limited.

I consulted literature from around the world to gain an understanding of the ways that the medication abortion regimen has historically been regulated in different settings and how this has affected its use and availability. A lot of the available literature examines mifepristone in the United States context, but this has little relevance to Canada because of significant differences in the health care systems and overall views on, and regulations of, abortion in each country.

The Australian literature about mifepristone proved to be the most relevant to the Canadian context for a number of reasons. Namely, the risk management scheme imposed by Health Canada with the initial approval of Mifegymiso® in 2015 was modelled after the regulations put in place by the Therapeutic Goods Administration (TGA) that accompanied the 2012 approval in Australia (CADTH 2015; Campbell, 2018). As well, both Canada and Australia are countries with a large landmass and relatively low population density, which has implications for the way that abortion care has historically been structured and delivered. My literature review included articles from a range of disciplines, including public health and health sciences, nursing, law, and sociology and anthropology.

The limited information from peer-reviewed sources about mifepristone in Canada meant that including media coverage filled an important gap in my knowledge and the overall narrative of medication abortion in Canada. I conducted a media audit by searching for articles that were related to mifepristone, Mifegymiso®, and medication abortion, published between 2010 and 2018 (inclusive). Although mifepristone was not approved by Health Canada until 2015, the pharmaceutical company Celopharma initially submitted the application in 2011, and resubmitted in 2012. The length of time that the Mifegymiso® application was under review by

Health Canada garnered significant media attention. I selected this date range to order capture any media coverage leading up to the application, the time that the application was under review, and the coverage of the approval and backlash to the restrictions. I also wanted to examine the volume of coverage and how this ebbed and flowed over time and in relation to different issues.

I carried out content and thematic analyses of online news coverage related to mifepristone in the Globe and Mail, CBC News, the Toronto Star, and Global News. I saved each news story as a PDF file and used ATLAS.ti software to manage all of the data. I began the analytic process with a close reading of the data. This served to familiarize myself with the content and tone of each piece of media coverage. I grouped and organized the data based on the main content area of the article and also into a chronological timeline. Organizing the data in these ways helped me to begin to identify narratives in the news coverage. Next, I created a codebook that my supervisor reviewed. I used *a priori* codes and categories based on the study research questions, as well as inductive techniques to identify emergent findings and themes.

Although content and thematic analysis are rarely discussed separately, but rather as processes in conjunction that cannot always be teased apart, we can make some distinctions between these two processes. I use content analysis to refer to a systematic method that makes valid inferences from verbal, visual, or written data in order to describe a specific phenomenon (Downe-Wamboldt, 1992). Content can refer to a variety of data, and can include anything from newspaper articles to web pages to interview transcripts (Graneheim & Lundman, 2004). Although content analysis is often described as "counting" various aspects of content, it is not solely concerned with quantifying data. Rather, it aims to investigate meanings, intensions, consequences, and context by identifying key words, phrases and sentences (Elo & Kyngäs, 2008). Essentially, this method serves as a way to summarize data in a systematic way.

Thematic analysis reaches a stage of interpretation and is an analytics strategy that focuses on identifying, analyzing, and reporting patterns (or themes) within the data (Braun & Clarke, 2006). Thematic analysis is a flexible process that is concerned with looking across a data set rather than within a single item. It is important to acknowledge that themes are not dependent on quantifiable measures; simply counting the instance of a pattern occurring is insufficient. Researcher judgment is necessary in determining themes and this process is often driven by the particular research questions and analytic frameworks related to the project (Braun & Clarke, 2006).

Once I had finished my first round of coding, I worked within each code to identify principal sub-themes that reflected finer distinctions in the data. I had regular discussions with my supervisor during which we were able to identify recurrent themes and began to draw connections between ideas. Finally, I turned to the interpretation phase of the analytic plan in which I focused on identifying relationships among themes and concepts.

By including media coverage and the perspectives of key stakeholders, I was able to document and explore the convergence and divergence between the different narratives that emerged surrounding the introduction of mifepristone in Canada. Although I do not have a chapter dedicated entirely to the media audit, I incorporated the findings from this inquiry into Chapter 3.

In-depth Interviews with Canadians Who Have Used Mifepristone and Misoprostol

This component of the dissertation aimed to document the experiences of people across Canada accessing medication abortion with mifepristone. The shifting regulatory and funding landscape of mifepristone provided key context for these interviews as we specifically wanted to

understand how these policies impact people's abortion experiences. We also wanted to explore participants' perceptions of how services could be improved.

In order to be eligible to take part in the study, participants had to have used mifepristone to terminate a pregnancy while living in Canada, be sufficiently fluent in English or French to answer interview questions, and have access to a telephone or Skype. Our approval from the University of Ottawa Research Ethics Board did not specify any age restrictions for participants, and so we were able to include the small number of minors (under 18 years old) who expressed interest in the study.

This study was based off of my supervisor's previous research project, the Canada Abortion Study (CAS). This was a large-scale national, qualitative study that documented the abortion experiences of people residing in every province and territory of the country. I served as the Study Coordinator for this project and we conducted interviews between 2012 and 2015. As a part of CAS, I led recruitment efforts, conducted interviews, and contributed to the data analysis and drafting of manuscripts.

When we carried out CAS, mifepristone was not yet available in Canada. Medication abortion with a different, less effective, and less acceptable regimen (methotrexate and misoprostol) was only available in a select number of clinics across the country which were concentrated in British Columbia and Alberta. As a part of CAS, we asked participants (who had all had at least one abortion) their thoughts about mifepristone. We found that participants were very excited about the potential to have a medication abortion and were receptive to receiving care across a variety of health service delivery settings (Vogel et al., 2016).

This component of my dissertation was designed as a companion piece to CAS and utilized the same overarching recruitment strategy, data collection method with a modified version of the interview guide, and analytic plan.

Recruitment.

We purposively recruited participants from selected provinces that we knew to have high volume medication abortion providers (Alberta, British Columbia, and Ontario). We also carried out targeted recruitment efforts in some of the Atlantic provinces, including Newfoundland and Nova Scotia, in order to capture participant's stories from different settings across the country. We also selected recruitment sites to include a variety of health service delivery settings.

We used a variety of community-based recruitment methods, which included creating a study website, posting flyers in abortion providing facilities, posting on social media (Facebook and Instagram), and creating ads on online classifieds websites (Kijiji and Used.ca). All of our recruitment materials used gender-neutral language and our eligibility criteria were intentionally open so as to be inclusive of people of all gender identities. The vast majority of our participants were recruited from flyers posted in clinics and ads on online classified sites.

All of our recruitment strategies required that anyone interested in taking part in the study reach out to me via email and express interest in participation. The initial email exchange allowed me to screen potential participants for eligibility, provide them with an electronic copy of the consent form, and answer any questions that they raised. We scheduled a mutually convenient time to talk (including evenings and weekends) over the telephone or Skype, depending on the participant's preference.

I sent each participant a reminder email approximately 24 hours before our scheduled call. If the potential participant did not answer the phone at the time we had scheduled to talk, I left a voicemail message (if possible) and sent a maximum of two follow-up emails in an attempt to reschedule. At the conclusion of each interview, we offered participants a $40 gift card to Amazon.ca.

Data Collection.

In conjunction with my supervisor at the University of Ottawa, we made slight modifications to the CAS interview guide in order to reflect the differences between a medication abortion regimen and instrumentation procedures. I conducted all of the interviews, which were audio-recorded and later transcribed. My supervisor audited a selection of the audio recordings and transcripts and provided feedback throughout the data collection process.

I conducted all of the interviews over telephone or Skype, and all of the interviews were conducted in English. The interviews lasted up to 90 minutes, with an average length of 60 minutes. At the beginning of each interview, I briefly reviewed the consent form with the participant and obtained verbal consent for their participation, which I documented on a printed copy of the form. Participants did not have to print, sign, or mail anything to consent to participate. As well, we allowed participants to consent separately to different aspects of participation: general participation, audio recording of the interview, and allowing us to use (masked and de-identified) quotes in publications and presentations. All of the people that I spoke with consented to general participation and audio-recording, but a select few did not want quotes from the interview to be used.

The Interview Process.

A well-developed interview guide should follow an arc and build in intensity, before ending with a denouement, in order to maximize the participant's comfort and experience (Johnson & Rowlands, 2012). After obtaining informed consent, I began the interview by asking general questions about the participant's demographics and background. This included asking about the participant's age, pronouns, self-identified race and ethnicity, occupation, current living situation, and sources of emotional support. We created the first few questions of the interview as "warm up questions"; while they solicit valuable information from the participant, their main goal is to provide an opportunity to establish rapport. These questions also gave me insight into what kind of an interviewee I was speaking with. Some participants are very talkative, while others require much more coaxing to expand on their responses. My experience as an interviewer suggests that you can get a good idea about how a participant will respond to questions over the next hour with a variety of well-crafted warm-up questions.

After the warm-up questions, I asked participants slightly more personal questions related to their general sexual and reproductive health history. At this point in the interview, I was still developing a rapport with the participant, but this section also elicited crucial information that I used to structure the remainder of the interview. For example, in this section I asked whether the participant had, either currently or in the past, experienced problems or challenges with regards to their reproductive health. I also asked about the participant's pregnancy history, including the number of deliveries, abortions, and miscarriages. Some participants have generally straightforward reproductive health histories, while others have histories that are more complicated and challenging to trace and understand. The information that the participant shared with me during this section of the interview directly influenced other questions that I asked later

on. For example, if the participant had more than one abortion in the eligibility period, or had previous abortions, I asked additional and/or different questions than from someone who only had one lifetime abortion. As well, in order to be respectful of the participant's time, I ensured that the interviews never exceeded 90 minutes in length, including the portion of the call during which I obtain informed consent. This set of questions gave me an indication of how long the interview would be and how I needed to manage the timing and flow of the interaction moving forward.

Next, we discussed the participant's abortion experience(s) in more depth. If the participant had more than one medication abortion in the eligibility period, I asked them which one they would like to discuss first. I have found that it aids in the flow of the interview to only discuss one abortion experience at a time. Thus, I went through the series of questions in entirety for one termination, and then repeated the series of questions again for any other abortion experience(s).

After verifying the (approximate) date of the participant's abortion, I asked questions related to the participant's pregnancy intentions and experience confirming the pregnancy. We then discussed the participant's decision-making process and experience locating a provider. Depending on when and where the participant had the termination, obtaining a medication abortion can include numerous visits to different health care providers, such as blood work, an ultrasound, a visit to a prescriber, filling a prescription, taking the medication and the actual abortion process, and a follow-up visit.

Based on this, I categorized the medication abortion process in Canada into four distinct phases: pre-abortion care, experience with the prescriber, the abortion process, and follow-up care. I asked participants to "walk me through" each phase of their abortion experiences, and

asked relevant follow up questions about each stage of the process. I asked specific questions about the wait times, number of appointments, process of obtaining care, interactions with health service providers, and travel. I also asked participants to describe their abortion process in depth, including a discussion of when, where, and how they took the pills, their bleeding patterns, and their experience with pain, blood, and the products of conception.

I then ended the interview with a number of "wrap-up" questions that are intended to give the participant a sense of closure about the interview experience. I asked them to reflect on their experience as a whole. I also asked a number of questions about whether they would recommend Mifegymiso® and the provider from which they obtained care, and how they think that services could be improved. I ended each interview by giving the participant an opportunity to ask me questions or comment generally on anything that I failed to ask about.

Justification of Telephone Interviews.

All of the interviews that I conducted with abortion patients were conducted over the telephone or Skype voice calls. Given our overarching research goals, eligibility criteria, and recruitment strategy, this choice was appropriate and enabled a broader subset of individuals to participate, increased participant comfort and disclosure, and yielded sufficiently rich data.

Methodological textbooks have typically discussed in-depth interviews as an in-person interaction (Irvine, 2011). While telephone surveys are common in quantitative research, in-depth qualitative interviews conducted over the telephone are often discussed as an inferior, albeit pragmatic, data collection strategy (Novick, 2008). Indeed, much of the literature that discusses the use of telephone or video calls for in-depth interviews focus on the pragmatic aspects of these media: they allow us to interview people across a wider geographic area, are

more convenient for participants and interviewers alike, and are less costly overall than in-person interviews (Carr & Worth, 2001; Sturges & Hanrahan, 2004). There is little literature that focuses specifically on interviewing over the telephone, and the literature that does exist tends to be framed around ways to overcome the "limitations" of using this medium (Carr & Worth, 2001; Irvine, 2011; Irvine et al., 2013).

I believe that the extent to which discussions of telephone interviews as an appropriate medium for data collection focus on pragmatism and convenience as the key advantages do a disservice to the true strengths of this medium. It contributes to the narrative that face-to-face interviews are the default and superior medium, while telephone interviews are selected because they are easier and therefore should be viewed with suspicion in academic communities. All methods have inherent advantages and disadvantages. Despite a continued bias by traditionalists against telephone interviews, their use in qualitative research conducted for both health sciences and social sciences research is increasing (Carr & Worth, 2001; Irvine, 2011).

There is a limited body of research that has directly compared face-to-face and telephone interviews. While the overall findings of these investigations agree on both the viability and value of telephone interviews, there is no consensus about whether or not telephone interviews have significant differences from those conducted face-to-face. Irvine and colleagues found that telephone interviews tend to be shorter in duration and that the interviewer "held the floor" for a greater proportion of time than the interviewee in telephone interviews when compared to face-to-face interactions (Irvine, 2011; Irvine et al., 2013). They also found that participants tended to ask for clarification more often in telephone interactions (Irvine et al., 2013).

These differences are interesting, but also suggest that the variances between the media can be mitigated with careful interviewing skills and attention to detail on the part of the

interviewer. Still, other studies comparing telephone and face-to-face interviews have found no discernable differences in the length, depth, or type of responses (Sturges & Hanrahan, 2004; Vogl, 2013).

Other have argued that telephone interviews are a more appropriate medium when dealing with "sensitive topics" (Sturges & Hanrahan, 2004; Trier-Bieniek, 2012). There is no universally accepted definition for what constitutes a sensitive topic (Lavrakas, 2011). It may refer to something that is likely to elicit an emotional reaction or something that is controversial (Lavrakas, 2011). I reject the idea that abortion should *de facto* be considered a "sensitive topic" because it seems to imply that people are unable to discuss their abortion experience without a degree of emotional distress. This assumption is not reflective of the way the vast majority of our participants described their own experiences. If we assume that abortion is somehow too taboo to discuss, we perpetuate abortion stigma.

Thus, while it is important to note that we did not opt to conduct telephone interviews because we assumed that participants would have a negative emotional response, I acknowledge the continued stigmatization and politicization of abortion. Telephone interviews allowed our participants to have greater freedom in choosing when and where they wanted to participate in the study, and if they wanted others around while they spoke with me. Many participants fit the phone calls in between other routine parts of their day, like driving, running errands and completing chores, or while their children played at the park. People's pets, children, partners, and housemates were featured regularly in the calls and it gave me a glimpse into participants' daily lives and relationship dynamics. This also facilitated rapport-building between me and the participant.

Of note, all of the participants that I interviewed as a part of my work in Tasmania (discussed below) were given the option of an in-person or telephone/Skype interview. All of the key informant stakeholders that I contacted opted to do an in-person interview, or had a strong preference for this if it was logistically feasible. All of the abortion patients that I spoke with opted to do a telephone interview, despite being offered the opportunity to do it in-person. While this is anecdotal evidence, this may speak to how power differentials and stigma influence participants' preferences for how to take part in an interview.

Data Analysis.

I took notes throughout all of the interviews and memoed shortly thereafter. As discussed above, I memoed in a variety of ways and this played a crucial role in the analytic process. This also helped me to identify when we had reached thematic saturation. Data collection and the analytic process for this project was iterative; that is, we began reviewing data as they were collected in order to identify recurrent themes, draw initial connections between ideas, and establish thematic saturation.

Our recruitment plan and eligibility criteria included participants from a very broad geographic range, and many of our first participants obtained abortion care from the same provider on the West Coast and were recruited via flyers in the clinic's waiting room. This meant that we reached thematic saturation for our main research aims in that particular setting somewhat quickly. However, we continued to purposively recruit from other settings and conduct interviews until we had reached thematic saturation across a wider variety of settings and contexts. Once we thought that we had reached thematic saturation, I conducted an additional four interviews to see if new themes or findings emerged.

Undergraduate research assistants transcribed the interviews. I reviewed all of the transcripts and checked a selection of them for accuracy against the original audio-recordings. My supervisor and I had frequent contact and regular meetings throughout the life of the project. In cases that I had an interview that I found to be particularly challenging or interesting, I emailed my supervisor and we either debriefed online or scheduled a time to talk. These discussions provided a space to debrief and reflect, identify themes, discuss emergent findings, and begin to draw initial connections between ideas.

I served as the primary coder for the study. I created a codebook of *a priori* and inductive codes which drew on the interview guide, overarching research questions, and interview notes, memos, and content. I sent the codebook to my supervisor for review and she provided feedback. I used ATLAS.ti to manage the data and I conducted a content and thematic analysis of the interview transcripts. Our thematic analysis centered on grouping categories of information, drawing connections between ideas, and understanding relationships. My supervisor reviewed a selection of the coded transcripts and my overall analytic process, and we resolved any rare disagreements through discussion.

In-Depth Interviews with Canadian Key Informants

This part of my dissertation aimed to explore how the Health Canada review and regulations of mifepristone was perceived by key stakeholders with involvement in reproductive health across Canada. I also wanted to document their professional experiences with mifepristone policy and advocating for evidence-based regulations. We selected key informants based on their professional status in Canadian and international agencies, non-governmental

organizations (NGOs), advocacy organizations, and/or academic institutions and their experience working on issues related to mifepristone.

In order to participate in this study, participants had to be sufficiently fluent in English or French to complete the interview, hold a senior level director/research, coordinator, or policy maker position in a relevant organization; and be working in the field of reproductive health and/or with expertise in mifepristone.

Recruitment.

This study used a combination of purposive and snowball sampling. In order to recruit an initial heterogeneous cohort of participants, I identified a diverse list of organizations of interest. I created this list based on my literature review, media audit, and professional knowledge of the reproductive health field in Canada. The list included Health Canada, Action Canada for Sexual Health and Rights, the Society for Obstetricians and Gynaecologists of Canada (SOGC), the Abortion Rights Coalition of Canada, and the National Abortion Federation (Canada). My supervisor reviewed this list and made additional suggestions of organizations that should be included. Then, I identified individuals affiliated with these groups who met the eligibility criteria. Once again, my supervisor reviewed this list and offered suggestions based on her professional knowledge and experience.

All of the key informants that I identified in this initial process had publicly-available contact information. I sent an introductory email that included an overview and rationale of the study, information about what was involved with participation, a copy of the consent form, and my and my supervisor's contact information. I received a response from every key informant that I contacted. Most were happy to participate in the study, but a few felt that they were not a good

fit based on the study aims. Those who declined to participate offered suggestions of other stakeholders that they thought would be more relevant for the project. Some stakeholders declined an interview but offered to answer questions over email.

For those participants that agreed to take part in an interview, we scheduled a mutually convenient time to talk. I gave Ottawa-based participants the option of meeting in-person at a location of their choosing or talking over the phone or Skype video. For those key informants that were based outside of Ottawa, I offered to conduct the interviews in person at one of the two main meetings in our field, The North American Forum on Family Planning in October 2018 and the National Abortion Federation Annual Meeting in May 2019, or over the phone or Skype.

Snowball sampling is a common strategy when conducting key informant interviews because participants have in-depth knowledge of those working in the field who may have relevant information (Noy, 2008). At the end of each interview, I asked participants if they had suggestions of other key informants that I should include in the study. If someone suggested a key informant that did not have publicly available contact information, I asked the original participant with whom I already had contact to forward my information to the potential participant. Then, if they reached out to me, I followed the same scheduling protocol described above.

Data Collection.

With input from my supervisor, we developed an interview guide specifically for this project. I conducted all of the interviews for this project. I obtained verbal consent from participants before beginning the interview, which I recorded on a copy of the consent form that I kept. We gave participants the option of consenting to different components of participation;

they could consent to general participation, audio-recording of the interview, quotes to be used in publications and presentations, quotes to be attributed to them as individuals, quotes to be attributed to them as representatives of their organization.

I began by asking questions about the key informant's professional background and training, current affiliations, and experience with mifepristone-related projects. Then, I moved to discussing the informant's professional experience with mifepristone in Canada, including her/his/their role in, or perceptions of, the Health Canada review process. Next, we discussed in-depth the policies and regulations surrounding mifepristone in Canada and what had contributed to provincial and federal changes to dispensing requirements, cost coverage, and the product monograph. We ended the interview with a discussion of what the informant saw as future directions for both mifepristone and abortion care in Canada, in the short-term and in the next decade. The interviews lasted no more than 60 minutes, and I audio-recorded them and later transcribed them myself.

Key informant's professional experiences and roles varied quite widely, which resulted in much more variation in the interview structure between these interviews than when compared to those I conducted with Mifegymiso® users. My supervisor audited a selection of the audio recordings and transcripts and gave me feedback throughout the process.

Data Analysis.

The analytic process for this study followed the same process and plan as described above for the interviews with Canadian Mifegymiso® users. I created a codebook which my supervisor reviewed. I served as the primary coder for this study but my supervisor reviewed a

selection of coded transcripts. I used ATLAS.ti to manage the data and carried out content and thematic analysis.

Canada Abortion Study Data and Ottawa Abortion Patient Interviews

Part of the data collected in Chapters 5 and 6 was collected as a part of the aforementioned CAS. My supervisor was the Principal Investigator of the study and I served as the Study Coordinator. We conducted a total of 305 interviews with people from every province and territory who had accessed abortion care across Canada (Foster et al., 2017; LaRoche & Foster, 2018; Vogel et al., 2016).

My supervisor and I discussed how a focused, qualitative case study could contribute to the literature about mifepristone in Canada. As a result, I conducted a secondary analysis of some of the data CAS data with Ottawa residents. I then conducted additional interviews with Ottawa residents who had an abortion since the introduction of mifepristone in 2017. The recruitment strategy and data collection for these interviews followed the same process as the interviews that I conducted with Mifegymiso® users. However, in order to be eligible for the comparative portion of this project, the eligibility criteria were that the participant had to: be sufficiently fluent in English or French to answer interview questions, have had at least one abortion (any method or procedure) while living in Ottawa since February 1, 2017, and have access to a telephone or Skype.

We also followed the same analytic process and plan as we did for the interviews I conducted with Mifegymiso® users. I carried out content and thematic analysis of all of the interviews. However, the case study had an additional analytic component in which I explored

the concordances and discordances in participants' experiences before and after mifepristone was made available.

Methods Related to Studying Mifepristone in Australia

In September 2018, I began my attendance at Macquarie University, Sydney, Australia as a part of my collaborative Cotutelle degree. I resided in Australia for 12 months and was affiliated with the Department of Anthropology during this time. All of the data that I collected in Australia were approved by the Human Research Ethics Committee at Macquarie University (File #3491).

In-depth Interviews with Australians Who Have Used Mifepristone and Misoprostol

This component of the thesis was designed as a companion piece to the interviews that I conducted with people across Canada who had used Mifegymiso® to terminate a pregnancy. MS 2-Step is the brand name for mifepristone and misoprostol composite pack that is sold in Australia. We used the same overarching recruitment strategy, interview guide, and analytic plan as we had for the interviews I conducted in Canada.

Before I began recruitment for this component of my dissertation, I conducted a literature review about abortion and medication abortion in Australia. I also had discussions with my supervisor at Macquarie University and selected key stakeholders, including advocates and abortion providers in Australia. The literature review and the discussions with stakeholders provided me with key information about how to modify the interview guide that we had developed for use with Canadians who had used mifepristone to terminate a pregnancy for the Australian context. For example, there are differences between the two countries' health care

systems, and it was important that the interview guide reflected these regulatory and structural differences.

Initial Recruitment Challenges.

Initially, we had planned that my interviews with Australian medication abortion users would only include those who had accessed mifepristone through telemedicine. At the time, Australia was unique as it was the only country in the world with a national telemedicine service for medication abortion. We wanted to focus on the experiences of abortion patients accessing care through this innovative service delivery model. However, response to these initial recruitment efforts was very limited. We also received feedback from key stakeholders that this would be a challenging population to reach. In response, we amended the eligibility criteria and expanded the study to include anyone who had used mifepristone to terminate a pregnancy in Australia since 2009.

Although mifepristone was not approved for general importation in Australia until 2012, the Therapeutic Goods Administration has an Authorised Prescriber Scheme which legally allows for the prescription of unlicensed drugs (Baird, 2015). A group of medical practitioners in South Australia applied to the TGA for authorization to prescribe mifepristone and misoprostol for first trimester abortion under this scheme in 2008, and supplies arrived in early 2009 (Mulligan & Messenger, 2011). This informed our timeline for eligibility and recruitment.

Of note, a stakeholder in Australia initially discouraged me from carrying out this study due to concerns about my recruitment strategy. The stakeholder voiced his opinion that "Australians do not want to talk about their abortions" after they have accessed services. He

stated that although I had success with this same recruitment strategy in Canada, the Australian context was significantly different. Fortunately, his predictions were not accurate.

Recruitment.

My recruitment strategy in Australia mimicked the strategy that we had used to recruit Canadian mifepristone users. However, there were a number of key differences. Namely, I did not have existing relationships with abortion providers and so I did not recruit directly through clinics. Recruitment for this project occurred entirely online, with postings on the Australian classifieds site Gumtree, and the social media sites Facebook and Instagram.

In comparison to the Canadian participants that I interviewed, the vast majority of Australian participants found out about the study through Facebook. I created a recruitment image and reached out to a number of Facebook pages and groups directly and asked them to share the graphic. The recruitment image was shared quite widely, by both individuals and groups on Facebook with large followings. I received an unexpected number of responses to the ad in a very short period of time and completed data collection over a four-week period.

Due to the qualitative nature of this study, the project was not representative and was never intended to be a national study. However, I purposively selected and reached out to groups that were located across a variety of regions, states, and territories when I asked them to share study information.

Data Collection.

Data collection for this study used the same scheduling techniques, consent procedures, and overarching interview process as the interviews that I conducted with Canadians who had used Mifegymiso® (described above).

The primary modifications that we made to the interview guide included adding more questions related to out-of-pocket costs for the medication, and questions about the legal status of abortion and referral processes. These reflected differences in the criminal status of abortion and the regulatory status of mifepristone between Canada and Australia. I also familiarized myself with key differences in terminology and incorporated this into my discussions with participants to reflect the local context. For example, in Australia, participants tended to use the term "M-TOP" (short for medical termination of pregnancy) instead of "medication abortion". The interviews were all conducted over the telephone or Skype audio and lasted between 60 and 90 minutes. I audio-recorded the interviews in entirety and took notes throughout.

One of the primary benefits of qualitative research and an inductive approach in general is that it allows for flexibility throughout the research process. Informed by my literature review, I knew that the criminal status of abortion in Australia varied from state to state. However, early on in the data collection process, I was surprised to learn about the extent to which this impacted the people I was speaking with, considering they had all been able to access safe, high quality care. We refined the interview guide to reflect this emergent finding. Informed by the (at the time) ongoing legislative battle for decriminalization of abortion in New South Wales, we added additional questions that asked about participants' opinions on these efforts. Thus, while we did not originally set out to gather data about how the criminalization of abortion affected the

experiences of those seeking care across Australia, we have included this emergent finding in the thesis as Chapter 8.

Data Analysis.

I transcribed approximately one third of the interviews with Australian participants. Undergraduate research assistants completed the rest of the transcriptions. I audited a selection of the transcripts against the original audio recordings and reviewed all of them.

Once again, I served as the primary coder for this study. I created a codebook that both of my supervisors reviewed. I then used ATLAS.ti to manage the data and carried out content and thematic analysis. Both of my supervisors reviewed a subset of the coded transcripts, and we had regular team meetings throughout the life of the project. I used these team meetings as an opportunity to debrief about interview content and to discuss key findings and themes as they emerged. Discussions with my supervisor at Macquarie University in particular helped me to understand and interpret the data within the Australian context.

An Exploration of the Shifting Landscape of Abortion care in Tasmania

This research project was conceived in response to conflicting media coverage about the availability of abortion care in Tasmania, Australia's only island state. The media coverage also seemed to conflict with what I had heard from Tasmanians as a part of the interviews I conducted with Australian MS-2 Step users (described above). In July 2019, I travelled to Tasmania to begin fieldwork and conduct an in-depth exploration of the landscape of abortion care.

Over the course of one month, I spent time in each of the state's main regions: the South (Hobart), the North (Launceston), and the Northwest (Burnie). We specifically selected these cities and regions based on where abortion services have historically been provided in the state and to allow me to develop state-wide insights and recommendations. Unfortunately, the length of my stay in Tasmania did not allow for me to conduct a complete, in-depth ethnographic investigation of the issue. This would have required much more time than was feasible given the limitations of my Cotutelle degree.

However, my time in Tasmania helped me to contextualize several issues that had been raised by interview participants. It also helped me to develop a much better understanding of the overall setting and further illuminated barriers faced by Tasmanians in accessing abortion care. For example, I did not have access to a car and I relied on public transit and the Tasmanian Redline bus route for all travel during my time in-state. It took over seven hours and multiple buses for me to travel from Burnie – a city in the north-west region of the state where there are no abortion services - to the capital city of Hobart in the south, which gave me an embodied sense of one of the challenges of accessing abortion care for lower-income people living in remote communities without providers.

In addition to my regular memoing, I kept a research journal throughout my time in the field. I wrote daily field notes reflecting not only on the findings of my formal interviews, but also my observations more generally about my life in Tasmania, including travel and informal conversations that I had with people I met. I took notes of conversations that I overheard about people discussing an anti-abortion billboard campaign that popped up shortly after I arrived in Hobart, and noted the unusualness of the anti-abortion ads that were suddenly appearing on my personal social media feeds. I also listened to local radio programs and engaged with local news

sources in an effort to gain a deeper understanding of what the focus of the narrative was in-state, as opposed to the mainland.

My time in Tasmania focused on gathering data from a variety of different sources and in many different forms, and my research journal helped me to begin to make sense of my findings and interpretations that often seemed to be in complete contradiction to one another. I developed ongoing relationships with a number of key informants in the state and checked in with them often to help make sense of the information I had heard and refine my interpretations. I had regular email contact with both of my supervisors throughout my fieldwork and checked in regularly; my supervisor from the University of Ottawa visited me in the field. I also arranged a phone call with my supervisor at Macquarie University to talk through my findings and experience in the field.

Interviews with Residents of Tasmania Who Have Had an Abortion Since 2010.

Consistent with the methodology described above, while I was in state, I conducted in-depth interviews with residents of Tasmania who had accessed abortion care since 2010. We selected this date range in order to capture a broad range of experiences that occurred before and after decriminalization and the clinic closures. As we had done with the other interviews with Australian abortion patients, we used a community-based and social media recruitment strategy to find participants. Because I was in Tasmania at the time that I conducted these interviews, I gave participants the option of meeting in-person at a location of their choosing to complete the interview. No one choose this option and I conducted all of the interviews over the telephone.

Key Informant Interviews and Participant Observation.

I met and conducted interviews with a variety of stakeholders across the state, including policy makers, advocates, clinicians, and employees of non-governmental organizations that worked to provide reproductive health care across the state. A subset of these interviews were formal key informant interviews and the methods mimicked that of my Canadian key informant interviews. All of these interviews were conducted in person and audio-recorded. I identified these key informants based on my literature review and media coverage. I also used a snowball sampling technique and asked the informants that I spoke with for recommendations of other stakeholders who may have relevant information. In addition, I conducted a number of more informal interviews and engaged in conversations with a variety of stakeholders and advocates throughout my time in Tasmania.

I was invited to several meetings, events, and casual coffee dates with stakeholders, all of which related to abortion rights that took place during my time in the state. I also attended a national conference about unplanned pregnancy and abortion that was sponsored by the Queensland based organization Children by Choice and Marie Stopes. Throughout my field work, I combined content and thematic analysis of my interview notes and transcripts with observation as a data collection tool to enrich my research findings. Participant observation uses all five senses to reflect on situations and events to generate rich and complex data about the reality of daily life. Marshall and Rossman define observation as "the systematic description of events, behaviors, and artifacts in the social setting chosen for study" (Marshall & Rossman, 1989, p. 79). Observation adds key context to interview data, and can serve as a way to check definitions of terms that participants use in interviews and observe situations that informants have described (Kawulich, 2005).

Data Analysis and Integration of Primary Findings.

The process of journaling and taking notes is considered both data collection and analysis (Flick, 2014; Kawulich, 2005; Marshall & Rossman, 1989). I memoed and kept a research journal throughout the entire research process. I organized my note-taking around fieldnotes – which included interview notes, observations, jottings, and maps – and questions that emerged for me during my the process. I also checked in regularly with my supervisors to discuss my reflections and findings. I used ATLAS.ti to manage the data in the form of interview transcripts, but I did not transfer my field notes and research journal into the program. With my fieldnotes, the analytic process was ongoing and iterative and it centred on grouping categories of information, drawing connections between ideas, and understanding relationships. My analysis also explored the concordance and discordance between information that I obtained from different sources.

Figure 1

The Cycle of Action Research

Image from Valencia College

Chapter 3:

Canada: It's About Time, But What's Next?

LaRoche, K. J. (in press). Canada: It's about time, but what's next? In A. M. Foster & L. L. Wynn (Eds.), *Abortion, politics, and the pill that promised the change everything: The global journey of mifepristone*. Palgrave Macmillan.

Canada: It's About Time, But What's Next?

Abstract

In examining the global availability of mifepristone, Canada has long stood out as an exception. For many years, it was the only developed country in the world without the medication registered, described as an "orphan country for mifepristone". Despite a developed health care infrastructure and the absence of criminal laws restricting abortion, Health Canada only registered the medication in 2015 and only after one of the lengthiest drug approval processes in Canadian history. However, the initial decision also included a number of non-evidence based restrictions and the federal government was unable to guarantee coverage of the medication through federal and provincial insurance schemes. Thus although Health Canada's approval represented a victory for reproductive health advocates in Canada, the restrictions made it unclear as to whether or not mifepristone could be leveraged to its full potential in order to increase access to abortion care across the country. Drawing from published and grey literatures, media accounts, and informal and formal discussions with abortion providers, researchers, and activists, this chapter explores the journey of mifepristone in Canada, from the controversial clinical trials that took place in the early 2000s to the uptake of the medication in the post-approval era.

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An Overview of Abortion in Canada

In 1988, Canada's historic *R. v. Morgentaler* decision eliminated all federal restrictions on abortion; this ruling remains unchanged and as of 2018 there were no criminal laws regulating the procedure (Norman 2012; Supreme Court Judgments 1988). The *Canada Health Act*, a piece of federal legislation that defines Canada's health care delivery system, requires abortion to be funded through both federal and provincial health insurance schemes which makes it a medically necessary service (Farid 1997; Kaposy 2010). In 1995, the Federal Minister of Health enacted a policy that decreed clinic-based procedures the same as those performed in a hospital, thereby requiring provinces to fund abortion care in both settings (Health Canada 2015a).

Because Canada is one of the few countries in the world to have completely decriminalized abortion, this fact is frequently cited by the anti-abortion movement as proof that Canada has made abortion overly accessible (Preborn Human Rights n.d.). Indeed, there is an entire anti-abortion website and annual campaign centered on the slogan of "We Need a Law". In contrast, Canada is often held up by reproductive health advocates as an idealized example of abortion legislation. This is especially true given the increasingly volatile nature of abortion politics characterized by Canada's closest neighbor, the United States. As policies in the US move towards making abortion care less accessible and more expensive for patients, the status of abortion in Canada as both legal and publicly funded has resulted in the perception that abortion care across the country is more available than it really is. Upon closer examination of the social, political, and geographic factors influencing Canadian abortion care, the history of the procedure is marked by uneven and unequal access to services that persist decades after decriminalization (Kaposy 2010).

While hospitals were once the primary setting for abortion care, the service delivery landscape has shifted in Canada such that the majority of procedures are now performed at

clinics (Norman et al. 2016). This has resulted in a concentration of services in urban city centers; the majority of clinics are located within 200 kilometers of the US border leaving large areas of the country without accessible abortion care (Sethna & Doull 2007). Women living outside of these areas often have to travel hundreds of kilometers and incur significant out-of-pocket costs to terminate a pregnancy, despite the fact that abortion is commonly represented as being a "free" procedure (Sethna & Doull 2007). In addition, significant differences in provincial and territorial regulations and the lack of coverage for clinic-based out-of-province procedures have resulted in inequitable access to services across the country (Cano & Foster 2016; Downie & Nassar 2007; Foster et al. 2017; Kaposy 2009).

One in three Canadian women will have an abortion over the course of their reproductive lives, but the vast majority of these terminations are performed through aspiration techniques (Norman 2012; Norman et al. 2016). Statistics indicate that in the early 2010s, medication abortion with methotrexate and misoprostol -- a less effective medication abortion regimen with a longer process and less acceptability to women than medication abortion with mifepristone and misoprostol -- accounted for less than 4% of the abortions that take place in Canada annually (Guilbert et al., 2016; Norman et al., 2016). This methotrexate and misoprostol option is largely unavailable outside of a handful of clinics in the western province of British Columbia.

Taken together, these factors mean that Canada's landscape of abortion care has been described as a "patchwork quilt with many holes" (Eggertson 2001: 847). Inconsistently applied funding regulations, few accessible providing facilities for the 6.3 million Canadians that live in rural and remote areas, and documented wait times exceeding eight weeks in certain regions and cities mean that women's experiences obtaining care vary tremendously by place of residence (Foster et al. 2013; Foster et al. 2017; Norman et al. 2013; Sethna &

Doull 2007; Statistics Canada, 2015). Thus, abortion remains a legal, medically necessary procedure that is often inaccessible and expensive.

The Promise of Mifepristone

Given this context, reproductive health advocates have long believed that Canada's patchwork landscape of abortion care would be an ideal setting to exemplify the true promise of mifepristone (Erdman, Grenon & Harrison-Wilson 2008). Indeed, recent statistics indicate that the vast majority of terminations that occur in the country take place before nine weeks' gestation (Abortion Rights Coalition of Canada 2016a), suggesting that there is considerable potential for mifepristone. Given the long wait times that have been documented across the country, it is possible that if women were able to access care in a timelier manner, an even greater number of abortions could take place in a time-period eligible for the mifepristone regimen (Foster et al. 2013).

With regard to abortion care, Canada is also facing a number of specific challenges with its health care infrastructure that could be potentially mitigated by the introduction of mifepristone. Namely, there are a decreasing number of medical students and residents training in abortion provision and as such the number of providers across the country is in decline (Eggertson 2001; Ogilvie 2010; Sabourin & Burnett 2012; Dressler, Maughn, Soon & Norman 2013). Canada has a large land mass but a low population density, meaning that the centralized provision of abortion care is impractical for many areas of the country. Incorporating early abortion care into Canada's primary health care system represents a pragmatic solution to these problems and could greatly improve access to the procedure. In Canada's publicly funded health care system, medication abortion performed with mifepristone also represents a cost-effective option (Limacher et al. 2006). Beyond this, there is some evidence to indicate that Canadian family physicians and nurse practitioners are open

to the idea of incorporating medication abortion into their practice (Raymond et al. 2002; Sheinfeld, Arnott, El-Haddad & Foster 2016).

But perhaps more fundamentally, Canadians want mifepristone. A 2015 survey indicated that across the country, the majority of Canadians (62%) were in favor of the medication being available and believed the drug had the potential to increase access to abortion care (Forum Research 2015). In a national study with women who had previously obtained abortions in Canada, participants were overwhelmingly positive about mifepristone. Despite minimal knowledge of the drug, once the interviewer described mifepristone many women indicated that they would have preferred to have a medication abortion (Vogel et al. 2016). Even for those women who would have preferred an aspiration procedure for themselves, they still felt that mifepristone represented a valuable option for other women that would advance social equity (Vogel et al. 2016).

Early 2000s: The Clinical Trials

Canada's history with mifepristone spans more than two decades. In April 2000, Health Canada, the federal regulatory agency with responsibility for national public health, approved an application for Phase I clinical trials of mifepristone to assess the drug's safety, identify side effects, and ascertain the appropriate dosage (Foss 2000). Two prior applications for the trials had already been submitted and rejected by the agency (Foss 2000). Although controversial, the approval of the clinical trials represented a significant victory for Canadian reproductive health advocates. Many were optimistic that data from the clinical trials would pave the way for an application to introduce mifepristone in Canada and the timing of the trials overlapped with the medication's anticipated approval in the neighboring US (Boonstra 2002; Foss 2000).

Health Canada is a federal institution but it maintains that the review and evaluation of clinical trials is based on the rigor of the study design, anticipated safety for participants, and a number of other criteria to ensure adequate monitoring and reporting of the results (Health Canada 2013). In order to maintain a separation between the evaluation of clinical trials and any perceived partisanship, there is no formal opportunity for the public to provide feedback on clinical trials prior to their commencement. This was no different in the case of the mifepristone trials. But that is not to say that the approval and initiation of the trials was without backlash.

Anti-abortion activists asserted that the trials were only approved after "aggressive lobbying" by pro-choice groups and vowed to fight the drug's introduction (Gosgnach 2001). In an era marked by numerous instances of anti-abortion violence, including a number of shootings and an incident of arson in the 1990s, the commencement of the trials coincided with further threats and acts of violence against abortion providers (National Abortion Federation n.d.). Ellen Wiebe, the director of the clinical trials, filed a police report stating that she received threatening voicemail messages less than a week after she publicly announced she was beginning the mifepristone trials (Spurgeon 2000). The following week, another abortion provider in the same region of the country was stabbed at his medical clinic (Spurgeon 2000).

One thousand Canadian women were expected to take part in the trials at sites across the country in the cities of Montreal, Sherbrooke, Vancouver, and Toronto (Foss 2000). However, in September 2001, a little more than a year after it began, the trial was cut short after the tragic and unexpected death of a 27-year old study participant from Quebec (Foss 2000). The woman suffered complications from a *Clostridium sordellii* infection; this rare bacterium is most commonly associated with infection following routine gynecological procedures, trauma, and childbirth (Aldape, Bryant & Stevens 2006; Chong et al. 2016). At

the time, the risk of *C. Sordelli* infection had not yet been associated with medication abortion, and the death of the Canadian participant was one of the first documented instances to link the two (Association of Reproductive Health Professionals 2008; Centers for Disease Control and Prevention 2005). Unsurprisingly, the death of the participant sparked negative media attention surrounding the already controversial clinical trials; however, these accounts generally failed to place the death in context (O'Bannon 2001; Schmidt 2001). The reports publicly portrayed mifepristone as dangerous rather than acknowledging the exceedingly rare nature of deadly *C. sordelli* infections. More fatal cases of *C. sordelli* have been associated with the postpartum period than with medication abortion in Canada, yet these cases have consistently been overlooked by the media (Leal et al. 2008; Sinave et al. 2002).

Despite efforts by clinical trial organizers to reiterate that mifepristone was safe and adverse events were rare in comparison to other commonly used medications (and, indeed, in comparison with pregnancy itself), the trials never resumed. The death of the participant fueled claims by anti-abortion advocates that mifepristone was harmful and unsafe for women (Gosgnach 2001). To this day, the death of the Quebec participant has continually been cited by the Campaign Life Coalition as an argument against mifepristone's introduction. This has been especially salient as the anti-abortion narrative in Canada has shifted in recent years to present abortion as harmful to women (Saurette and Gordon 2013).

2002 to 2011: Leading Up to the Application

Outwardly, the suspension of the clinical trials appeared to halt the journey of mifepristone in Canada. Indeed, an application for the drug's approval would not be filed with Health Canada until more than a decade later in December 2011. However, beginning in 2006, the newly formed Canadian chapter of the National Abortion Federation (NAF) was

meeting with drug manufacturers in an effort to convince them to submit an application to Health Canada.

The manufacturers' hesitation to submit stemmed from the fact that medications in Canada are cost-controlled while the regulatory approval costs are high. This point, coupled with the fact that in many countries medication abortion has been less profitable than anticipated resulted in only modest predicted revenues (Erdman, Grenon & Harrison-Wilson 2008). Although abortion is common in Canada, there are less than 100,000 procedures reported annually, representing a relatively low overall volume for the procedure in comparison to countries with larger populations (Norman et al. 2016). Women's lack of knowledge about medication abortion options in general also meant that consumer demand was low (Vogel et al. 2016). Even after being approached by NAF Canada directly, several existing mifepristone manufacturers expressed that the cost of an application coupled with the limited Canadian market meant that they were unwilling to move forward with a submission.

This crucial context raises broader questions about how Health Canada's review process is structured and whether or not government inaction and political bias played a role in why mifepristone was unavailable in Canada for so many years. Health Canada has a passive regulatory system that is designed to maintain independence in the drug review process. Many have argued that it would have been inappropriate for Health Canada to solicit a pharmaceutical company to submit an application for mifepristone. Given the contentious nature of abortion, there is an argument to be made that such a move from Health Canada would have been perceived as politically biased and stimulated a response from anti-abortion activists which could have potentially plagued mifepristone's introduction to the country.

However, Health Canada has instituted several programs to address issues in their process, thereby negating the claim that it is essential for the regulatory body to keep an

arms' length at all times. As an example, in an attempt to remedy the financial barriers to drug approval applications, Health Canada has instituted a cost-reduction program (Health Canada 2015b). This program targets so-called "orphan drugs" (medications that remain commercially underdeveloped due to limited potential for profitability) and medicines for rare diseases. Thus, despite its substantial public health promise, mifepristone was not eligible for either for these programs.

Mifepristone was also ineligible to qualify for a priority review under Health Canada's regulations. In order to obtain priority status, a medication has to be identified for life-threatening or serious conditions, or clinical trials must have demonstrated that the new medication "significantly increases efficacy or decreases risk compared with existing therapies" (Erdman, Grenon & Harrison-Wilson 2008: 1767). Because the criteria only consider the efficacy of currently available procedures (in this case, aspiration abortion) and not the accessibility of these options, mifepristone was not considered to offer an advantage over aspiration procedures and was ineligible for priority review.

Beyond the issue of government inaction, some reproductive health advocates and legal scholars have argued that the current Health Canada process is politically biased, and specifically so against reproductive health technologies (Azzarello & Collins, 2004). This is due in large part to the stringent requirements for the approval of oral contraceptives, which have been described as "onerous" in comparison to the requirements in the US and Europe (Erdman, Grenon & Harrison-Wilson 2008: 1768).

Beyond comparing the Health Canada review process to those of other regulatory bodies worldwide, there are discrepancies in the length of time that it takes Health Canada to process approvals for contraceptives when compared to other classes of pharmaceuticals (Contraception Consensus Working Group 2015). The time-to-approval period for contraceptives in Canada is more than two years longer than approvals for new medications

in other drug classes (Contraception Consensus Working Group 2015), despite the fact that these contraceptive medications have a significant evidence base that has demonstrated their safety in other jurisdictions (Erdman, Grenon & Harrison-Wilson 2008). As a result of these processes, Canada has significantly fewer options for hormonal contraception available when compared to the US, France, Sweden, Denmark, and the United Kingdom (Azzarello & Collins, 2004; Troskie, Soon, Albert & Norman 2016). Notably, as of 2018, the contraceptive implant, one of the most effective methods of long-acting reversible contraception, remained unavailable in Canada (Contraception Consensus Working Group 2015).

Yet there has been no effort by Health Canada to address the noted inefficiencies in evaluating and approving contraceptive and reproductive health medications. In 2015, the Society of Obstetricians and Gynaecologists of Canada (SOGC) advocated for Health Canada to consider a proactive process to invite prospective manufacturer applicants for reproductive health related medications (Contraception Consensus Working Group 2015). This call is consistent with the argument made by Canadian legal scholars that while the "government may not obstruct the approval of safe and effective medicines, [it cannot] remain passive when financial and political barriers [impede] the introduction of essential reproductive health medicines on the market" (Erdman, Grenon and Harrison-Wilson 2008: 1768).

Despite this confluence of factors that made it difficult for mifepristone to break into Canada, in October 2011 joint efforts between the National Abortion Federation, the pharmaceutical company Linepharma, and reproductive health advocates across the country resulted in an application to review mifepristone being quietly submitted to Health Canada (Grant 2015). In December 2012, Linepharma resubmitted the application due to incomplete information included in the initial filing.

2011: Submission of the Application

Both the submission and resubmission of the application in 2011 and 2012, respectively, were discreet and not immediately reported in the media. In comparison to the controversial clinical trials that took place a decade earlier, backlash against the submission of the application was limited. There was little mention of the filing in the media until the mifepristone dossier had been under consideration for almost a year.

The limited debate stemming from the application is due at least in part to a shift in the Canadian political climate since the commencement of the clinical trials. Polls consistently show that the majority of Canadians are in favor of legal access to abortion services (Russell 2016). Former Prime Minister Stephen Harper (of the Conservative Party) had also made it clear that he had no intention of reopening the abortion debate in Canada, despite his own personal views on the procedure (Galloway 2012). For example, in 2011 when Conservative Member of Parliament Stephen Woodworth proposed a private member's bill (Motion 312) that would have required Parliament to examine the point at which life begins, he was accused of attempting to reopen the abortion debate through backdoor channels (Galloway 2012; Payton 2012). Prime Minister Harper voted against the bill and the motion was ultimately defeated 203 to 91 (Payton 2012).

The majority of the controversy that ultimately emerged from the 2011/2012 mifepristone application stemmed from the length of the review process. The typical length of time for Health Canada to issue a decision on a new drug application is 300 days; this deadline is considered to be an internal service standard (Health Canada 2018). However, a spokesperson for the organization has said that processing an application can take upward of two years if more information is requested from the pharmaceutical company (Grant 2015).

Using the 2012 resubmission as the start of the clock, the 300 day deadline passed in the autumn of 2013. In 2014, the country's New Democratic Party (NDP) began publicly

pushing for progress on the review of the drug (Payton 2014; Proussalidis 2014). They also called for assurance that the delays in the process were not due to the ideological positions of anyone involved in evaluating the submission. At the time, mifepristone had been under review for more than 750 days, more than double the length of time indicated by the internal service standard. The timeline was significantly longer than any other drug that had been approved in the previous two years (Grant 2015). The process had also exceeded the median length of time to approval for hormonal contraceptives in Canada, which was 529.5 days between 2000 and 2015 (Troskie et al. 2016).

Despite the length of the application process, those who had attended the meetings with Health Canada were optimistic that approval was imminent and that political bias had not affected the length of review. They were hesitant to further politicize the process and quietly asked reproductive health advocacy groups across the country to refrain from letter writing campaigns to Health Canada.

Conversely, some anti-abortion groups called on Health Minister Rona Ambrose to block the application from moving forward. Ambrose was one of the Conservative Party members who voted in favor of Stephen Woodworth's Motion 312 in 2011. Anti-abortion groups consistently brought up the death of the Quebec woman in 2001 and also asserted that complications associated with medication abortion are chronically underreported (Campaign Life Coalition n.d.). As such, these groups used inflated statistics to demonstrate what they refer to as the "real risk" of mifepristone (Campaign Life Coalition n.d.). However, in response to both the NDP and anti-abortion groups, the Health Minister stated that Health Canada is an independent, evidence-based regulator over which she had no influence (Payton 2015).

In January 2015, Health Canada issued a statement that the decision on mifepristone would be further delayed pending receipt of additional information from Linepharma (Grant

2015). The government agency publicly reported that there was insufficient or missing safety data included in the application. Given the already extended timeline of the mifepristone application, the delay caused further controversy and was picked up by the media (The Globe and Mail 2015; Grant 2015). However, with reassurance from the National Abortion Federation, reproductive health advocates were optimistic that the delay signaled the file would ultimately be approved.

2015: The Approval

After one of the longest drug review processes in Canadian history, Health Canada announced the approval of mifepristone as part of a combination package under the trade name Mifegymiso® on July 29, 2015 (Health Canada 2016; Woo 2015). At nearly four years since the original submission in 2011 and nearly three years since the first resubmission, the approval process was significantly longer than Health Canada's typical nine month timeframe for reviewing medication applications. However, the organization has insisted that the delays stemmed from a lack of information in the second application provided by Linepharma (Grant 2015).

With the approval came a number of restrictions that were incongruent with the current evidence base about how mifepristone could be prescribed and dispensed; the decision limited use to 49 days, required that the medication be provided by physicians, and ordered the use of ultrasound for both gestational age assessment and the exclusion of ectopic pregnancy (Health Canada 2016). Physicians who wished to prescribe mifepristone were also required to take an online training module that had not been finalized at the time of the approval (Grant 2016a).

Prior to the announcement, some advocates had been hopeful that Health Canada would set a positive precedent for the deregulation of medication abortion with the decision

by basing it on the most recently available and rigorous evidence. There was a cautious anticipation that the gestational age limit would go up to 70 days'. Instead, the quantity and details of the non-evidence based restrictions felt like a heavy blow, even in the face of the significant victory that mifepristone would finally be available in Canada.

Some advocates argued that with these restrictions in place, mifepristone would be unable to have a significant, positive impact on the availability of abortion services across Canada and that the public health implications would be severely muted (Picard 2016). Although the gestational age limit presented a notable challenge, there had been particular backlash from health care professionals with regard to the physician-only dispensing rule (Norman & Soon 2016; Kirkey 2016).

Unlike in other jurisdictions around the world, the Health Canada decision meant that patients would not be able to receive a prescription for the medication and then fill it at a pharmacy. The drug's distributor, Celopharma, explained "the patient will not have the prescription in (her) hands" (Kirkey 2016:paragraph 4). Instead, the original decision required that the patient take the mifepristone at the medical facility under the supervision of a physician and then take the misoprostol at home. Many felt that this was a particularly punitive requirement because physician-only dispensing of medications in Canada is a practice usually reserved for cases where there is potential for suspected drug diversion or misuse, such as with methadone (Kirkey 2016).

Health care professionals argued that this regulation was unnecessary, unfeasible, and burdensome for all parties (Grant 2016a). In July 2016, the British Columbia Health Minister, Terry Lake, wrote a letter to the Federal Health Minister Jane Philpott and asked her to intervene on the regulations stipulated by Health Canada before the medication became available. He noted, "Taken together, these regulations are onerous, create administrative and

practical barriers for women to access medical abortion and do not contribute to patient safety" (Grant 2016a: paragraph 9).

Specifically, it was noted that many doctors, especially those with small practices in more rural and remote areas, lack the infrastructure to dispense medications directly and receive payment for them (Kirkey 2016). Within the Canadian health care system where "the monetary exchange is practically nonexistent between patient and health care provider" (Ridic, Gleason & Ridic 2012: 113), the regulations surrounding mifepristone were unprecedented and meant that it was unlikely that any physicians who were not already providing abortion care would be inclined to incorporate mifepristone into their practices.

Stakeholders were divided in their opinions about both the length of the review process and the restrictions. On the other hand, those closely involved with the Health Canada process were unsurprised by the details of the decision. Some of the restrictions that seemed most unexpected to those on the periphery, such as the mandated training module and gestational age limit, had actually been suggested by the pharmaceutical company in the application to Health Canada. These regulations were modelled after the application that was reviewed, and eventually accepted, to allow the distribution of mifepristone in Australia just a few years earlier.

Those directly involved with the review also emphasized that the length of the process was due at least in part to the fact that both mifepristone and misoprostol were reviewed. Health Canada had refused to consider an application for mifepristone alone because it would have required the off-label use of misoprostol. As such, Health Canada reviewed both medications and approved a combination pack, thereby making Canada one of the few countries in the world where misoprostol can be used on-label for early pregnancy termination.

Despite the intense disappointment expressed by many reproductive health advocates, others emphasized that the approval itself was such a significant victory that it trumped the restrictions that came along with it. The National Abortion Federation felt that Health Canada was amenable to easing the regulation of mifepristone and that with continued advocacy, the restrictions would be eased and eventually align with the available evidence base.

From Approval to Introduction

After approval but prior to the medication's introduction, media reports began to circulate that the drug would not be covered by the majority of provincial health insurance schemes and would instead cost patients an average of CAD300 (USD225) out-of-pocket (Grant 2016a). Due to the fact that aspiration procedures are, for the most part, covered by both federal and provincial health insurance schemes but only available in cities, a direct cost of Mifegymiso® to patients would reinforce existing inequities in who can access timely and affordable abortion care across Canada. Women in urban areas would have to choose between paying for a medication abortion and obtaining a free aspiration abortion, while women in rural areas would have to choose between paying for medication abortion or paying to travel to access an aspiration procedure.

In Canada, in order for drugs to be added to the list of publicly funded medications, an application must be submitted to the Common Drug Review. This committee of experts advises all of the English-speaking provinces and territories on which drugs should be added to the formularies; however, as of 2014, there is a CAD$72,000 (USD55,000) cost associated with the application (Grant 2016b). In May 2016, the distributor, Celopharma petitioned the Canadian Agency for Drugs and Technologies in Health (CADTH), the independent body that oversees the Common Drug Review, to drop or defer the fee associated with the application. When the original mifepristone dossier was submitted to Health Canada in 2011,

there was no fee associated with the Common Drug Review and Celopharma said that they simply had not budgeted for it. CADTH rejected Celopharma's request to waive the application fee for fear that it could set a bad precedent (Grant 2016b). They also noted that CADTH and Health Canada are two separate agencies and therefore the length of time that Health Canada took to review the application does not have any bearing on the application fee to be paid to CADTH.

It would seem that the reasons stated by so many pharmaceutical companies for refusing to proceed with the process of bringing mifepristone to Canada for decades were prescient. Between the extensive costs associated with the initial submission and resubmission of the application to Health Canada for review, the length of the review process, the regulatory restrictions put in place by Health Canada that significantly limited the availability of the drug, and the shifting requirements of government agencies, the $72,000 fee represented just one more significant challenge to recouping initial costs.

In response, the Abortion Rights Coalition of Canada (ARCC) issued a statement calling on the openly pro-choice Prime Minister of Canada, Justin Trudeau of the Liberal Party, who had been elected in October 2015, as well as the federal Minister of Health, Jane Philpott, to intervene and ensure the coverage of mifepristone (ARCC 2016b). Although both had openly made statements in support of increased access to abortion care across Canada (Smith 2015), issues related to the cost of the drug falls on the individual provinces. When asked about the prohibitive cost of Mifegymiso®, Minister Philpott stated that "delivery of care is the responsibility of provinces and territories" and the regulatory bodies are responsible for ensuring quality of care (Global News 2016).

Still, leading up to the introduction, some incremental progress was made in loosening Health Canada's restrictions. As the National Abortion Federation had predicted, In October 2016, Health Canada eliminated the requirement that patients had to take the

mifepristone in front of a physician (Health Canada 2017b). Linepharma also presented a new submission to Health Canada that proposed extending the gestational age limit to 63 days. In 2017, British Columbia became the first province to endorse pharmacist dispensing of Mifegymiso® due to the fact that the majority of physicians in British Columbia are not legally authorized to sell and dispense medications (College of Pharmacists of British Columbia 2017; College of Physicians and Surgeons of British Columbia 2017).

Similar to the submission and review of the application, establishing a timeline for when mifepristone would actually become available in the country was full of delays. With the approval in July 2015, it was expected that the medication would be available approximately a year later in July 2016 (Kirkey 2016). Some media outlets reported that the drug would roll out in the late fall of 2016 or early 2017 (Grant 2016a). The required training module for Mifegymiso® providers by the SOGC launched on January 3, 2017 (Grant 2017).

The Introduction

Finally, at the end of January 2017, two clinics, one in Alberta and one in British Columbia, received the country's first shipments of Mifegymiso® (Grant 2017). The first abortion performed with Mifegymiso® in Canada took place in Calgary. In the following months, mifepristone slowly made its way into clinics and medical practices across Canada, the vast majority of which were pre-existing abortion providing facilities. A number of providers from all provinces and territories completed the certification module and shortly after the introduction, Health Canada eliminated the requirement that pharmacists complete a special training module to order and dispense the medication (Health Canada 2017b). By May 2017, mifepristone had become available in nine provinces. However, it was still unavailable in Quebec and Canada's three territories of Yukon, the Northwest Territories, and Nunavut.

Immediately following its debut, the out-of-pocket cost of Mifegymiso® resurged as an issue. A petition directed at Eric Hoskins, the Ontario Minister of Health, quickly began to circulate, with hundreds of people signing in the hope that the medication would be covered by the provincial insurance plan OHIP (Planned Parenthood Ottawa n.d.).

After the delay caused by the application fee, Celopharma did eventually gather the necessary funds and submit an application to CADTH. In April 2017, the CADTH Canadian Drug Expert Committee issued its final recommendation on Mifegymiso® and recommended that the drug be covered by provincial and territorial health insurance plans (CADTH 2017). Although this represented an important step towards universal cost coverage, the decision came years after the initial approval and months after the drug first became available. This caused confusion among both patients and providers. Shortly thereafter, in response to concerted efforts by Canadian reproductive health advocates, including community and non-governmental organizations, researchers and academics, and coverage in the media Celopharma submitted a Supplemental New Drug Submission (SNDS) in the spring of 2017 to have several of the Health Canada restrictions reviewed (Action Canada for Sexual Health and Rights n.d.).

In an unexpected move, New Brunswick was the first province to pledge cost coverage for Mifegymiso® in May 2017 (MacKinnon, 2017). New Brunswick has been historically fraught with inaccessible abortion care and negative media attention surrounding inequitable access in the province, meaning that the announcement was especially important in this setting (Eggertson 2001; Foster et al. 2017; Sethna & Doull 2007). Following New Brunswick, Alberta and Ontario also pledged universal coverage in quick succession (Population Institute Canada 2017). Advocates were able to leverage the guarantee of some provinces to initiate a slow but steady wave of other provinces and territories also pledging to fund Mifegymiso®. At the end of 2018, eight of 13 provinces (Alberta, British Columbia,

New Brunswick, Newfoundland and Labrador, Nova Scotia, Ontario, Quebec and Yukon) have initiated universal cost coverage (Thomson 2018; Weeks 2018). Prince Edward Island and Manitoba have agreed to cover the cost of the medication at sites that have previously been providing surgical procedures, while in Saskatchewan, there is partial coverage and the cost charged to the patient depends on individual drug coverage and eligibility through benefit programs (Weeks 2018). The Northwest Territories has pledged a form of partial cost coverage for Mifegymiso® (CBC News 2018).

After reviewing the SNDS, Health Canada issued updates to the Mifegymiso® monograph and risk management plan on November 7, 2017 (Health Canada 2017b). These updates mean that the Health Canada guidelines now align more closely with the body of global evidence. Namely, the gestational age limit was extended from 49 to 63 days, the physician dispensing requirement was eliminated, and a wider range of health professionals with prescribing authority, including nurse practitioners, are now eligible to prescribe Mifegymiso®. Health professionals are no longer required to register with the drug's distributer, Celopharma.

What's Next?

After a more than two-decade journey and the recent hard-won victory of finally getting the gold standard of medication abortion registered, the story of mifepristone in Canada is still unfolding. Although the initial restrictions posed significant challenges to the successful integration of medication abortion into the health care system, both the drug's distributor and Health Canada have indicated that they are receptive to bringing the Canadian regulations in line with the global body of evidence. Indeed, changes to the regulations issued by Health Canada before the introduction, and the response to the SNDS, bode well for the

future of Mifegymiso® in Canada. In response to the media coverage that criticized the initial Health Canada decision, The Chief Medical Officer for Health Canada had stated,

> In almost every other country, because of the potential risks associated with [mifepristone], there is [sic] some sort of constraints and restraints on how to access that. We're always open to making changes. [But] if I can underscore one thing, it has to be supported by appropriate science and evidence. (Grant 2016a: paragraph 31)

This statement was particularly poignant given the overwhelming evidence that worldwide, policy and decision-making surrounding mifepristone has not been based on science and evidence. Rather, the safety of the medication is frequently eclipsed by the political nature of abortion. In this way, the approval of mifepristone in Canada was not unusual for the way that medication abortion is typically regulated in other jurisdictions. However, it was exceptional for the way that medications are regulated in Canada.

Yet, there are also a number of social and political influences that gave hope to reproductive health advocates in Canada. Overwhelmingly, any media attention surrounding the introduction of the drug had been critical of the length of the application process, the regulations instituted by Health Canada, and the prohibitive cost of the drug. In contrast, critiques of the fact that mifepristone is now available in the country have been few, indicating limited backlash.

These regulatory changes combined with the palpable excitement among Canadian abortion providers has resulted in renewed optimism that the promise of mifepristone can be fully realized. Collaborative efforts between existing providers and primary care practitioners interested in prescribing Mifegymiso® have emerged across the country. New models of service delivery, including telemedicine efforts, collaborative prescribing agreements, and outsourced options and procedures counseling, are being explored. And local and national communities of practice represent key opportunities for resource sharing and creating a supportive and destigmatizing environment for providers. After decades of setbacks and challenges in getting mifepristone into Canada, the focus has now shifted to expanding the

pool of providers and getting the medication into Canadian women's hands. Whether Health Canada can or will address the barriers that delayed the introduction of mifepristone into Canada for decades is another story that has yet to be seen.

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Chapter 4:

"It Gives You Autonomy Over Your Own Choices": a Qualitative Study of Canadian Abortion Patients' Experiences with Mifepristone and Misoprostol

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"It Gives You Autonomy Over Your Own Choices": A Qualitative Study of Canadian Abortion Patients' Experiences with Mifepristone and Misoprostol

Abstract

Objectives: The gold standard of medication abortion, mifepristone and misoprostol, became available in Canada in 2017 as a combination pack under the trade name Mifegymiso®. We aimed to document people's experiences deciding to use and accessing medication abortion and generate insights for how information and services could be improved.

Methods: We conducted semi-structured, in-depth interviews with 64 people who had used the mifepristone/misoprostol regimen to induce an abortion in seven different Canadian provinces. We used ATLAS.ti to manage our data, which we analyzed for content and themes using inductive and deductive techniques.

Results: The overwhelming majority of participants reflected positively on their experience with mifepristone/misoprostol for early abortion. Most people reported that medication abortion offered increased autonomy, privacy, and convenience compared with instrumentation procedures and especially liked being able to have the abortion in a comfortable and familiar environment. The small number of participants who reflected more negatively on their experiences generally did not feel well informed about what to expect. Several participants reported that the media served as a key information source for finding and accessing services.

Conclusions: Although our sample of Canadian abortion patients appear to be highly satisfied with the mifepristone and misoprostol regimen, there are several avenues by which

medication abortion care could be improved. Providing more detailed information about pain management and the products of conception and lifting up the voices and stories of those who have used mifepristone and misoprostol could help patients manage expectations and would likely be welcomed.

Implications: Changes to the Mifegymiso® product monograph since its introduction seem to have addressed a number of barriers described by early users of mifepristone and misoprostol. Continued engagement with clinicians to ensure that the process is not overly medicalized appears warranted.

Keywords: abortion, mifepristone, medication abortion, primary care

1. Introduction

In 2017, the gold standard of medication abortion, mifepristone and misoprostol, became available in Canada as a combination pack under the trade name Mifegymiso® (Linepharma, France) [1]. Many people perceived the introduction of the regimen in Canada as overdue especially as the neighboring United States approved mifepristone for early abortion 17 years earlier [2–4]. Further, research conducted with Canadian abortion patients before the regimen became available indicated that there was strong interest in medication abortion with mifepristone and misoprostol [5]. A 2015 survey indicated that across the country, the majority of Canadians (62%) were in favor of mifepristone being available and believed the drug had the potential to increase access to abortion care [6].

Despite its impressive safety record, mifepristone has been historically burdened by overregulation [7–9]. The initial approval in Canada was no exception and limited use to 49 days [10]. Media reports highlighted that certain regulations – in particular, the requirement that the drug be dispensed by a physician and not by pharmacists – would significantly mute the public health impact of the drug to expand access to care [11,12]. Cost coverage was also an issue. Although abortion has long been defined as a medically necessary service and covered by provincial and territorial insurance schemes, Canada does not have a universal drug coverage plan. As a result, provinces and territories had to individually pledge funding for Mifegymiso® which occurred on significantly different timelines [11,12].

In November 2017, less than a year after the introduction, Health Canada issued significant changes to Mifegymiso®'s Product Monograph and Risk Management Plan [13]. Notably, these amendments extended the gestational age limit from 49 to 63 days from the first day of the last menstrual period, allowed the drug to be dispensed by pharmacists, and broadened the eligibility for prescribing Mifegymiso® to include any health practitioner with prescribing authority [13].. In April 2019, Health Canada eliminated the requirement that an

ultrasound be completed before prescribing the regimen [14] and by the end of 2019, all provincial and territorial insurance schemes covered the cost of Mifegymiso®.

Global evidence suggests that mifepristone and misoprostol is highly acceptable to patients [15-17]. Yet, the introduction of mifepristone in Canada provided a key opportunity to document the experiences of people across the country deciding to use and accessing mifepristone/misoprostol in the midst of a shifting regulatory environment. In response to conversations with stakeholders, we wanted to help providers and policy makers gain an in-depth understanding of patients' experiences with the regimen and learn about ways that medication abortion users think that services can be improved.

2. Methods

Between June 2017 and November 2019, we conducted semi-structured, in-depth interviews with 64 people residing in Canada who used Mifegymiso® to terminate an early pregnancy. In order to be eligible to participate in the study, participants had to have had at least one medication abortion with mifepristone while living in Canada, be sufficiently fluent in English or French to answer interview questions, and have access to a telephone and/or Skype. We offered all participants a CAD40 (USD30) gift card in gratitude for their time. We modelled our recruitment strategy, interview guide, and analytic plan after a previous large-scale, national, qualitative study about the experiences of Canadian abortion patients that we carried out as a research group [18-19].

2.1 Recruitment

We used a multi-modal, community-based recruitment strategy to spread word about the study. This included creating a study website, posting on social media, posting on online classifieds sites such as Kijiji, and distributing paper flyers in local businesses and

community organizations. A number of abortion clinics posted flyers about the study in their waiting rooms. Those interested in the study reached out to the Study Coordinator (KJL) who responded to questions, ensured eligibility, and scheduled a mutually convenient time to talk.

2.2 Data collection

KJL, a PhD candidate in population health who has extensive experience conducting qualitative research with abortion patients, conducted all of the interviews as a part of her dissertation project. All of the interviews took place over the telephone/Skype and averaged 60 minutes. With participants' permission, we audio-recorded all interviews and later transcribed them. KJL took notes throughout the interview and memoed shortly thereafter, a process that allowed for reflections on the interaction and early identification of key themes [20-21]. AMF, a medical doctor and medical anthropologist, provided guidance throughout the data collection phase.

During each interview, we began by asking open-ended questions about participants' demographics, background, and general sexual and reproductive health histories. This included their pregnancy and abortion histories. We then asked a series of questions about participants' abortion experiences with medication abortion including the decision-making process, the steps involved in locating a provider, details of the medication abortion experience, and overall reflections on the process. We ended the interview by asking about participants' opinions on the mifepristone/misoprostol regimen and ways that they thought services could be improved. We asked participants to provide information about all of their abortions; for those who had previously obtained an aspiration or surgical abortion we asked them to compare the different methods.

2.3 Data analysis

Undergraduate research assistants transcribed the majority of the interviews; KJL transcribed a subset and audited a selection of completed transcripts. We had regular team meetings throughout the life of the project, which was a key part of our analytic process. During these meetings, we debriefed about the interview content and began to identify common themes, draw initial connections between ideas, and identify when we had reached thematic saturation. Given the geographic and temporal variation reflected in our sample, we had multiple points of thematic saturation that corresponded to major milestones in the regulatory journey of Mifegymiso®. Ultimately, we were confident we had reached overarching thematic saturation after 60 interviews; we conducted four additional interviews as confirmation. Drawing on interview transcripts, notes, and memos, we conducted content and thematic analyses of the interactions using both a priori (predetermined) codes and categories based on the research questions and inductive analysis techniques to identify emergent ideas.

KJL created an initial codebook and served as the principal coder for this study. We used ATLAS.ti version 8.1.3 to manage our data. AMF reviewed the codebook, a subset of audio recordings, and a selection of the coded transcripts. We resolved rare disagreements through discussion.

The University of Ottawa Research Ethics Board approved this study. In the results section we present our key themes and use illustrative quotes to support the findings. We have removed/masked all identifying information and assigned pseudonyms to participants.

3. Results

3.1 Participant characteristics

Our 64 participants had used mifepristone and misoprostol to terminate 65 pregnancies between May 2017 and March 2019 and resided in seven provinces (Alberta, British Columbia, Manitoba, Newfoundland, Nova Scotia, and Ontario, and Quebec) at the time of their abortion(s). All were Canadian citizens or had permanent residency status. Our participants ranged in age from 17 to 41 at the time of the interview, with an average age of 27.8. We asked participants to self-identify their race or ethnicity. The majority of our participants identified as white (n=41); we also had a number of participants who identified as Asian, including those who self-identified as Chinese, Japanese, Korean, South Asian and South East Asian (n=14) and First Nations, Inuit, or Métis (n=3). We asked participants about their gender identification and pronouns; 62 identified as women and use she/her pronouns, one identified as gender non-binary and used they/them pronouns, and one identified as a man and used he/him pronouns.

Participants reported using mifepristone/misoprostol between 28 and 62 days gestation; the vast majority had a complete abortion with the standard regimen. Some participants (n=7) obtained additional doses of misoprostol or ultimately had an instrumentation procedure, but all of our participants completed their abortion. Our participants obtained care at a variety of health service delivery settings, including at freestanding abortion clinics, in hospitals, and from family physicians.

3.2 Strong preferences influenced participants' decision to use medication abortion

Most participants in our study reported that personal and/or logistic preferences undergirded their decision to have a medication abortion. Participants described a number of features of both the abortion process and the delivery of care that were especially appealing.

Veronica, age 32 from Alberta said, "I liked the idea of being at home when it was occurring. And then also on the practical note, I wasn't sure if it would easy for me to schedule a ride afterward, home – which the [aspiration abortion] required you to have." Many participants identified being able to have the abortion at home as particularly important.

Most participants perceived medication abortion as a less invasive option than an instrumentation procedure, thus allowing for a more private and "natural" abortion experience. Diana, aged 34, from British Columbia explained, "It was pretty early on still, so that to me seemed like the least invasive and, you know, you're in the privacy of your own home so it just seemed okay."

Very few people reported that they had a medication abortion because it was easier to access or the only option available to them. In fact, a number of participants, particularly those who obtained their abortion in the wake of the introduction, explained that they encountered significant barriers to obtaining mifepristone/misoprostol but persevered because they greatly preferred a non-instrumentation option. As Cora, age 29 from British Columbia said

> So I called that clinic and…they said they have a medication shortage and so that really caused a lot of panic in me…So then I booked the surgical abortion with that clinic and then called another clinic. So there's basically three clinics that do it here and [the second clinic I called] said 'No, we're still having the shortages.' But they gave me the number to the [third] clinic that I ended up going to [because they had the medication in stock]."

3.3 The changing regulatory landscape created barriers to care

The regulatory changes at both the federal and provincial levels that occurred over the course of our study impacted patients' experiences. Most notably, participants who obtained the regimen before Mifegymiso® was covered by insurance in their province of residence consistently stated that the out-of-pocket costs were burdensome. As Rhona, age 40 from Newfoundland, explained "But the thing is – why people don't want to keep the children is

because they're having financial hardships and you're asking for 300 dollars for a pill." Grace, age 22 from British Columbia, reported that she had difficulty securing such a large amount of money up front, and said "Maybe like if you [could] make payments, instead of one like big payment."

However, even after provinces implemented universal cost coverage, misinformation among clinicians about the regulatory changes created barriers. Josephine, age 34 from Ontario, described her experience trying to fill her prescription at a local pharmacy:

> And [the pharmacists] said, 'Well it's going to be very expensive.' And I said 'Well, no it's not because the pills are free, because they're covered by [Ontario health insurance].' And we had quite the argument over it…At the time it had been free for six months…I can pull up about 10 articles from the news saying that these pills are free and they argued against me and eventually they went behind and made a few phone calls and then came back and they were like 'Oh yeah, you're right'. I was like 'Of course I'm right, look at all these sources that I can pull up.'

Participants did not characterize these interactions as judgmental or stigmatizing but rather as frustrating and requiring significant self-advocacy. Many of these participants also reported that media coverage served as an essential tool for initially informing them about medication abortion and disentangling the shifting regulations surrounding mifepristone/misoprostol.

3.4 Medication abortion patients were generally satisfied with the mifepristone/misoprostol regimen

Participants in our study reflected positively about their medication abortion experiences and reported that they would recommend the method to others. For most, the initial features that drew them to using mifepristone/misoprostol, such as privacy and convenience, continued to be positive features of the abortion process. Livia, aged 24, from British Columbia was able to fill her prescription at a pharmacy and take both parts of the medication abortion regimen at a time and place of her choice. She captured the sentiments of many of our participants when she said,

> There is something comforting about being able to do the process at your own time. To have your time, to be able choose when it's happening. It gives you autonomy over your own choices, and I think it also gives you that responsibility as well. You know, you're taking it yourself; you're making the decision yourself. And there was something more…it was just more relieving to be able to do the second part with my partner, in a place that I knew I felt safe and comfortable, and I didn't have to worry about seeing someone I knew, or having someone come in. You know, I was just able to do that quietly at home and I appreciated that.

Many participants described the length of the process as the biggest drawback of the mifepristone/misoprostol regimen. Noelle, age 28 from Ontario, explained, "I mean I'm glad that I was able to have the experience at home…because I wouldn't have wanted to walk past protestors for sure. That would have made it a lot harder. But one thing that kind of made me…think twice I guess is the fact that it took a long time. Like whereas if I had gone in for a surgical appointment it would have been done and dusted like that [day]." Patients who had to interface with multiple health service providers in different locations over the course of their abortion were especially likely to raise this as a downside.

Participants who described themselves as being well informed and knowing what to expect were especially satisfied with their medication abortion experiences. In contrast, most of those who expressed negative feelings about mifepristone/misoprostol specifically described feeling unprepared for the pain, physical abortion process, and/or seeing the products of conception. The few participants who had an incomplete abortion with the initial medication abortion regimen all reported that they would still recommend the regimen to others. However, they emphasized the need for clinicians to provide more information about the possibility of having an incomplete abortion or ongoing pregnancy and needed additional treatment or an aspiration procedure. Virginia, aged 27 from Ontario, that the care she received would have been improved by "Just explaining the facts and…And them really saying 'Know that there is a chance that it might not work.' Because I specifically asked for something that would work."

3.5 Medication abortion users wanted more information in the form of personal stories

Our participants identified a number of ways in which information and services could be improved. For those who obtained the combination pack prior to universal cost-coverage, the issue of insurance coverage emerged as significant priority. However, participants who obtained a medication abortion in all regulatory phases since the regimen's introduction described the need for more comprehensive information about pain management and the products of conception. Indeed, a number of participants explained during counseling they were informed that having a medication abortion was "like having a heavy period". While this rang true for some, others found the pain/cramps, bleeding patterns, and kind of blood/products that they expelled during their abortion was significantly different from this description. Although not necessarily negative, this mismatch in expectations was surprising. As Kelly, aged 26 from Nova Scotia said, "The clots I was just kind of amazed by. I was just like, holy shit, that's huge…It was just a bit of a shock to see the size of them."

Participants mentioned, without prompting, that a number of clinic websites gave extensive information about medication abortion with mifepristone and misoprostol, both with respect to the logistics and the abortion process itself. Participants repeatedly stated that they trusted these resources and felt positively about them, as Zoe's experience in British Columbia illustrates:

> [When I became pregnant], I was like oh [I] know exactly where I need to go because I visited the website previously…So I knew that they also offered these services and it was pretty easy to get in touch; they had all the information on the website, detailed out like which option was better and which option for what and how the process goes. So it was really clear I would say.

Although participants appreciated the medical information on these websites, a number of medication abortion patients expressed a desire to hear the personal stories of those who had used mifepristone and misoprostol. Gloria, aged 25 from British Columbia, explained:

> The [clinic] website…had a lot of information…But one thing that helped me quite a bit is going onto forums and Reddit and stuff, for other women's experiences. And it was just more like…they would do a walk-through of their own experience and I had a better idea of what to expect. Because the information [on the clinic website] it was more like, like a lot of numbers. Like take two doses and then 24-48 hours, take this, and you should feel this and… I feel like the forums and stuff provided a more like, I guess, human aspect to it. And I could understand it a little bit more.

Like Gloria, a number of participants reported turning to social media and websites like Reddit to address this need. However, participants were somewhat conflicted because they were uncertain about the trustworthiness of these non-clinic websites. Based on her own desire for personal stories about the medication abortion process, Jessica, age 28 from Alberta, meticulously documented her abortion process, including the time at which she took each medication, the timing and duration of each symptom, and her pain rating. She explained, "So I'm planning on putting it on Reddit because a lot of people really appreciate the step-by-step. And I find it really helpful to read the step-by-step."

4. Discussion

The demand for medication abortion in Canada is evident. Approximately 100,000 abortions take place in Canada each year and the overwhelming majority occur in the first trimester [22]. In 2017 Mifegymiso® was prescribed more than 4,000 times [23]. In 2018, after Health Canada issued substantial updates to the Product Monograph and Risk Management Plan and most provinces covered the costs of Mifegymiso® [13], this number jumped to more than 10,000 prescriptions [24]. All indications suggest this trend will continue [25].

Consistent with a global body of evidence [16-17], the Canadians abortion patients we spoke with had predominantly positive experiences with the mifepristone and misoprostol regimen and felt that medication abortion was an important addition to reproductive health care available in the country. Our findings echo qualitative studies conducted in the United

States that have also found that the perceived naturalness and privacy of medication abortion contribute to how abortion seekers decide to use, and reflect on, their abortion with mifepristone/misoprostol [26-27]. Our participants were successfully able to use mifepristone/misoprostol manage their symptoms and decide when to seek additional follow-up care. They were also able to navigate a complex and shifting regulatory landscape and advocate for themselves to obtain their preferred method of abortion care. Although clinicians, advocates, and patients have welcomed the changes to the regulations surrounding Mifegymiso®, the shifting regulatory environment has been challenging to keep up with, implement, and interpret. It is not uncommon for there to be a discrepancy between policy and practice with health care [19], but continuing to work with clinicians to ensure that updated regulations are being followed represents an important direction for future work. Further, as medication abortion becomes increasingly available in primary care settings across Canada, direct engagement with general practitioners, nurse practitioners, and pharmacists will be necessary to ensure that services are not overly medicalized and that information is provided clearly and consistently.

Our findings indicate that patients who felt well informed about the abortion process and side effects reflected the most positively on their medication abortion experiences. Previous research has found that experiencing less pain and bleeding than expected is an independent predictor of a positive medication abortion experience [16]. This suggests that improving information may improve patients' reflections on their experience. Our participants highlighted a number of ways in which information about pain management and visible products of conception could be improved and were especially keen on lifting up individual personal experiences. As trusted sources, abortion providing facilities may want to take this into consideration and incorporate patient narratives onto their websites. Importantly, many of the factors that that participants described as contributing to their

decision to use mifepristone/misoprostol and the reasons that they reflected positively on their experiences were related to non-clinical factors. This indicates that improving non-clinical interventions has the potential to improve the overall experiences of abortion seekers.

Finally, participants in our study relied heavily on media coverage about Mifegymiso® to interpret the shifting regulations surrounding the regimen and used these stories in their self-advocacy. Supporting efforts by the news media to provide accurate, evidence-based coverage of reproductive health and abortion care is critical. Researchers, clinicians, and advocates should also continue to engage with Canadian journalists so that mainstream media outlets can be effective channels to disseminate information about medication abortion.

4.1 Limitations

Qualitative methods provide an excellent mechanism for in-depth exploration of participants' experiences, beliefs, and behaviors. However, the method does not yield representative and generalizable results. Although multimodal recruitment of a purposive sample of people who had used mifepristone across Canada gives us confidence that the themes we identified are significant, we are unable to assess the degree to which these experiences represent broader trends. Further, this project centered exclusively on those people who used mifepristone; we did not capture the experience of those who wanted to have a medication abortion but were unable to navigate access barriers.

4.2 Conclusion

The mifepristone/misoprostol regimen is an important addition to the landscape of abortion care across in Canada and abortion patients generally reflected positively on their experience with the mifepristone and misoprostol regimen. Identifying ways to provide more

information about the medication abortion process, showcasing individual patient experiences, and engaging with journalists to support evidence-based and medically accurate media coverage are priorities for action.

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Chapter 5:

How Did the Introduction of Mifepristone Impact the Availability of Abortion Care in Ottawa? A Qualitative Study with Abortion Patients

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How Did the Introduction of Mifepristone Impact the Availability of Abortion Care in Ottawa? A Qualitative Study with Abortion Patients

Abstract

In 2017, mifepristone and misoprostol became available for early pregnancy termination as the combination-pack Mifegymiso® in Ottawa, Canada. We conducted 40 semi-structured telephone interviews with Ottawa residents who had abortions before mifepristone's introduction (n=20) and after mifepristone/misoprostol became available (n=20) to explore their experiences obtaining care. We audio-recorded and transcribed all interviews and analyzed these data for content and themes using deductive and inductive techniques. Prior to the introduction of mifepristone, our participants reported obtaining abortion care at two facilities and many faced long wait times. Those who had an abortion after mifepristone became available reported obtaining care from a wider array of providers and few waited more than two weeks. However, several mifepristone/misoprostol users reported having to go through a process that involved as many as 10 health service encounters. Both groups reflected positively on their abortion experiences, but some patients who obtained mifepristone/misoprostol outside of an abortion clinic did not feel as well informed as they would have liked. The introduction of mifepristone appears to have expanded the number of service delivery points and reduced wait times for those seeking abortion care in Ottawa. Identifying ways to expand access to medication abortion information and streamline services appears warranted.

Keywords

Canada, health services, medication abortion, mifepristone, patient experiences

Sections: Public health, science and policy

Introduction

Canada's capital city of Ottawa is located in the province of Ontario and has a population that recently reached one million (Britneff, 2019). In Canada, there are no federal restrictions on abortion and services have historically been provided in both hospital and clinic settings (Norman et al., 2016). The gold standard regimen of medication abortion – mifepristone and misoprostol – was not approved in Canada until 2015 which meant that the vast majority of abortions performed in the country were completed with instrumentation methods (Norman et al., 2016). When mifepristone and misoprostol are used together, they are safe and highly effective at terminating a pregnancy up to 10 weeks' gestation (Chen & Creinin, 2015).

Prior to the introduction of mifepristone, Ottawa had two primary abortion providers: one freestanding clinic and one hospital, both of which provided instrumentation procedures. For anyone with provincial health insurance, these services were provided at no direct out-of-pocket cost to patients (Kaposy, 2009). However, long wait times for abortion care in Ottawa have been the subject of media attention for years (Dube, 2007). These wait times have been exacerbated during the summer when one of the two providers shuts down for the month of August (National Abortion Federation, 2007). Although medication abortion with the methotrexate/misoprostol regimen was available in Canada prior to the introduction of mifepristone (Yalahow et al., 2020), only 4% of all abortions were induced with these medications (Guilbert et al,. 2016) and neither facility in Ottawa offered this type of abortion care.

In 2015, Health Canada approved mifepristone as part of a combination-pack with misoprostol under the trade name Mifegymiso® for early abortion (Health Canada, 2016). The mifepristone-misoprostol regimen became available in Ottawa in February 2017; provincial cost coverage was announced in August 2017 (Population Institute Canada, 2017).

Thus for nearly seven months, patients were required to pay approximately CAD400 out-of-pocket for a medication abortion while aspiration procedures were available free-of-charge for those with provincial health insurance (Kaposy, 2009; Foster et al, 2013).

Medication abortion with mifepristone and misoprostol has the potential to increase access to abortion, but only if the regimen is offered in a variety of settings, including those where aspiration procedures are not available. However, with the initial introduction, Health Canada instituted a number of non-evidence based restrictions. These included limiting use to 49 d from the first day of the last menstrual period (despite evidence showing that mifepristone and misoprostol can safely be used up to 70 d gestation (Hsia et al., 2019; Sanhueza Smith et al., 2014), requiring an ultrasound before provision, making health professionals register with the distributor in order to prescribe or dispense the drug, and only allowing physician-dispensing (Health Canada, 2016). In Canada, physician-dispensing is extremely uncommon and the majority of general practitioners do not have the infrastructure to dispense medications or take payment from patients (Norman & Soon, 2016; Ridic, Gleason & Ridic, 2012). Health Canada also announced a mandatory online training program which was not available at the time of the drug's approval (Health Canada, 2016).

Advocates across the country argued that the Risk Management Plan put in place by Health Canada was not evidence-based and would significantly limit the potential impact of the drug (Picard, 2016). On a provincial level, the College of Physicians and Surgeons of Ontario and the Ontario College of Pharmacists issued guidance early on in 2017 that greenlighted off-label use and pharmacist dispensing of the drug (Vogel, 2017). This followed similar guidance issued by the British Columbia Colleges in January 2017 and helped to set a precedent for other provinces to follow suit (College of Physicians and Surgeons of British Columbia, 2017). In July 2017, the College of Nurses of Ontario was the

first governing body to support nurse practitioners in prescribing the mifepristone/misoprostol combination product (College of Nurses of Ontario, 2017).

In November 2017, Health Canada made significant amendments to the product monograph and eased restrictions (Health Canada, 2017). The revised regulations extended the gestational age limit from 49 to 63 d, no longer required health professionals to complete a training program or register with the distributor, and allowed pharmacy-dispensing. With these shifting regulatory barriers in mind, we set out to explore how the introduction of mifepristone has influenced access to abortion services across Ottawa, with a specific emphasis on patients' experiences.

Materials & Methods

We conducted 40 semi-structured, in-depth interviews with Ottawa residents who had abortions before the mifepristone/misoprostol combination product became available (n=20) and after the regimen's introduction in February 2017 (n=20). In order to be eligible for the study, we required participants to: have had at least one abortion while residing in Ottawa before 2013 (Phase 1) or in/after February 2017 (Phase 2), be sufficiently fluent in English or French to answer interview questions, and have access to a telephone and/or Skype. We interviewed Phase 1 participants over a one-year period in 2012-2013 and interviewed Phase 2 participants over an 18-month period in 2017-2019. All of the interviews took place within five years (Phase 1) or one-year (Phase 2) of the index abortion. We offered all participants a CAD40 gift card.

Recruitment

We used a multi-modal, community-based strategy to recruit Ottawa residents who had abortions before and after mifepristone became available. Our recruitment strategy

included creating a study website, posting on social media (such as Facebook, Instagram, and Reddit), posting on online classifieds sites (such as Kijiji and Craigslist), and distributing flyers around the city. Anyone interested in participating reached out to the Study Coordinator (KL) who then responded to any questions, ensured eligibility, and scheduled a mutually convenient time for the interview.

Data collection

We audio-recorded and transcribed all of the interviews which lasted an average of 60 min. We used an interview guide that we developed for use in a national qualitative study that aimed to document the experiences of Canadians accessing abortion care in different provinces and territories (Cano & Foster, 2016; Foster et al., 2017). KL, a graduate student in health sciences at the University of Ottawa, and AF, a global sexual and reproductive health researcher, conducted the majority of interviews in Phase 1; KL conducted all of the interviews in Phase 2. We began each interview by asking participants about their demographic information, general background, and general sexual and reproductive health history. Next, we discussed the participant's abortion experience(s) in more depth. This discussion included the circumstances surrounding the pregnancy, the process of making the decision to have an abortion and identifying a provider, the abortion experience itself, and reflections on ways that abortion care could be improved. For participants who had more than one lifetime abortion, we asked them to provide information about each event. We took notes during, created analytic and reflexive memos shortly after, and eventually transcribed the content of the interviews (Birks, Chapman & Francis, 2008).

At the time that we conducted interviews for Phase 1 of the study, mifepristone was not yet available in Canada. However, we provided participants with information about the regimen through nine weeks' gestation and asked whether they would have considered

receiving this kind of an abortion. We have previously published about a broader sample of Canadian abortion patients' thoughts on mifepristone (Vogel et al., 2016).

Data analysis

We analyzed our transcripts, notes, and memos from both study phases for content and themes using predetermined codes and categories based on the research questions and those that emerged from the data (Fereday & Muir-Cochrane, 2006). In order to identify common themes, draw initial connections between ideas, and establish thematic saturation in Phase 2, we began reviewing data as they were collected; regular team meetings throughout the life of project gave us an opportunity to debrief on the interviews and discuss themes as they emerged (Bowen, 2008).

We managed our data from both phases of the study in ATLAS.ti. KL created an initial codebook and served as the principal coder. INL-G transcribed Phase 2 interviewers and assisted with coding. AF reviewed a subset of audio recordings, full transcripts, and coded transcripts. We initially analyzed interviews from each phase of the study separately. In the final analytic stage, we integrated the findings, paying specific attention to concordance and discordance.

In this paper, we use pseudonyms and participants' preferred pronouns and mask personally identifying information. We have organized our results around study phase and domains of inquiry and use quotes to illustrate key themes. The University of Ottawa's Research Ethics Board approved this study.

Results

Participant characteristics

Our overall sample ranged in age from 17 to 36 at the time of the interview with an average age of 25.9. Participants reported on 43 abortion experiences that occurred between four and 15 weeks' gestation. The vast majority of respondents in both phases identified as White. We present basic demographic information about the two study populations in Table 1.

Phase 1: Before the introduction of mifepristone

Phase 1 participants reported on 23 aspiration and surgical abortion experiences that took place between 2008 and 2012. All participants reported obtaining care at one of two facilities: one freestanding clinic and one hospital. As mifepristone was unavailable in Canada at the time, few participants that we interviewed had any prior knowledge of medication abortion. However, the vast majority responded favorably when we presented them with information about the mifepristone and misoprostol regimen. In addition, participants were receptive to the idea of obtaining abortion care in a variety of settings from a range of health service professionals.

Consistently, participants identified long wait times as one of the most pressing areas for improvement in abortion service delivery in the Ottawa area. Phase 1 participants reported waiting between one and six weeks after making their decision and initiating contact with a service provider to access services; more than half of the participants had to wait three or more weeks. As explained by Selena who had her abortion in 2012:

> I would say that services are limited. I don't think that there are enough providers to meet demand to get things done in a timely manner…Based on my experience, I would say once somebody has made the decision, they don't want to be kind of sitting around and waiting for it for so long…I found that when there to get the procedure done, everything is super fine, and well-organized, everyone's friendly and the environment is pleasant. So I think my only gripe is the waiting time.

Our participants described wait times as both emotionally and physically challenging. Taylor had to wait 2.5 weeks for her appointment in 2011 and said, “Mostly I was pretty upset because we were ready to have it [the abortion] over and done with…And physically [the waiting period] was awful because it was [more time] being really, really sick. So needless to say, I wasn’t very happy.”

Despite the long wait times, many participants in Phase 1 were able to self-refer for their abortion. Participants reported that it was common knowledge that there was an abortion clinic in the city. Even if a participant was unable to name the clinic or did not know specific details about where it was located, having knowledge about the existence of the clinic facilitated the process of locating a provider. As explained by Heather, aged 28, who had her abortion in 2008: “I’d known about [the clinic] already…I knew that they were there just from interactions with other people, not in regards to my own situation, but just from – I just knew about them anyway.” Heather obtained care in the way that most of our Phase 1 participants did: she took an at-home pregnancy test and then contacted the clinic directly to make an appointment.

In Phase 1 of the study, the average numbers of encounters reported by participants to access care was 2.2. We defined an “encounter” as a time when a participant interacted with the health care system as a part of the process of obtaining abortion care. For example, Amy explained, “[In] my opinion it kinda took too long. It started because the hospital is two days, the first day you have to go and get checked out, they look at you and see if you’re pregnant and make an appointment, and it’s the set up date before the [abortion].” Amy had confirmed her pregnancy with a general practitioner at a community health center and then had to go to the hospital twice over 2 d; she had three encounters in order to have her abortion.

Those who accessed care at the freestanding clinic reported the most streamlined process and, in most instances, these patients had one appointment during which they

received an ultrasound, counselling, and their abortion in the same place over the course of 1 d. Phase 1 participants generally reported most favorably on this streamlined model of care.

In Phase 1, only one participant reported paying a direct out-of-pocket cost for her abortion. She had recently moved to Ottawa at the time she became pregnant and while she had provincial health insurance from another Canadian province, she was not yet enrolled in the Ontario Health Insurance Plan (OHIP). The CAD500 bill came as a surprise to Hannah and she said that it was difficult for her to come up with the money. "And I didn't realise until I went there and they said, 'Oh, you have [health insurance from a different province]? Oh well…this is what we have to do.'…It was – it was difficult. But it was one of those things where I just put it on my line of credit and you know, it took me a while to pay it back." Although other participants did not report direct costs associated with their abortion, most Phase 1 participants reported incurring out-of-pocket costs related to childcare or taking time off work for their abortion. Those who had long wait times associated with their abortion were more likely to report that they took time off work and that this had a negative financial impact.

Phase 2: After the introduction of mifepristone

Phase 2 participants reported on 20 abortion experiences; 15 of these were medication abortions completed with mifepristone/misoprostol and five of these were instrumentation procedures. Predictably, more patients reported choosing medication abortion after the introduction of mifepristone. In addition, after the introduction of mifepristone, even patients that had aspiration or surgical procedures generally had some knowledge about medication abortion.

Some participants who had instrumentation procedures stated that they would have preferred to have a medication abortion, but they were either unable to locate a provider or

the price of mifepristone before provincial cost coverage was prohibitive. Alexis, aged 27, who had a aspiration abortion at the freestanding clinic in April 2017, explained: "At the time, the process [of trying to get a medication abortion] seemed pretty overwhelming to me … So, I didn't want to start the process of trying to get the pill and then find out that my pregnancy was too far along for it…I think there was some conflicting information about whether or not it was covered in Ontario yet or, you know, how available it was."

Following the introduction of the mifepristone/misoprostol combination product, our 20 participants reported obtaining care from seven distinct providers. Interestingly, none of our Phase 2 participants reported obtaining care from the hospital that provided surgical procedures identified in Phase 1. This indicates that by mid-2019 there were at least eight abortion providers in the Ottawa area. All of the additional providers that we identified during Phase 2 of the study provided medication abortion; we did not hear about any new aspiration or surgical abortion providers.

Compared to Phase 1 participants, participants in Phase 2 had generally shorter wait times. They reported on wait times between one d and five weeks; half of Phase 2 participants were able to initiate the abortion process in one week or less. However, participants in Phase 2 who had medication abortions with mifepristone reported between 4 and 10 encounters, with an average of 6.5. Encounters for medication abortion frequently included an initial consultation, blood work, an ultrasound, filling a prescription, and a follow-up appointment. Noelle had her abortion in early 2018 and explained, "I had an appointment…during that process like almost every week. Because the first one was to get the pregnancy test, then I went to have the appointment at the clinic and then I had to get [a] blood test, so it just felt like it was like almost every week I was like seeing the doctor or whatever. So no it doesn't take a very long time but it felt like a long time." For Rh-negative

patients, there were additional encounters associated with obtaining Rho(D) immune globulin (WinRho).

Carrie, who accessed care in April 2018, explained that while she was satisfied with her medication abortion experience overall, finding time for the number of required encounters was challenging. “The only thing I found a little inconvenient was the appointment times. There are people who cannot get there during the day, or…what if I couldn’t drive? Or if I was working, what would I do in that situation?” The highest number of encounters for Phase 2 participants occurred in the rare instances that the medication abortion was unsuccessful. The process that these patients were required to go through in order to obtain additional misoprostol and/or a surgical intervention was often unclear and involved additional wait times.

More participants in Phase 2 reported having a direct out-of-pocket cost for their abortion. In the majority of cases, the cost was associated with obtaining mifepristone/misoprostol before provincial cost coverage was announced. Participants reported paying between CAD0 and CAD400 for their abortions. For those who accessed care before cost coverage, the combined regimen’s price tag was a significant barrier. No participants reported a direct cost for instrumentation procedures.

Finally, some Phase 2 participants who obtained medication abortion were not as well informed as they would have liked to be. They reported on some gaps in their knowledge about the process. Specifically, they wanted more information about the number of encounters involved with obtaining medication abortion and a realistic discussion about what could happen if the regimen fails. Dani, aged 28, had their abortion in August 2018 and said, “I think the information should be way more widely known…really organized information on how appointments work and in what order you have to do them in would be helpful.”

Discussion & Conclusions

Globally, the overregulation of mifepristone has significantly muted the promise and potential of the drug to increase access to abortion services (Finer & Wei, 2009; Schaff, 2010; Raymond et al., 2017). However, the case of Ottawa is encouraging. Thanks in large part to effective advocacy campaigns, consistent media coverage, and a strategic plan from a pharmaceutical champion, restrictions surrounding mifepristone in Canada have changed to align more closely with a global body of evidence. Indeed, Canada's changes in the regulation of mifepristone have leapfrogged other countries where the regimen has been available for a much longer period of time (Foster et al., 2015; Raymond et al., 2017). For example, although the United States Food and Drug Administration approved the use of mifepristone for early induced abortion in 2000, non-evidence based restrictions on drug distribution and practice restrictions on clinicians persist (Raymond et al., 2017; Grossman et al., 2019). In Ontario, early support for evidence-based policies from the Colleges has also been important for the integration of mifepristone into primary care (College of Nurses of Ontario, 2017; College of Physicians and Surgeons of Ontario, 2017).

The experiences of our patients accessing care before and after the introduction of mifepristone indicate that policy changes, such as cost coverage of the medication, have a significant impact on the experiences of those accessing abortion care. Abortion patients in the city reported accessing care in a wider variety of health service delivery settings. While the increased availability of medication abortion has not addressed all access issues in Canada's capital, our findings are encouraging and suggest that the decentralization of abortion care is feasible and may mitigate a subset of barriers. As well, obtaining medication abortion in a variety of settings appears to be acceptable to Ottawa abortion patients.

Still, there is room for improvement. Our findings suggest that increasing access to information about medication abortion in Ottawa appears warranted. Our participants'

experiences highlight that patients have different preferences for service delivery and that communicating clearly about the differences between the processes for obtaining medication and instrumentation procedures is essential. For some patients, having a greater number of encounters that are shorter in duration and initiating the process sooner after making the decision to have an abortion was more convenient and preferable. For others, especially those who lacked access to transportation or had a less flexible schedule, the number of encounters involved with medication abortion were challenging to navigate.

Efforts to streamline the process of obtaining medication abortion could have substantial benefits. Health Canada has recently eliminated the requirement for an ultrasound to be performed before administering mifepristone (Health Canada, 2019). In addition, congruent with an emerging body of evidence about the need for Rh testing, the National Abortion Federation (NAF) has recently updated their clinical policy guidelines. The NAF Clinical Policy Committee now recommends that "it is reasonable to forgo Rh testing and anti-D immunoglobulin for women having any type of induced abortion before 8 weeks from the last menstrual period." (Mark et al., 2019) They also note that, "Forgoing Rh testing and anti-D immunoglobulin for medication abortion under 10 weeks may also be considered." (Mark et al., 2019). As the evidence continues to grow, we are hopeful that other regulatory bodies will also update their guidelines to reflect this change.

Incorporating alternative strategies for follow-up after medication abortion could be another way to reduce the number of encounters and center patient autonomy. Research has shown that both self-assessment and telephone follow-up are feasible and accurate for medication abortion patients and have the potential to save resources (Bracken et al., 2014; Perriera et al., 2010; Oppegaard et al., 2015). As providers in Canada become more comfortable with offering medication abortion it may be possible to explore additional ways

to streamline and demedicalize the process, including providing prescriptions in advance of need or offering the mifepristone/misoprostol combination product directly form pharmacists.

Limitations

The abortion landscape in Canada has been in flux over the last few years as regulations surrounding the mifepristone/misoprostol combination product have evolved at both the federal and provincial levels. Although we spoke with abortion patients in Ottawa who obtained medication abortion care at different points in mifepristone's journey, some of the barriers we identified early in the Phase 2 data collection process have since been addressed through policy reform. Although multimodal recruitment of a purposive sample of people who had terminated a pregnancy in Ottawa gives us confidence that the themes we identified are significant, we are unable to assess the degree to which these experiences represent broader trends. There may also be additional providers of abortion care that we did not identify through this project and patients' experiences with those providers may be different. Finally, this article focuses on the availability and accessibility of facility-based abortion services. Future research would benefit from exploring other dimensions of access.

Conclusions

Following the introduction of mifepristone, abortion patients in Ottawa reported obtaining care from a greater number of providers across a wider variety of health service delivery settings. Patients generally reflected positively on this. Although participants who accessed medication abortion reported on generally shorter wait times, they also reported on a process that required more encounters with the health care system. This was a preferable and more convenient option for some participants but not for others. Efforts to streamline the

process of obtaining medication abortion in Ottawa appear warranted and could continue to improve access to abortion in Canada's capital.

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Table : Demographic and abortion characteristics of Phase 1 and Phase 2 participants in Ottawa (N=40)

	Phase 1	**Phase 2**
Total participants	20	20
Age		
Under 18	0	1
19 to 25	11	8
26 and older	9	11
Race		
White	17	16
Black	1	1
Asian	0	1
First Nations, Inuit, Métis	1	0
Biracial	1	2
Total number of study period abortions	23	20
Type of abortion		
Instrumentation	23	5
Medication	0	15
Location of abortion		
Free-standing clinic	19	5
Hospital	4	1
Primary care provider	0	3
Other	0	11

Chapter 6:

Does Motherhood Influence Abortion Decision Making and the Process of Obtaining Care? Results from a Large-scale Qualitative Study in Canada

LaRoche, K. J, & Foster, A. M. (under review). Does motherhood influence abortion decision making and the process of obtaining care? Results from a large-scale qualitative study in Canada. *Women's Health Issues*.

Does Motherhood Influence Abortion Decision Making and the Process of Obtaining Care? Results from a Large-scale Qualitative Study in Canada

Abstract

Objective: Although many women who have abortions are already mothers, little research has examined how previous pregnancies and experiences of parenting shape women's subsequent abortion-related decisions and experiences. No research has explored these dynamics in Canada. Our qualitative study aimed to fill this gap.

Methods: In 2012-2016, we conducted 305 semi-structured interviews with Anglophone and Francophone women from across Canada who had recently had an abortion. We audio-recorded and transcribed all interviews and conducted content and thematic analyses using deductive and inductive techniques. We focus here on the 94 interviews with mothers who had a subsequent abortion.

Results: Many participants talked about how their children factored into their decision to have an abortion, but participants also talked about a broad, nuanced range of circumstances. The experience of continuing a pregnancy and/or giving birth did not influence participants' certainty about their decision to terminate a subsequent pregnancy. A number of participants shared that having children, and finding childcare in particular, made the process of obtaining an abortion harder; this was especially true for women who obtained hospital-based abortions that required multiple appointments with different providers over several days.

Conclusions: Mothers discussed both childbirth and abortion as important events in their reproductive careers. Mothers also talked about compounded challenges in accessing abortion

care and continuing to parent. Our findings highlight the importance of streamlining abortion services and suggest that efforts to reduce wait times and expand the number and location of service delivery points could meet a significant need.

1. Introduction

Many of the societal, cultural, and political narratives that surround abortion position abortion in opposition to motherhood. This is due, at least in part, to abortion stigma. Kumar, Hessini and Mitchell highlight that abortion challenges not only the "inevitability of motherhood" (Kumar, Hessini, & Mitchell, 2009, p. 628) but that it also transgresses long-held ideals of personal subordination to community needs. Abrams posits that a pregnant woman who chooses abortion "embodies the archetype of a bad mother by 'abandoning' her child" (Abrams, 2015, p. 179). Thus, rather than conceptualizing both abortion and motherhood as two equally valid choices that women may make throughout their reproductive lives, the dominant societal narrative in North America has come to view these as mutually exclusive.

Saurette and Gordon have documented how this narrative has been repackaged by the anti-abortion movement in recent years (Saurette and Gordon, 2013; Saurette & Gordon, 2016). The discourse of the anti-abortion movement in the US and Canada has shifted away from fetus-first language to instead portray abortion as harmful to women. Integral to this messaging is the fact that abortion is a direct threat to not only individual motherhood, but the institution of motherhood as a whole. A popular anti-abortion blog called "ProWoman ProLife" captures this sentiment well:

> "We need more discussion, then, of abortion as a women's issue. Abortion damages women. It does them physical and psychological harm...a culture in which abortion is seen as essentially harmless wreaks profound changes to our collective understanding of motherhood, sexuality, the obligations of mothers and fathers to each other and their children, and adulthood." (As cited in Saurette & Gordon, 2013, p. 171)

However, this dynamic is not limited to discourse generated by the anti-abortion movement; the abortion-motherhood dichotomy is also embedded in discussions and debates in the reproductive health and policy spheres. In 2014, then Canadian Prime Minister Stephen Harper made the decision to exclude abortion care from Canada's initiative to fund maternal

health care in developing countries, thus making a decisive statement about how these two types of reproductive health care are incongruous and mutually exclusive (Mackrael, 2014). As another example, abortion is explicitly excluded from most global "family planning" initiatives, including Family Planning 2020 (FP 2020). Indeed, none of the indicators that are reported on annually by the 68 countries in the initiative include abortion. Although one indicator ("Number of unsafe abortions averted due to the modern contraceptive use") does reference abortion, it does so by framing abortion in opposition to contraception. A report produced by Catholics for Choice in 2014 acknowledges that this framework may be tempting to use but is ultimately problematic: "Insisting that abortion is not a legitimate part of family planning, and that contraception is a way to reduce the number of abortions, undermines women's reproductive health and rights" (Gerber Fried & Hendrixson, 2014, p. 23).

This polarizing frame fails also to account for the fact that many patients who have abortions are already mothers. Although Canada does not routinely collect demographic data on those having abortions, research from the United States suggests that a majority of abortion patients have previously given birth (Jerman, Jones, & Onda, 2016). This is consistent with data collected worldwide (e.g., Gao et al., 2015; Mondragón et al., 2011).

Despite these overarching characteristics, there is a dearth of nuanced discussion about mothers who choose to terminate a subsequent pregnancy. In addition, little research has examined how previous pregnancies and experiences of parenting shape women's subsequent abortion-related decisions and experiences. No research has explored these dynamics in the Canadian context. Our large-scale qualitative study aimed to fill this gap.

2. Methods

Between 2012 and 2016, we conducted 305 semi-structured interviews with Anglophone and Francophone women from across Canada who had recently had an abortion. In order to be eligible for the study, participants had to have terminated a pregnancy in the five years prior to the interview, be at least 18 years old, be sufficiently fluent in English or French to answer interview questions, and have access to a telephone or Skype.

2.1 Recruitment

We used a multi-modal recruitment strategy that included creating a study website; posting on social media such as Facebook, Twitter, and Reddit; posting on online fora such as listservs and local classifieds websites; and posting flyers around cities. In addition, if participants felt comfortable doing so, we asked them to share information about the study with anyone that they thought might be interested. We used a purposive sampling strategy that recruited participants from different provinces and territories, and different age groups (aged 18-24 and 25 and older at the time of the interview).

2.2 Data collection

After screening those who expressed interest for eligibility, we scheduled interviews at a mutually convenient time. The interviews lasted an average of 60 minutes. AMF, a medical anthropologist with more than two decades of experience conducting qualitative research, or a trained member of our all-female study team, conducted the interviews. The interviews were semi-structured, meaning that we used an interview guide but we adapted the questions based on the participant's responses. In addition to the information provided below, we have described our methods for this study in detail elsewhere (Cano & Foster, 2016;

Foster, LaRoche, El-Haddad, DeGroot, & El-Mowafi, 2017; LaRoche & Foster, 2018; Vogel, LaRoche, El-Haddad, Chaumont, & Foster, 2016).

We began by asking participants to introduce themselves, during which time we gathered demographic data. Then, we moved on to discuss the participant's general sexual and reproductive health history, with specific questions about the participant's pregnancy history and experiences accessing SRH services. Next, we discussed the participant's abortion experience (the index abortion) in more depth, beginning with questions about the circumstances surrounding the pregnancy that was terminated. We asked participants about their decision-making process and how they went about finding information and scheduling their appointment(s). We then asked participants to walk us through the day of their abortion, with specific follow-up questions to gather information about direct and indirect costs, ultrasound, counselling, and follow-up. Finally, we asked participants how they felt about their decision to have an abortion, and ended the interview by asking participants to reflect on their experience and ways that they thought services could be improved. If participants had more than one abortion in the five years preceding the interview, we repeated all questions for each abortion in that timeframe.

With the participant's permission, we audio-recorded the interview and took detailed notes throughout. Each interviewer memoed shortly after completing the interview in order to document initial reactions, reflect on interview content, and begin to draw connections between ideas (Birks, Chapman, & Francis, 2008). We transcribed all interviews in entirety. We translated French-language interviews into English for ease and congruence with data analysis.

2.3 Data analysis

We used ATLAS.ti version 8 to manage our data and carried out content and thematic analyses. KJL, the overall Study Coordinator, served as the primary coder and created a codebook using *a priori* codes and categories based on the research questions; AMF reviewed this codebook. While reviewing the data, we used inductive analytic techniques to identify emergent ideas (Elo & Kyngäs, 2008). Our thematic analysis centered on grouping categories of information, drawing connections between ideas, and understanding relationships in the data (Braun & Clarke, 2006). We held regular team meetings throughout both the data collection and data analysis process; we resolved disagreements through discussion.

This study received approval from the Health Sciences and Sciences Research Ethics Board at the University of Ottawa (File #H-08-12-08). In this paper, we organize our results around key themes. We use illustrative quotes to showcase themes and ideas and narrative vignettes to provide a thick description of individual participant's experiences (Sandelowski, 1994; Zeller, 1995). We use pseudonyms throughout the paper and have removed or masked any information that could potentially identify our participants. We report on the age of the participant at the time of the interview.

3. Results

3.1 Participant characteristics

Our 305 participants in the broader study were located in every province and territory. Table 1 details the location of our participants, language minority status, and self-identified race or ethnicity. Of the 305 total participants, we identified 94 who were mothers and discussed a subsequent abortion. Many more participants had continued a pregnancy and

were mothers at the time of the interview, but the 94 participants that we focus on in this paper were parents at the time of the index abortion.

The 94 mothers who had a subsequent abortion were from every province and territory, excluding the Northwest Territories. Table 2 details participants by province and language. This subset of participants included 81 Anglophone participants and 13 Francophone participants. The majority of participants that we spoke with identified as White, but a number of participants identified with other racial and ethnic identities, including First Nations, Inuit and Métis (FNIM).

Our participants ranged in age from 20 to 52 at the time of the interview, with an average age just over 30. Our participants talked about having one to seven children, with an average of 1.8 children. Importantly, our participants shared information with us about a variety of family makeups, structures, and parenting arrangements. These included families with biological children, step-children, and foster children; some parents had children for whom they had full-custody, while others had no custody or shared custody with another parent. Some mothers were single parents while others described co-parenting arrangements or parenting within a nuclear family. The vast majority of mothers in our study had children under the age of 10; however, some had both adolescent and adult children. For this study, we included all of these family makeups in order to capture a broad range of experiences of motherhood. The mothers in our study reported on having between one and four lifetime abortions. The majority had one abortion in the five years preceding the interview.

3.2 Children influenced abortion decision-making to varying degrees

The overall sample of participants in our study described a variety of reasons for choosing to have an abortion. Some of the most commonly cited factors included career and/or educational aspirations, not feeling ready to parent or not having a desire to parent,

financial instability, relationship instability, and past reproductive health experiences. A minority of participants described health and medical concerns that contributed to their decision. Although not all concerns were applicable to all participants, the overwhelming majority of women talked about a combination of factors, indicating that pregnancy decision-making is rarely based on a single influence or circumstance.

This was also true for the subset of 94 mothers who made the decision to abort a subsequent pregnancy. Kayla's story (Fig. 1) illustrates that, although many of these women talked about how their children played into their decision, mothers discussed their children in addition to other contextual factors and circumstances. As described by Keira, age 21 from Newfoundland, "I had already had a baby already. And I didn't expect to be in a relationship with [the person I became pregnant with]. I was still young." Keira's quote shows that her child was but one factor that she took into account when making her decision.

Like Kayla, when mothers did explicitly talk about their children as a part of their decision-making process, they commented on issues of their child(ren)'s wellbeing and their experiences parenting. Kendra, age 21 from Alberta, expressed concern for her daughter's happiness and welfare as being at the center of her decision. "My first decision maker [for my abortion]…was the fact that I had a daughter. She needed…me the most."

Other participants talked specifically about the experience of parenting as contributing to their decision making process. Danika, aged 28 from Manitoba, said succinctly "I wasn't ready to have another baby that I couldn't take care of." Crystal, aged 33 from Nova Scotia, further elaborated on this idea:

> "And I got pregnant, and because of how hard it was with my second pregnancy and having a six-year old, and having a two-year old, and knowing that I'd have to do it again all by myself, just when things were starting to work out in my life. And I know this sounds bad, but I honestly truly feel like I didn't have any more left of me to give."

These women described the idea of parenting another child as overwhelming; more often, it was mothers who were single parenting that talked about this when discussing their decision.

Yet, concerns about parenting and children's wellbeing are intertwined and not necessarily distinct concerns. In fact, most participants described these two issues as being inextricably linked, as captured by Melissa, aged 22 from Manitoba. She commented, "My daughter - she's never met her father and I wouldn't want to be in that same situation, you know, unmarried with another kid, different dad. None of the dads are around or anything like that. And also I at the time had just become not financially independent and I just knew that it was not the right time."

3.3 Mothers were as confident in their decision to have an abortion as those who were not mothers

The overwhelming majority of participants in our study expressed certainty about their decision to have an abortion, as showcased in Kiersten's story (Figure 2). In general, women also expressed contentment, happiness, and relief about their decision after the fact. This was true for the majority of participants in the overarching sample, regardless of whether or not they had given birth or parented before their abortion. Our participants had a deep and nuanced understanding of the implications of pregnancy, childbirth and parenting, even if they had not had these experiences themselves.

The quotes below from Rebecca and Andrea exemplify the confidence with which both nulliparous and primiparous women made the decision to terminate their pregnancies. In both cases the participants similarly described the circumstances surrounding their unintended pregnancy; they were in long-term relationships but experienced financial and occupational instability. Both participants had an understanding of how pregnancy and

parenting would have affected their lives. These experiences are reflective of the fact that pregnancy and parenting are not intrinsically related with decision-making confidence.

Rebecca, aged 30 from British Columbia, chose to terminate her first pregnancy. “I knew that my husband and I wanted to have babies together but…we were both kind of flailing around. I was still in school and my husband had taken…a long time to get him to where he is in his work…so we weren’t stable at all. We were in a crappy place and we just we knew we wanted to have kids together and start a family but knew that we had a lot of work to do before we were ready for it.” She was “100 percent” certain about her decision, and reflected positively on this choice because it allowed her and her husband to have a planned pregnancy later on that resulted in the birth of their daughter.

Andrea, aged 29 from Yukon, had just bought a house with her long-term partner and 3-year old daughter when she had an unplanned pregnancy. She only seriously considered a termination. “I mean the idea of a baby is nice, obviously, babies are nice…I knew what I wanted to do but I talked about it with my husband…I wasn't permanent in my position [at work] at the time. [We thought] ‘Okay, well what's good for us as a family in the long term?’…Our house didn’t even have an extra bedroom and we just bought it, so we would have had to move, and we had just moved in.” In reflecting on her decision, Andrea noted that, “It feels fine [because it was the right decision for me].”

Almost all of the 94 mothers in our study expressed certainty and confidence in their decision to terminate a pregnancy after embarking on motherhood. Participants who felt less certain about their decision generally described feeling less supported by those to whom they disclosed their pregnancy. As well, women who reflected less positively on their decision to terminate were usually less certain about their decision beforehand. We did not find any evidence to demonstrate that previous pregnancies or parenting experiences made

participants more likely to want to continue future pregnancies, or affected participants' certainty about their decision.

3.4 Parenthood compounds challenges in accessing abortion care

Almost all of the participants in our study discussed logistical issues with regard to scheduling their abortion and accessing care. Regardless of parity, participants talked about long wait times and difficulty making time for and travelling to multiple appointments as barriers to having their abortion. The subset of mothers in our study talked about these same issues but often found that the challenges were compounded when compared to the overall sample.

Consistent with Theresa's experience (Fig 3), most of the participants who were parenting at the time of their abortion shared that having children added significant logistical issues that they had to contend with when scheduling and obtaining abortion care. Oftentimes, finding appropriate childcare was a barrier. This was especially true for women who obtained hospital-based abortions that required multiple appointments with different providers over several days. Women who obtained their abortion at a freestanding clinic generally described fewer appointments and a more streamlined process than women who obtained hospital-based abortion care.

Our participants who were co-parenting often relied on this partner to provide childcare while they obtained their abortion. However, in cases when the co-parent was also their support person, participants' described their need for childcare and emotional support as in conflict. As Anika, aged 26 from Alberta, explained, "My son was with us so he couldn't go [into] the women's clinic. You can't have kids in there. So that means my boyfriend couldn't come in or couldn't wait with me or couldn't do anything. I was all by myself. I

mean I get it. No one who's not having a kid wants to see your small child but it still wasn't convenient."

Justine, aged 22 and also from Alberta, echoed this sentiment when she was asked what it would have meant for her to be able to obtain abortion care closer to her home instead of having to travel to another city. She said, "I would have had day care [for my child]. Which means my boyfriend could have been there with me."

Other women relied on family members or friends to help with childcare during their appointments. However, in a number of cases, participants noted that they did not feel comfortable disclosing their pregnancy status or intentions with this caregiver. Harlow, aged 23, explained, "It's just not the conversation I wanted to have with my parents. They'd be very upset. They would be pushing for the adoption [which is not what I wanted]." Harlow ended up leaving her daughter with her parents while she obtained her abortion, but she did not tell them why she needed a babysitter.

Participants also frequently discussed how childcare was an added out-of-pocket cost associated with obtaining their abortion. Kerri, aged 23 from Saskatchewan, was able to rely on a network of family members to provide childcare throughout her numerous appointments. She said, "I imagine most parents who have been in my situation, who don't have resources like that, would definitely have to pay an arm and a leg." Due to the issues surrounding childcare, the 94 mothers in our sample reported more often that they had significant out-of-pocket costs associated with their abortion when compared with the overall sample.

Additionally, the mothers in our study faced compounding barriers to accessing care with both travel and wait times. Alice, age 30 and from Ontario, was faced with a long wait time that impacted how effectively she felt she was able to parent during that time. She said, "If it could have been done locally, I would have had it done sooner. Then I could just move

on and be able to function like a proper mother that way. Just have those six weeks dragging on."

Alice also talked about how she was faced with a difficult decision of having to wait longer or travel to a clinic further away in order to obtain care sooner. She said, "I think in my circumstances, I probably still would have waited because having to care for my children like overnight myself, it would have not have been feasible to get up and go to [another city]."

4. Discussion

In our national qualitative study exploring women's abortion experiences, a large subset of participants were mothers who made the decision to have a subsequent abortion. Although there is no Canadian national data available about the demographics of abortion patients, this finding alone demonstrates what those working in the field of reproductive health have long known: many abortion patients are mothers (Jerman, Jones, & Onda, 2016). Although this characteristic of abortion patients is well known, it has not stopped the social and political rhetoric that so often pits abortion against motherhood. Anti-abortion discourse tends to portray motherhood as a virtuous choice in direct contrast to the villainous act of abortion (Saurette & Gordon, 2013). This dichotomy leaves little space for the many women who inhabit both of these identities.

Instead of talking about abortion in opposition to motherhood, our findings support the movement to talk about women's reproductive lives, including their experiences and decisions, in a more holistic way. We support the use of the term "reproductive careers" as a way to signal the inter-relatedness of reproductive health events that occur throughout an individual's life (Bessett, 2010; Nash, 2014). This is further supported by the fact that, consistent with a broader body of literature, the mothers in our study described an array of

circumstances and feelings surrounding their pregnancies and decision to have an abortion (Biggs, Gould, & Foster, 2013; Foster et al., 2017; LaRoche & Foster, 2018). Although women reported that their children influenced the decision-making process to varying degrees, they also talked about many other factors. Our participants did not describe motherhood as an event that superseded everything else with regard to their future reproductive health decisions; instead, motherhood is but one part of their reproductive career that may contribute to decision-making later on. In addition, our participants discussed a deep and nuanced understanding of the implications of pregnancy, childbirth and parenting, no matter where they were in their reproductive careers.

In 2018, Prime Minister Justin Trudeau authored a commentary in the Lancet (Trudeau, 2018) describing Canada's vision for global health and gender equality. The piece describes Canada's financial commitment to improving gender equality, with a specific focus on empowering women and girls through improving sexual and reproductive health. What is notable about the article is not that Trudeau specifically discusses abortion, but that he writes about a broad vision of reproductive health and gender empowerment, including gender based violence, HIV, contraception and abortion.

The seamless inclusion of abortion in this discussion is refreshing, and perhaps indicative of shifting social discourse around abortion as a part of comprehensive health care. In 2014, Melinda Gates of The Gates Foundation stated, "The question of abortion should be dealt with separately. But in the United States and around the world the emotional and personal debate about abortion is threatening to get in the way of the lifesaving consensus regarding basic family planning," (as cited in Gerber Fried & Hendrixson, 2014, p. 22). Her statement captured the thoughts of many working in the reproductive health field; that unfortunately, abortion is too fraught and too difficult of a topic to tackle. This is a classic example of abortion exceptionalism that has led to the siloing of abortion with regard to

research, the provision of health care, and more. This thought process also contributes to the mutually exclusive ways that abortion and motherhood are discussed, despite, as demonstrated by our findings, the fact that these issues are not at all separate and instead have significant overlap.

But Trudeau, and by extension the Canadian government, offer an alternative framework through which to include abortion in holistic health care and gender empowerment. Top down initiatives like this can play an important role in changing our day-to-day conversations. Although this is not sufficient on its own, it represents an important step towards challenging abortion exceptionalism.

At the time we conducted these interviews, mifepristone, the gold standard of medication abortion was not yet available in Canada. However, mifepristone became available under the trade name Mifegymiso® in July 2015 and was prescribed for the first time in January 2017 (Lunn, 2018). Although mifepristone is not a panacea, expansion of medication abortion services across the country has the potential to mitigate some of the challenges identified by the mothers in our study (Erdman, Grenon, & Harrison-Wilson, 2008; Finer & Wei, 2009). Specifically, permitting patients to take the medications at a time and place that is convenient for them offers increased flexibility with regard to scheduling. This may be a strategy to mitigate the need for childcare and allow patients who wish to have a support person with them during the abortion process the ability to do so.

Understandably, the vast majority of abortion providing facilities in Canada are not able to provide childcare. However, in moving towards a holistic understanding of reproductive health issues, it is essential to recognize that abortion is not separate from motherhood, but for many women, a part of it. Thinking about childcare as a way to support patients seeking abortion care represents an opportunity to expand conversations about

abortion and may represent an avenue that reproductive health and justice organizations can use to expand access to care.

4.1 Limitations

Qualitative methods provide an excellent mechanism for in-depth exploration of participants' experiences, beliefs, and behaviors. However, the method is not intended to yield representative and generalizable results. Although multi-modal recruitment of a purposive sample of women who resided across Canada at the time of their abortion gives us confidence that the themes we identified are significant, we are unable to assess the degree to which these experiences represent broader trends.

4.2. Conclusions

Mothers discussed compounded challenges in accessing abortion care and continuing to parent, including incurring significant out-of-pocket costs and finding appropriate child care. Our findings highlight the importance of streamlining abortion services and suggest that efforts to reduce wait times and expand the number and location of service delivery points could meet a significant need.

5. Implications for policy and practice

Policies that silo reproductive health experiences from one another do not accurately reflect the lived experiences of our participants. Efforts to reframe the dichotomous narrative that pits motherhood and abortion against each other appears warranted. Recent efforts by the Canadian government to reintegrate abortion within the broader sexual and reproductive health and rights, maternal and child health, and gender empowerment, equality, and equity fields reflects one important step in this direction.

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Table 1: Characteristics of participants in the Canada Abortion Study (N=305)

Province	**Anglophone**	**Francophone**	**White**	**FNIM**	**Total (%)**
Alberta	20	0	15	2	**20 (7%)**
British Columbia	32	1	27	3	**33 (11%)**
Manitoba	20	0	9	6	**20 (7%)**
New Brunswick	26	7	28	0	**33 (11%)**
Newfoundland and Labrador	13	0	9	1	**13 (4%)**
Northwest Territories	1	0	1	0	**1 (>1%)**
Nova Scotia	20	0	19	1	**20 (7%)**
Nunavut	1	0	0	1	**1 (>1%)**
Ontario	60	11	51	5	**71 (23%)**
Prince Edward Island	20	0	18	2	**20 (7%)**
Quebec	10	27	9	0	**37 (12%)**
Saskatchewan	20	0	14	4	**20 (7%)**
Yukon	16	0	9	3	**16 (5%)**
Total	**259 (85%)**	**46 (15%)**	**209 (69%)**	**28 (9%)**	**305 (100%)**

Table 2: Characteristics of mothers in the Canada Abortion Study (N=94)

Province	**Anglophone**	**Francophone**	**White**	**FNIM**	**Total**
Alberta	10	0	9	1	**10 (11%)**
British Columbia	5	0	4	1	**5 (5%)**
Manitoba	7	0	4	2	**7 (7%)**
New Brunswick	11	4	10	0	**15 (16%)**
Newfoundland and Labrador	4	0	2	0	**4 (4%)**
Northwest Territories	0	0	0	0	**0 (0%)**
Nova Scotia	5	0	5	0	**5 (5%)**
Nunavut	1	0	0	1	**1 (1%)**
Ontario	14	3	7	3	**17 (18%)**
Prince Edward Island	7	0	6	1	**7 (7%)**
Quebec	2	6	2	0	**8 (9%)**
Saskatchewan	6	0	5	1	**6 (6%)**
Yukon	9	0	5	1	**9 (10%)**
Total (%)	**81 (86%)**	**13 (14%)**	**59 (63%)**	**11 (12%)**	**94 100%)**

Figure 1: Kayla's story

Kayla is 25 years old and from Prince Edward Island. She has been pregnant three times in her life. She carried her second pregnancy to term and gave birth to her son; she terminated the other two pregnancies. Although her life circumstances were different at the time of each pregnancy, Kayla described a similar process that involved weighing a complex web of factors for making her decisions.

When she became pregnant for the first time, Kayla did not want to be pregnant and did not have a desire to parent. In addition to being in a new relationship and financially unstable, she did not feel ready to parent and was concerned that a child would compromise her educational and career aspirations. Her boyfriend supported her and Kayla felt very confident in her decision. Kayla reflects positively on her choice to have an abortion because it meant that she was more prepared when she became pregnant for the second time. She confidently chose to carry that pregnancy to term and looked forward to parenting.

Kayla's third pregnancy occurred shortly after the birth of her son. At that time, Kayla did not want to be pregnant but did have a desire to parent. However, she also talked about how the birth of her child had brought up some issues in her relationship and she and her partner were struggling to connect. She was concerned about the prospect of being a single parent of two children. Although she felt able to provide financially for her son, the unexpected pregnancy shortly after giving birth complicated her plan for financial independence. Kayla was also deeply concerned for the wellbeing of her son; she felt this could be compromised by adding a second child to the family. She made the decision to terminate her pregnancy and now reflects on the decision as "definitely for the best".

Figure 2: Kiersten's story

Kiersten is a 21 year old single mother from Manitoba. She has been pregnant three times; she carried her first pregnancy to term and gave birth to her daughter, her second pregnancy ended in a miscarriage, and when she became pregnant for the third time, Kiersten decided to have an abortion.

When she found out that she was pregnant for the third time, Kiersten was "shocked and unhappy". Her unintended pregnancy felt overwhelming in the face of other circumstances in her life that she described as "exceptionally stressful". Kiersten was experiencing some legal troubles and was recently unemployed. Beyond this, her relationship with her boyfriend – although positive – was new and she was uncertain about parenting with him. Kiersten also talked about what this might mean for a future child as well as her three-year old daughter's wellbeing. She summarized her feelings by saying that she felt that it would have been selfish to continue with the pregnancy.

Kiersten confidently made the decision to have an abortion because she knew it was the "right choice" and spoke about it with a number of people in her social support network. The people that Kiersten told reacted positively to her decision. Reflecting on her choice now, Kiersten is "100% sure it was the right decision".

Figure 3: Theresa's story

Theresa was 44 and living in Northern Ontario when she became pregnant for the fifth time. A mother of four and grandmother of two, Theresa felt that she was already barely able to make ends meet. Her relationship was unstable and she didn't see herself parenting with her current partner. She explained that she is tired; she adores her children and grandchildren but didn't want to start over with another baby.

Although Theresa made her decision soon after learning she was pregnant, the process of obtaining an abortion was complicated. At that time, the only providing facility in her region was the hospital and obtaining her abortion required five separate visits. She first went to a local health clinic and they confirmed that she was pregnant. She was then sent to a separate facility to obtain an ultrasound. It took over a week to schedule and she learned at that visit that she was 9 weeks pregnant. The next appointment was with her gynecologist and the first available appointment was 10 days after her ultrasound. When she was finally referred to the hospital she had to wait over two weeks to schedule the abortion. And the process took two days – a pre-op visit and then the abortion itself the following day. All told, it took Teresa over five weeks to obtain the abortion after she had made the decision to have one; and thus rather than having an abortion at 8 weeks from the first day of her last menstrual period (LMP), she had her abortion at 13 weeks LMP. Because she had provincial insurance the abortion itself was covered, but she incurred significant out of pocket expenses because of travel, lost wages, and having to find care for her youngest daughter.

Chapter 7:

"We've Got Rights and Yet We Don't Have Access." Exploring Patient Experiences Accessing Medication Abortion in Australia

LaRoche, K. J., Wynn, L. L., & Foster, A. M. (2020). "We've got rights and yet we don't have access": Exploring patient experiences accessing medication abortion in Australia. *Contraception*, *101*(4), 256–260. https://doi.org/10.1016/j.contraception.2019.12.008

"We've Got Rights and Yet We Don't Have Access." Exploring Patient Experiences Accessing Medication Abortion in Australia

Abstract

Objectives: Across Australia, multiple strategies have emerged to decentralize abortion care and increase access to mifepristone, including incorporating medication abortion into primary care and offering mifepristone via telemedicine. We aimed to explore the experiences of patients accessing medication abortion care across these different health service delivery formats and different geographic areas.

Study design: We conducted in-depth interviews with 22 people from across Australia who had used mifepristone for abortion. We audio-recorded and transcribed all interviews and managed our data with ATLAS.ti. We used deductive and inductive techniques to analyze these data for content and themes.

Results: Although participants were generally satisfied with the abortion care they received, many described medication abortion care in Australia as inaccessible and confusing to find. Our participants incurred variable and often significant financial costs when obtaining their abortion care and many reported that their interactions with general practitioners when trying to locate an abortion provider were uninformative and stigmatizing. Participants were enthusiastic about obtaining medication abortion through a variety of service delivery modalities, including telemedicine, and believed these strategies could increase equitable and affordable access.

Conclusions: Barriers to finding and accessing abortion care persist across Australia. Efforts to challenge the over-regulation of mifepristone, increase the affordability of medication abortion, and enhance training opportunities to educate a variety of clinicians about medication abortion and support provision from a range of providers appear warranted.

Implications

The continued over regulation of mifepristone creates barriers for incorporating mifepristone into primary care settings and has significant implications for patient access and abortion stigma. Regulatory reform and provider education and training have the potential to improve abortion patients' experiences with medication abortion.

Keywords

Abortion, medication abortion, mifepristone, health service delivery, telemedicine, primary care

1. Introduction

Despite extensive and longstanding evidence regarding the safety and acceptability of the use of mifepristone and misoprostol to induce an early abortion, a 1996 amendment to the Therapeutic Goods Act of 1989 restricted the importation of mifepristone in Australia [1]. Although a 2006 bill overturned this amendment, the absence of a pharmaceutical champion meant the drug was neither produced nor marketed in the country [2]. Individual physicians familiar with mifepristone availed themselves of a Therapeutic Goods Administration regulation that allowed them to import small quantities of the drug for use in their personal practices, but the mifepristone and misoprostol regimen was not widely available. Only after submission of a comprehensive and costly application did the Therapeutic Goods Administration finally approve mifepristone for use in early abortion in 2012 [3].

Although the approval of mifepristone was a victory for reproductive health advocates, the Therapeutic Goods Administration imposed an extensive risk management scheme and implemented a number of non-evidence based restrictions [3]. In conflict with the global evidence and best practices [4], the restrictions originally limited use of the medication to 49 days gestation or less, limited prescribers to general practitioners (GPs) and obstetrician-gynecologists (OB/GYNs), required both GPs and OB/GYNs to register with MS Health (the lone mifepristone supplier), and required GPs to complete a training program [3]. The Therapeutic Goods Administration permitted mifepristone dispensing by pharmacists but required the pharmacies to register. Consistent with global evidence [4], the Therapeutic Goods Administration extended the gestational age limit to 63 days in 2015, but as of June 2019 the restrictions on prescribers and pharmacies remained in place [2].

In practice, mifepristone availability in Australia is complicated further by the variation in legal status, regulation, and accessibility of abortion at the state level [5]. Although abortion is technically available across the country, a variety of both legal and non-

legal barriers to accessing care exists [6,7]. Evidence also suggests that rural residents face compounded access barriers [8,9].

The geographic vastness and population distribution of Australia means that centralized abortion services in major cities leave large areas of the country underserved. In response, multiple strategies to decentralize abortion care have emerged, including the incorporation of mifepristone into primary care settings and provision of the drug via telemedicine [10]. By way of example, the Tabbot Foundation, a telemedicine service established in 2015 to expand abortion access to rural and regional populations [11], provided medication abortion by mail to patients once they had confirmed and dated their pregnancy locally via ultrasound [12]. Although the Tabbot Foundation provided medication abortion to thousands of patients [12], the organization shuttered in March 2019 citing that the model was not financially viable [13].

Although research conducted with clinicians across Australia indicates support for strategies to decentralize abortion care [14,15], little literature focuses on the patient experience. To date, no studies have rigorously explored the experiences of Australian abortion patients obtaining mifepristone through different service delivery models in different geographic areas. We aimed to address this gap.

2. Methods

In March and April of 2019, we conducted interviews with women, transgender folks, and gender non-binary people from across Australia who had used mifepristone for abortion. We based our interview guide on a guide developed for a large-scale qualitative study with Canadian abortion patients [16-19]. Informed by a literature review and feedback from key stakeholders, we made small revisions to the guide and tailored it to the Australian context. Our eligibility criteria included having used mifepristone to terminate a pregnancy while

living in Australia, being at least 18 years old at the time of the interview, being sufficiently fluent in English to answer the interview questions, and having access to a telephone/Skype. The Human Research Ethics Committee at Macquarie University approved this study.

2.1 Recruitment

We used a multi-modal recruitment strategy that included posting on the Australian online classifieds site Gumtree, posting on social media (such as Facebook and Instagram), and asking community groups and organizations to share information about our study. KL was responsible for recruitment with input from and regular check-ins with LW and AF. After verifying eligibility and addressing any questions or concerns that the respondent had, KL scheduled a mutually convenient time to talk.

2.2 Data collection

KL, a Canadian PhD student in Population Health with training in medical anthropology, conducted the interviews while residing in Australia. All of the interviews took place over the telephone or Skype and lasted between 60 and 90 minutes. We provided each participant with an electronic version of the consent form and then obtained verbal consent before beginning the interview. LW, an American-Australian cultural anthropologist, and AF, an American medical anthropologist and medical doctor, both of whom have extensive experience conducting qualitative research on abortion, provided feedback throughout the process.

We began each interview by asking open-ended questions related to the participant's background information and general sexual and reproductive health history, including their pregnancy and abortion history. We then inquired about the respondent's abortion experience beginning with an exploration of the circumstances surrounding the index pregnancy,

including the abortion decision-making process, and steps involved in locating a provider. We then discussed the details of the participant's abortion experience(s), including what it was like to get and take the medications and reflections on the overall process. We ended the interview by asking about the participant's opinions about the provision of mifepristone through different health service delivery formats and how services and access to those services could be improved. We asked participants to provide information about all of their abortions; for those who had previously obtained an aspiration or surgical abortion, we asked them to compare the different methods.

KL took notes throughout the interviews and memoed shortly thereafter, a process that served as an opportunity to identify key ideas and reflect on her positionality and the co-construction of information during the interview [20,21]. With the permission of participants, we audio-recorded all interviews and then transcribed them. We offered participants an AUD40 (USD28) gift card to Woolworths for their time.

2.3 Data analysis

We began reviewing data as we collected them, an iterative process that allowed us to identify common themes, draw initial connections between ideas, and establish thematic saturation as we continued to conduct interviews. Our regular team meetings throughout the life of the project allowed us to debrief on the interviews and discuss themes as they emerged. We believed we had reached thematic saturation after 18 interviews and conducted four additional interviews as confirmation. Drawing on interview transcripts, notes, and memos, we conducted content and thematic analyses of the interactions using both predetermined codes and categories based on the research questions and inductive analysis techniques to identify emergent ideas.

We used ATLAS.ti version 8.1.3 to manage our data and KL created an initial codebook and served as the principal coder. AF reviewed a subset of audio recordings and full transcripts and both LW and AF reviewed the codebook and a selection of coded transcripts. Guided by regular team meetings and discussions, our thematic analysis centered on grouping categories of information, drawing connections between ideas, and understanding relationships. We resolved rare disagreements through discussion.

In the results section we present our key themes and use illustrative quotes to support the findings. We have removed/masked all identifying information and assigned pseudonyms to participants. For currency conversions, we use the June 2019 exchange rate when AUD1 equaled USD0.69.

3. Results

3.1 Participant characteristics

Our 22 participants came from every state in Australia as well as Australian Capital Territory, with more than half from Queensland (n=6) and New South Wales (n=6). They ranged in age from 19 to 45 years old at the time of the interview, with an average age of 28. Twenty participants identified as women and used she/her pronouns; two participants identified as transgender or gender non-binary and used they/them pronouns. The vast majority (n=20) identified as White.

Our participants discussed medication abortion experiences that took place between 2009 and 2019. Participants reported using medications to induce an abortion between 42 and 63 days, with an average gestational age of 48 days at the time of mifepristone use. Our participants obtained medication abortion care through a variety of health service delivery settings, including freestanding abortion clinics and Marie Stopes (n=10), general practitioners and gynecologists (n=5), sexual health and community health centers (n=4), the

Tabbot Foundation (n=2), and a hospital (n=1). Our participants reported that they were able to administer the mifepristone and misoprostol regimen successfully and tolerate side effects. All but two of our participants reported having a complete abortion with mifepristone and misoprostol and none of our participants experienced serious adverse outcomes, irrespective of service delivery modality.

3.2 Locating a provider was often complicated and stigmatizing

The vast majority of our participants described a high level of certainty about their decision to terminate their pregnancy. Although all participants were ultimately able to obtain abortion care, the process of locating a provider was complicated. For the majority of our interviewees, making an appointment with a family doctor was the first step to finding an abortion provider. This process held true even for those who ultimately ended up accessing care through settings that did not require a referral. Jessica, aged 27 from Queensland, contacted her family doctor because "I didn't know how to go and get an abortion, basically." Cassia, aged 30 from Western Australia, said, "I actually thought you could get the pill from the GP. I didn't realize it would be that complicated."

Most of our participants who first interacted with a family doctor when trying to locate an abortion provider reported that these providers were generally not well informed about the local availability of abortion care. Ellin's appointment with her family doctor in Tasmania was one of the most positive interactions: "So my GP…had no idea. But he made a few phone calls to sort of check what the protocols and all that sort of thing would be. And he then referred me to a family planning clinic that's run locally."

More often, interviewees described judgmental and unhelpful interactions with clinicians. Some, like Scarlett, aged 24 from New South Wales, were also told inaccurate information about the risks of abortion:

> "[The doctor] just sort of told me the risks…Like, you know there's a risk of infertility and all sort of stuff…So I think she was definitely trying to skew me away from it…But to me, that sort of reaffirms this opinion in my head that like, I'd really stuffed up and I was doing a really bad thing. And it just sort of reaffirmed all this negative. So it's taken me so long to realize that actually what I did wasn't a bad thing."

Alana, aged 30, from Victoria, recalled her interaction with a family doctor by saying: "I told her I couldn't have the baby, and she said it was a miracle that it even happened. I was 28. She advised me that at my age [I should] think about it as my one opportunity...I asked her where I could get [an abortion] and she said they didn't do that there and she didn't know anyone locally who [did]. I wanted to understand my options, but she didn't tell me them which was a lie. There are options."

3.3 Participants were shocked at how expensive medication abortion was

Although the Australian health system provides subsidies for many services, abortion is not fully covered. Participants reported paying between AUD0 and AUD1200 (USD 0-825) out-of-pocket for their medication abortion, with a mean of AUD337 (USD232). Many participants also incurred additional expenses related to travel, lost wages for time off work, and/or childcare. Consistently, our participants discussed the hardships in coming up with the money for their abortion. Bowie, aged 29, from Tasmania said "I was living pay check to pay check. And [the cost of the abortion] was a pay check."

Several participants asked for an advance from their employer to pay for their abortion. Others had to borrow money from friends or family. However, for many participants, abortion stigma influenced if, when, and to whom they felt comfortable disclosing their pregnancy status. Emma, aged 35 from Tasmania said, "So then I have to lie to people about why I'm not going to be able to pay rent or I'm not going to be able to pay for this. Because I can't exactly just tell everyone, 'Oh I'm pregnant' and get judged."

Ruby from Queensland was 16 when she became pregnant and was told that she would have to pay AUD540 (USD371) for her abortion. “I had money, but like I couldn’t afford to have an abortion. In a way it was cheaper for me to raise a child.” Ruby had a pre-existing relationship with a youth social worker who told her about an abortion fund that could help with the cost and logistics of scheduling the procedure. Without help from the abortion fund, Ruby would not have been able to access care.

Participants perceived this as an inequity and in conflict with the national values that undergird the Australian health system. Jessica, aged 27 from Queensland summed up the sentiments expressed by many of our participants when she said “You have to be above a certain income to make [getting an abortion] easy.”

3.4 Participants expressed enthusiasm about accessing care through different service delivery models

In general, patients reflected positively on the abortion care that they received, regardless of the setting. However, patients’ perceptions about the quality of care was also related to convenience. Two of our participants reported that they had to travel to another state to access abortion care; three drove more than four hours. Those who travelled significant distances and pay substantial sums out-of-pocket expressed more disappointment in the quality of their care. Olivia, aged 20 from Queensland, explained, “I was okay with the price from what I was expecting the experience was going to be like. After the experience with the clinic itself, I was really, really angry with the amount that I paid and the treatment that I received.”

Although only two participants used the Tabbot Foundation’s telemedicine model to have their abortion, they both spoke highly of the care that they received and characterized the service as efficient and convenient. Laura, aged 40 from New South Wales, said, “I just

found everybody that I spoke to at the Tabbot Foundation, from the lady that I spoke to when I made my initial inquiry to the nurses to the GP, was so non-judgmental. And you got the feeling they really believed in what they were doing, which made everything so much nicer."

However, very few of our participants were aware of the Tabbot Foundation or had previous knowledge about using telemedicine to obtain medication abortion. We asked interviewees what they would have thought about receiving care in this way had it been offered to them at the time of their abortion. All reflected positively on this option and felt that it was crucial to expanding access to abortion. Frankie, aged 33 from New South Wales said, "I think [telemedicine] would be amazing. It's not a medication that anyone would be abusing recreationally. It has one specific purpose and if it's not available for people the consequences can be quite dire for their health. I think making it available to people in Australia is huge. We can't just rely on the cities making it available."

Participants also expressed enthusiasm about the prospect of being able to access care from a family doctor. Ellin, aged 24 from Tasmania said: "[If going to my family doctor] had been an option…I'd be jumping for joy. Like, I know there would still be a waiting period. But if that had been an option to go to my GP and have all this done, like oh my god. That would have saved so much grief."

There was consensus among our participants that medication abortion needed to be available in more settings across Australia and that using different health service delivery formats was one way to do this. As Elisabeth, aged 30 from rural New South Wales, said, "We've got rights and yet we don't have access."

3.5 Some participants preferred medication abortion, but for others it was the only accessible option

When we asked participants how they made the decision to have a medication abortion instead of an aspiration abortion, they described a variety of reasons for their choice. For many participants, being able to have their abortion at home was preferable and the option felt less invasive. Hannah, aged 29 from New South Wales, said: "Being able to manage it at home was more preferable to me as well, so I could take some time off work…when I knew that things were going to happen. I guess it just gave me a little more privacy, and wouldn't be such an invasive experience either."

However, other participants noted that medication abortion was the only accessible option for them. In some cases, mifepristone was all that the participant could afford, as the fees associated with an aspiration procedure were even more prohibitive. Laura, aged 40 from New South Wales said, "So 200 dollars [USD138] is still a lot of money, especially at that time it was. But it was 450 dollars [USD309] less than going to the clinic [for an aspiration abortion]." Jessica from Queensland echoed this sentiment: "[Cost] was also a deciding factor in choosing to do [a medication abortion] because it's cheaper to do the pills. I had no money at 20 and I couldn't ask any family members. I tried to think about how I could do it without putting myself into any debt."

The lack of aspiration abortion providers in some areas also constrained some participants' choices. Alana from Victoria explained: "I think the surgical felt like the easier option for me…but [medication abortion] was the only option I had locally."

4. Discussion

Australia is a geographically vast country that has both a dispersed population and low population density. Indeed, the country's landmass rivals the size of the continental US,

while its population is less than that of Texas [22,23]. This context creates a variety of considerations for the delivery of health services. For example, the 2016 National Strategic Framework for Rural and Remote Health [24] highlighted the necessity of health care service delivery models that "overcome the challenges of geographic spread, low population density, limited infrastructure and the significantly higher costs of rural and remote health care delivery," [p 1]. Based on this recommendation, the promise of medication abortion seems especially salient in the Australian context.

Yet, the legally inconsistent status of abortion across Australia – in addition to the overregulation of mifepristone – means that increasing access to abortion care has additional challenges when compared to other common and safe procedures [5,6,25]. The story of mifepristone in Australia to date reaffirms that availability of the medication is not synonymous with accessibility and additional strategies are critical to improving access to abortion care across the country.

Consistent with the experience of pregnant people worldwide [26], our participants were generally satisfied with the abortion care they received and found medication abortion to be an important option. However, costs, lack of local service providers, and judgmental encounters with GPs characterized their experiences. In particular, inconsistency and lack of predictability around cost interacted with a culture of stigma to leave patients confused about how to access abortion and struggling to pay for it. The cost of medication abortion, even when it was lower than the cost of an aspiration procedure, was surprising and often non-transparent to patients and influenced disclosure; some participants had to tell people about their pregnancy that they otherwise would not have, while others hid their struggles to pay out of fear of judgment.

Australia is a mixed healthcare setting where the state covers many services through Medicare, but not all procedures are covered. Some procedures are provided in both public

settings (for free) and private settings (at cost to the patient), depending on the clinic, hospital, and private healthcare insurance and providers have considerable discretion in how much they charge patients above and beyond the basic cost covered by Medicare. This creates a tension of expectations, such that our research participants argued that abortion is a right and expected a base of services, yet sometimes experienced scenarios where costs were non-transparent. Many of our patients did not know who would provide abortion procedures and to what degree cost was negotiable.

Supporting efforts to ensure full Medicare rebates (reimbursement) for both abortion care in general and medication abortion specifically is a critical step to meeting needs. In the case of medication abortion, this includes fees associated with referrals, ultrasounds, and blood work. Further, it appears that family doctors are uniquely positioned to make patients aware of their options and figure out how to access abortion services. Thus, engaging with non-abortion providing GPs and other primary care providers to ensure they can appropriately refer patients to area providers is critical [15,27].

However, there is also a need to increase the local availability of abortion care. Participants in our study were clear in that they supported the integration of medication abortion into both primary care and telemedicine services. Advancing these models of service delivery will involve different approaches. For medication abortion to be fully incorporated into primary care, a number of the regulatory barriers (including the training and registration requirements for GPs) will need to be lifted [2]. Further, it will also be important to explore mechanisms for other members of the health care team, such as nurse practitioners, to prescribe [28-29]. Undoubtedly, the recent closure of the Tabbot Foundation complicates efforts to expand access to telemedicine. However, Marie Stopes International continues to operate a telemedicine service across Australia [30]. A minimum first step would be to identify ways to share information about this service to both clinicians and the public.

Information highlighting that the majority of private abortion providers do not require a referral to obtain care may also be warranted.

4.1 Limitations

Qualitative methods provide an excellent mechanism for in-depth exploration of participants' experiences, beliefs, and behaviors. However, the method does not yield representative and generalizable results. Although multimodal recruitment of a purposive sample of people who had terminated a pregnancy across Australia gives us confidence that the themes we identified are significant, we are unable to assess the degree to which these experiences represent broader trends. Additionally, a few participants reported on abortion experiences up to ten years ago and as with any form of self-reported data, memories may be subject to recall bias. Further, this project centered exclusively on those people who used mifepristone; we did not capture the experience of those who wanted to have a medication abortion but were unable to navigate access barriers.

4.2 Conclusion

Significant barriers to locating and accessing affordable abortion care persist across Australia. Mifepristone continues to represent a promising option for increasing access to abortion care in this geographically vast area. However, additional efforts to deregulate mifepristone, increase Medicare rebates to enhance affordability, and expand the pool of both primary care and telemedicine providers are required.

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Chapter 8:

"We Have to Make Sure You Meet Certain Criteria": Exploring the Criminalisation of Abortion in Australia on Patient Experiences

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"We Have to Make Sure You Meet Certain Criteria": Exploring the Criminalisation of Abortion in Australia on Patient Experiences

Abstract

Introduction: Nine different sets of laws govern abortion in Australia and the criteria for an abortion to be considered lawful vary considerably by jurisdiction. We explored how the criminal status of abortion affected patients' experiences accessing care in a country where abortion services are widely available.

Methods: We conducted qualitative, in-depth interviews with 22 people who had an abortion in Australia since 2009 across a variety of legal contexts. We audio-recorded all interviews and then transcribed them in entirety. We used ATLAS.ti 8.1.3 to manage our data and carried out content and thematic analyses using deductive and inductive techniques.

Results: At the time of their procedures, more than half of our participants (n=13) obtained their abortion in a state that had criminal sanctions associated with procuring an abortion and required abortion seekers to meet strict legal requirements to access care. In general, participants reported confusion about the legal status of abortion. Participants that had an abortion in criminalised settings described significant negative emotional impacts that were directly linked to the law. They were often required to fit their abortion story into a state-mandated narrative. Further, criminalising abortion meant that some of our participants felt they could not be honest with clinicians for fear of being denied care. Our participants were overwhelmingly in support of decriminalisation of abortion and increased consistency in legal status across Australia.

Conclusions: The criminalisation of abortion in some Australian states negatively impacts patients' emotional wellbeing, undermines the patient-clinician relationship, and perpetuates abortion stigma. In the absence of legislative reform, training for clinicians – including abortion providers and general practitioners – to explain the implications of the legal status to their patients appears warranted. Patient-centred resources, such as a web site with state-specific information, could fill an important knowledge gap for the public.

Key points

- The criminalisation of abortion in some jurisdictions has significant negative effects for patients accessing abortion care across Australia
- Abortion patients believe it is essential to decriminalise the procedure in order to combat abortion stigma
- At a minimum, abortion providers in criminalised settings need to explain the legal status to patients so that they can understand the process

Introduction

Prior to federation, abortion in Australia was governed by the United Kingdom of Great Britain and Ireland's *Offenses Against the Person Act of 1861* which restricted both the procurement and provision of abortion.[1] Now, the procedure is governed by the states and territories, which means that changes to abortion legislation have occurred – to varying degrees – on a jurisdiction-by-jurisdiction basis.[2] As a result, despite being both a safe and common medical experience, abortion is governed by nine different sets of laws and the criteria for an abortion to be considered lawful can vary considerably.[2] Only the Australian Capital Territory (ACT) has removed all criminal sanctions associated with abortion, while Victoria, Tasmania, the Northern Territory, Queensland, and most recently New South Wales (NSW) have significantly liberalised their laws and fully decriminalised procuring an abortion.[2–4] However, these legislative changes also ushered in new offences relating to an unqualified person performing, or assisting with procuring, a termination.[2] South Australia and Western Australia have both made amendments to the *1861 Act*, but abortion remains governed by criminal laws.[1]

Despite the patchwork of legislation, safe abortion is provided liberally in many parts of the country through both the public and private sectors.[5] Leading up to and following the 2019 federal election, the issue of decriminalisation garnered renewed public interest and media coverage.[6] Media reports suggest that the criminalisation of abortion affects patients' ability to access care[7], yet this claim has not been rigorously explored in the Australian context. Research conducted across the country has documented a number of barriers that patients face in accessing abortion care.[8–11] Further, research carried out with stakeholders and clinicians has demonstrated that having abortion on the criminal code affects physicians' practices and their willingness to be involved with abortion-related training or provision.[12,13]

There is also broad support – from both the public and clinicians – for the decriminalisation of abortion.[14,15]

However, there is a dearth of research that focuses specifically on how the criminal status of abortion influences patients' experiences from the patient perspective.[9] To date, the voices of abortion patients are notably absent from the peer-reviewed literature on this topic. Our qualitative study aimed to address this gap. We wanted to explore differences in the experiences of patients who accessed care in both criminalised and decriminalised settings across Australia. We also aimed to document our participants' thoughts about these policies.

Methods

In early 2019, we conducted interviews with 22 women, transgender folks, and gender non-binary people from across Australia who had obtained a medication abortion. The data collected for this study aimed to document the experiences of patients using mifepristone across Australia.[10] The influence of the legal status of abortion on patient experiences became apparent early on during data collection. This paper focuses specifically on this emergent finding.

Eligibility criteria

In order to be eligible for the study, we required that participants had at least one abortion with mifepristone while living in Australia, be at least 18 years old at the time of the interview, be sufficiently fluent in English to answer interview questions, and have access to a telephone or Skype.

Recruitment

We used a multi-modal recruitment strategy that included liaising with community groups and organisations to share information about our study, posting on social media (such as Facebook and Instagram), and posting on the online classifieds site Gumtree. KL was responsible for recruitment with regular input from AF and LW. After verifying eligibility, KL scheduled a mutually convenient time to talk with anyone who expressed interest in participating in the study.

Data collection

KL, a Canadian PhD student in Population Health with training in medical anthropology from Macquarie University, was responsible for data collection with regular feedback from both LW and AF. LW is an American-Australian cultural anthropologist and AF is an American medical anthropologist and medical doctor; both have extensive experience conducting qualitative research related to abortion.[10,16] KL conducted all of the interviews while living in Australia. The interviews lasted between 60 and 90 minutes and all took place over the telephone or Skype.

We modelled our interview guide after a large-scale qualitative study on abortion patients' experiences in Canada.[16] KL began each interview by asking open-ended questions related to the participant's background and general sexual and reproductive health history. She then turned to the respondent's abortion experience beginning with a discussion of the circumstances surrounding the pregnancy that resulted in abortion, the abortion decision-making process, and the steps involved in locating a provider. She then discussed the details of the participant's abortion experience(s) and reflections on the overall process. For participants who had more than one lifetime abortion, she asked them to provide information about each termination.

Early on in the interview process, participants organically brought up how the legal status of abortion in their state influenced their process of locating a provider. After the second interview, we modified the interview guide to include specific questions about these issues, such as, "Were you aware of the legal status of abortion in your state at the time?" We also asked whether participants were aware of legal reform efforts and their opinion on decriminalisation.

KL took notes throughout the interviews and memoed shortly thereafter. The memoing process served as an opportunity to identify key ideas and reflect on her positionality and the co-construction of information during interview.[17,18] She obtained permission from all participants to audio-record the interviews and then transcribed them in entirety. We offered participants an AUD40 gift card to Woolworths as a thank you for their time.

Data analysis

We began reviewing data as we collected them to identify common themes, draw initial connections between ideas, and establish thematic saturation. We had regular team meetings throughout the life of project which gave us an opportunity to debrief on the interviews and discuss themes as they emerged.

Drawing on interview transcripts, notes, and memos, we conducted content and thematic analyses of the interactions using both *a priori* (predetermined) codes and categories based on the research questions and inductive analysis techniques to identify emergent ideas. We used ATLAS.ti version 8.1.3 to manage our data and KL created an initial codebook and served as the principal coder. We developed our initial codes from the literature and the interview guide; we refined initial codes and added new codes as we became more familiar with the data. AF reviewed a subset of audio recordings, full transcripts and a selection of

coded transcripts. Guided by regular team meetings and discussion, our analysis centred on grouping categories of information, drawing connections between ideas, and understanding relationships. We resolved rare disagreements through discussion.

In the result section, we present our key themes and use illustrative quotes and vignettes to support the findings related to the relationship between the legal status of abortion and participants' experiences. We use pseudonyms and have redacted all personally identifying information. Throughout this paper we refer to participants by their preferred pronouns and their age at the time of the interview. We received approval for this study from the Macquarie University Human Research Ethics Committee (file #3491).

Results

Participant characteristics

Our 22 participants discussed their first trimester medication abortion experiences that took place between 2009 and 2019 across all states and the ACT. Our participants ranged in age from 19 to 46 at the time of the interview and the vast majority identified as White (n=20). More than half of our participants (n=13) obtained their abortion in a state where procuring a first-trimester termination was subject to criminal law at the time of their procedure. We describe participant characteristics in Table 1.

Confusion about the criminal status of abortion has a negative emotional impact, necessitates secrecy, and reinforces stigma

Few of our participants were aware of the legal status of abortion in their state prior to the pregnancy that resulted in abortion. Indeed, our participants usually became aware of the issue during the process of trying to locate a provider. For many, this added confusion to the process; there was a lack of clarity about what it would mean to access a service that was

subject to criminal law. For several others, the criminalized nature of abortion made them feel defiant in the face of what they perceived to be an unfair law. Elisabeth, aged 30 from NSW said, "I was very much like, that's stupid and you're not stopping me. I'll figure it out."

Many found the piecemeal nature of abortion legislation across Australia to be difficult to interpret and noted that it was challenging to find state- or area-specific information. Charlotte, aged 25 from NSW, explained: "I didn't realise beforehand and after all of the research I found out [about the criminal status of abortion] and it was quite disturbing actually. But then to find out that all of these clinics are still running…and the change of regulations in each state, which all didn't make much sense to me."

The confusion that stemmed from the legal status of abortion had a significant emotional impact on a number of our participants that impacted their experience of accessing care. As Simone's story shows (Fig. 1), she experienced fear and confusion throughout her entire experience because she was unsure how the legal requirements of obtaining care in NSW would affect her.

For many, the criminal status of abortion felt like a moral judgment and contributed to the feeling that abortion was something that should not be talked about. Elisabeth from NSW said: "I believe that they're very hush hush and they have to be because it is illegal to have abortions in NSW." Similarly, Ruby, aged 22 from Queensland said, "Yeah, [the community organization that helped me find services] said where I was going to [have my abortion] was a legal place, but what I was doing was illegal...They said just not to speak too much about it." Multiple participants brought up this issue of secrecy and in their retelling, they recalled it as being directly linked to the legal status of abortion. This is indicative of the relationship between the legal status of abortion and abortion stigma, and how the two contribute to and perpetuate each other in a cycle of silence.

Legal status influences patients' abortion narratives and creates a hierarchy of deservedness

Overwhelmingly, our participants cited similar reasons for wanting to terminate their pregnancy regardless of whether or not the procedure was subject to criminal sanctions in their state. This included not feeling ready to parent, not wanting to be pregnant or parent, not wanting to parent in their current relationship or with their current partner, career and/or educational aspirations, and a lack of financial stability.

However, participants who accessed care in states where abortion was criminalised were often required to fit state-mandated narratives about what constituted an acceptable reason for wanting to have a termination. Inherently, this created a hierarchy of deservedness, where abortion seekers with certain personal circumstances "deserved" information and care more than others. This imbued a sense of judgment about whether or not a particular patient's reasoning was sufficient.

Frankie's experience in NSW encapsulates this dynamic well. We asked Frankie about why they wanted to have an abortion at the clinic, but their first response did not meet the state narratives for an exception to obtain a legal abortion. Frankie explained: "I said I was too young and my life wasn't set up for having a kid and they flipped back to the page with my date of birth on it. They were like 'Twenty-seven is not too young, wait too long and you won't be able to have children.' I said I feel too young and I don't have a stable job and…they checked the money box. Financially I wouldn't be able to have a child."

In contrast to Frankie's experience, at age 16, Ruby (Fig. 2) was never required to justify her decision during her experience in Queensland. Indeed, her story already fit neatly into state narratives about the circumstances in which it was acceptable to have an abortion. Ruby's experience was a stark contrast to other participants who obtained care in

Queensland, most of whom were required to explain and defend their decision making process in order to obtain care.

Multiple participants recalled how they were required to frame their desire for a termination in a way that checked certain boxes. Laura, aged 40 from NSW said, "Because [the nurse] was like 'You know, we have to make sure you meet certain criteria because of the legality surrounding abortion in NSW.' I think she ended up listing mental health and financial."

Amanda, aged 23 from Queensland, felt strongly that patients should not have to justify their decision to have an abortion. She recalled this as the one drawback of the care that she otherwise described positively. She said: "I think it was incredibly professional, minus that one question about why you're having the abortion… I just said because I want one."

The criminalisation of abortion undermines the patient-clinician relationship

Participants repeatedly recounted that the perception of abortion as an illegal activity interfered with the physician-patient relationship at some point in obtaining care. For many patients, it introduced a sense of wariness about how honest they could be with the physician; this same guardedness was not reported by our participants who obtained their abortion in decriminalised settings. Several participants reported being dishonest with their abortion-providing clinician because they were fearful about repercussions.

As but one example, Amanda from Queensland had her termination when abortion was criminalised in the state. She said "I was very aware of [the legal status of abortion]. I didn't see my GP [general practitioner] before making my decision and I lied to the [abortion] doctor [at the clinic] because she asked what my GP said. I told her I had seen my GP because I didn't want that to slow down the process…Especially because of the law, I

didn't know how that would affect me." Consistent with Amanda's experience, in all of the cases of dishonesty that participants reported to us, the truth of their situation would not have influenced the participant's ability to access legal care. However, the criminalisation of abortion made our participants feel as if they had to lie to their provider.

The criminalisation of abortion also introduced the expectation that the clinicians providing care were required to be judgmental or act in a way that was not in the patient's best interest. Frankie, aged 33, said, "In Australia because of the legal status of it, they need to pass some judgment…Like, why can you not have a child? It's not about 'Okay, you're here to not have a child.' You have to give your reason." Frankie was also shown the ultrasound image from their pregnancy and said, "Yeah I think they had to, like they have to show you the heartbeat [because of the law]." Hannah's story (Fig. 3) also reflects how the law made her feel as if the clinician was not acting either in her best interest or in a way that was congruent with the clinician's standard of practice.

Other participants also recalled interactions with clinicians that felt unnecessarily rigid or strict, like Jessica, aged 27 from Queensland who said, "It was weird, but like I am assuming because of the criminalised nature of it at the time, it had to be done that way. I didn't feel like she didn't trust me, it was like how they had to do it."

Abortion patients feel that decriminalisation is a necessary first step towards improving access and reducing abortion stigma

All of our participants, regardless of the state in which they resided, expressed overwhelming support for the decriminalisation of abortion across Australia. Participants felt that the current laws were punitive rather than protective. As Sienna, aged 23 from Queensland said, "I think it makes no sense and I think it's completely ridiculous and super stigmatising…I see it as health care that people choose to make some kind of a moral

playground." Although participants acknowledged that decriminalisation in and of itself was insufficient to improving access to abortion, it was generally viewed as a crucial first step. Sienna continued, "[Abortion needs to be] made available in hospitals at no cost, and in rural areas…" Amanda, also aged 23 from Queensland said, "They need to legalise it, there needs to be more resources, and the government needs to play a role [in making abortion more accessible]." Participants also articulated the need for legislation surrounding anti-abortion protesting.

Discussion

The calls for abortion law reform across Australia are not new. Indeed, clinicians, scholars, and advocates have been urging policy makers to liberalise the abortion laws for years.[19,20] While success has been incremental, advocates are optimistic that the momentum from the historic liberalisation of the New South Wales' abortion laws in 2019 will be useful in continuing to campaign for national decriminalisation. In South Australia, abortion is still subject to criminal laws and must take place in a hospital to be considered lawful. The state also imposes a requirement such that anyone obtaining an abortion in the state must have been a resident for at least two months beforehand.[2]

Our findings echo what advocates of decriminalisation have long argued: the laws in Australia need to change. Despite the fact that abortion is available in a variety of settings across the country, our participants' experiences emphasised the very real and concerning consequences of criminalising a medical procedure. That participants reported feeling obligated to lie to their health care provider is both deeply alarming and entirely preventable. Although laws restricting access to abortion are commonly justified as being protective of patients, our findings add to the significant body of literature that shows the criminalisation

of abortion is harmful from both a public health and human rights standpoint.[21,22] There is no justification for continuing to use outdated laws to punish abortion patients and providers.

Still, the decriminalisation of abortion should not be considered a panacea and instead represents a first step towards advancing health and gender equity. It is imperative that decriminalisation efforts are tied with other efforts to address the variety of logistical, geographical, and financial barriers that continue to make abortion difficult to access for many across Australia.[9–11] This includes expanding avenues for reimbursement and financial coverage, better integrating abortion care into the public system, and lifting restrictions on mifepristone and medication abortion providers.[10,23,24] Improving access for rural and regional populations is also essential.[8]

In the absence of legal reform, our findings highlight a number of strategies that could be used to improve patient experiences. Primarily, the creation of patient-centred language-accessible resources that include state-specific information has the potential to fill a considerable knowledge gap. The online resource developed by the group Children by Choice, which details the legal status of abortion in each jurisdiction, serves as a good model that could be more widely distributed.[25] This kind of information could also be valuable for clinicians.[12] Ensuring that patients have adequate information about how the legal status of abortion may affect their experience has the potential to demystify the process and reduce the stress that our participants described as stemming from confusion and the fear of the unknown. One way to make this information more widely available could be to engage with clinicians – including GPs and abortion providers. Across Australia, it appears that GPs play an important role in helping patients find and access abortion services[10], which makes them a crucial population to involve in these strategies.

Limitations

As is typical of qualitative research, our study is subject to recall bias, and in some cases, participants were commenting on an experience that occurred a decade ago. The issue of decriminalisation in NSW was featured prominently in the media at the time that we were conducting the interviews and we are unable to assess the potential influence of contemporary media coverage on how participants reported their experiences. As well, we only completed interviews with people who were ultimately able to obtain care. These data cannot illuminate the experiences of those who may have wanted an abortion but were unable to navigate the legal context.

Conclusion

The criminalisation of abortion across Australia has significant implications for patients' experiences accessing care and for abortion stigma. While abortion law reform should not be considered a panacea, it represents a critical step towards advancing abortion rights and health equity in Australia. Our findings suggest that in the absence of – or leading up to – legal reform, it would be beneficial for clinicians to explain to patients what the implications of the law are in order to increase patients' clarity when obtaining care.

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Table 1. Participant characteristics

State/territory	Number of Participants	Number of reported abortions subject to criminal law
Australian Capital Territory	1	0
New South Wales	6	6
Northern Territory	0	0
Queensland	6	6
South Australia	1	1
Tasmania	4	0
Victoria	2	0
Western Australia	2	0*
TOTAL	**22**	**13**

** Note: In Western Australia, the offence of "unlawful abortion" can only be committed by the persons involved in performing the abortion. The person procuring the abortion is not subject to any legal sanctions.*

Figure 1. Simone's story

Simone was 24-years old and living in NSW when she found out she was pregnant for the first time. Although she knew almost immediately that she wanted to have an abortion, she did not have any prior knowledge about where or how to locate a provider. When searching online to try to find a clinic that did not require a referral, Simone found out that abortion was still listed on the criminal code. She found this information both shocking and intensely distressing and it coloured her entire abortion experience. Simone said her only frame of reference for abortion was that it was illegal and she thought her experience would mimic what she had seen on American television shows. She expected there to be protestors and to experience harassment when she went for her abortion.

When Simone arrived at the clinic, the legal status of abortion was never explicitly discussed. However, she felt that the clinicians were looking for certain answers during her counselling session. She described herself as being "terrified" to give the wrong answer and feared that she would be forced to continue with her pregnancy if she said the wrong thing. She also felt that the clinicians she interacted with inherently did not trust her.

The clinic requested that someone come to pick up Simone after she took the first pill of the medication abortion regimen in their office. Simone had not previously shared information about her pregnancy or abortion decision with anyone. However, she interpreted the clinic's request as a legal requirement and she did not think she was permitted to leave the clinic without an escort. Simone described herself as stressfully "hovering" around the waiting room for her friend to join her, but feared that either she or her friend would be implicated in some way for obtaining an illegal service.

Figure 2. Ruby's story

Ruby found out she was pregnant for the first time at age 16. She was homeless, working part-time, and trying to finish high school. Although she did not feel ready to parent, Ruby assumed at first that she would have to continue with the pregnancy because she had heard abortion was illegal in Queensland. Because of the legal status, she thought abortion was something that could not be talked or asked about and she was unsure how to go about finding a provider. She was worried that she could get in trouble for even asking about it.

Ruby had an existing relationship with a social worker who offered to help her navigate the system and linked her with an organization that covered the cost of the abortion for her. Without this help, Ruby acknowledges that she would not have been able to have her abortion.

In contrast with other participants who accessed care in Queensland in this period, Ruby was never asked to justify her decision to have an abortion at the clinic. She felt that her interactions with the clinicians were surprisingly non-judgmental; but, according to Ruby, she felt that it was obvious why she could not continue with her pregnancy. She remembers being referred to as a "child" which may have influenced how she was treated.

Ruby is very much in favour of decriminalising abortion across Australia and she followed the case closely in Queensland. She thinks that if abortion is decriminalised, people will finally be able to speak openly about their experiences.

Figure 3. Hannah's story

Hannah was in her early 20s and living along the New South Wales-Queensland border when she became pregnant. She was certain that she did not want to continue with her pregnancy, but she feared initially contacting a provider because she was worried about being judged. As well, she did not understand what would be involved in accessing abortion because at the time, it was listed on the criminal code in both states where she could drive herself to access care. Hannah feared that she would be told she could not have an abortion because it was illegal and she delayed contacting the clinic because of this, despite her high level of certainty about the decision.

Once Hannah actually called to make an appointment, the clinic spoke openly with Hannah about the legal status of abortion and what criteria she would be required to fulfill in order to have a legal termination. This was a relief. However, when Hannah was confronted with the questions and asked to justify her decision to terminate, she still felt that the questions were unhelpful and stigmatizing. She expressed that she understood why she had to be asked those questions, but she did not want to answer them. She also felt like the clinician did not want to be asking the questions and was uncomfortable doing so. This dynamic made it seem as though the legal requirements of providing and receiving abortion care in Queensland superseded the needs of both her as a patient and the clinician.

Chapter 9:

The Shifting Landscape of Abortion Care in Tasmania, Australia: Findings From a Qualitative Study

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The Shifting Landscape of Abortion care in Tasmania, Australia: Findings From a Qualitative Study

Abstract

Objectives: Tasmania is an island state of Australia that has experienced a significant shift in the service delivery landscape of abortion care over the last decade. These changes have largely been tied to the introduction of medication abortion with mifepristone. We aimed to document how these changes affected the experiences of Tasmanians trying to access abortion care.

Methods: We conducted 20 in-depth interviews with people who had obtained at least one abortion while residing in Tasmania since 2010. We audio-recorded and later transcribed all of the interviews. We used ATLAS.ti to manage our data and carried out content and thematic analysis using deductive and inductive techniques.

Results: The changing landscape of abortion care in Tasmania has exacerbated the challenges of locating a provider and being able to obtain timely, affordable care. Abortion services are available in-state, but the current landscape of abortion care in Tasmania is inconsistent and inequitable. As well, there is a commonly held misconception that abortion care is unavailable on the island.

Discussion: Engagement with clinicians and working to create a clear referral pathway is a strategy that could help to alleviate barriers to accessing care. Educating general practitioners about the variety of funding schemes available in-state to offer financial assistance to those seeking abortion care could also be beneficial.

Implications: Tasmania is an example of potential unintended consequences associated with expanding innovative and demedicalized models of abortion care. This may be relevant to other settings, such as Canada, where there is interest in employing these models of care.

Key words

Abortion, Australia, health service delivery, primary care, mifepristone, telemedicine

1. Introduction

Tasmania is an island state of Australia with both the smallest landmass and smallest population [1, 2]. In 2013, Tasmania made strides to significantly liberalize its abortion law [3]. *The Reproductive Health (Access to Terminations) Bill 2013* removed abortion from the criminal code; however, it is still a criminal act in the state for someone who is not a medical practitioner to perform an abortion [3]. The bill also eliminated the requirement that two physicians sign off on a procedure under 16 weeks' gestation and prohibited picketing within 150 meters of abortion providing facilities [4]. Tasmania's reformed regulations represented some of the most progressive abortion legislation in Australia at the time [5].

Despite the introduction of such protective legislation, the landscape of abortion care in Tasmania has shifted dramatically in the past decade. At one point in time, there were three freestanding clinics operating in the state. One clinic was located in the northern region of the state in the city of Launceston and two clinics operated in the state capital of Hobart [5]. These clinics were serviced by "fly-in-fly-out" doctors who travelled out-of-state from Melbourne to provide abortions approximately one day every two weeks [5]. A sole physician intermittently provided aspiration and medication abortions in the northwest region of the state until his retirement in 2016 [5].

Mifepristone, the gold standard of medication abortion, became available for commercial import in Australia in 2012 [6]. In 2014, one of the clinics in Hobart closed, citing increased costs associated with new accreditation rules as the reason the "service [had become] uneconomic" [7]. With two clinics still operating in the state, the remaining providers assured the public that they would be able to meet the current demand for abortion in the state [8].

In 2015, The Tabbot Foundation launched the world's first national telemedicine program for medication abortion [9]. Offered to residents throughout Australia, The Tabbot

Model allowed patients to have a telephone consultation with a clinician, linked them with a local provider for screening tests, and then mailed the medication directly to the patient [9]. The Foundation also organized local follow-up for patients. Early reports indicated that 41% of those accessing care through Tabbot were from Tasmania [10].

The Launceston clinic closed in 2016 [11]. Then, Tasmania's last freestanding abortion clinic closed in late 2017. Media reports associated the clinic closures with the success of the Tabbot model because the telemedicine service had substantially reduced demand for aspiration and surgical procedures in the state [11]. To the surprise of many, the Tabbot Foundation shuttered in April 2018, reporting that the model was not financially sustainable [12].

Media attention surrounding the issue has put pressure on the state government to address the lack of affordable aspiration options for abortion care in-state [13, 14]. Amid mounting pressure, the state government promised to introduce a low-cost "surgical" provider in Hobart [15]. However, the outcome of this process has been unclear; the latest media reports in November 2018 stated that a service would begin taking appointments imminently and that patients would not need a referral from a general practitioner [16]. As of November 2019, no clinics have reopened in the state.

While abortion is legally permissible in Tasmania, media reports continue to suggest that the clinic closures mean residents lack *de facto* access to safe abortion care [17-19]. Interstate travel is costly and often prohibitive. Motivated by these reports, our qualitative study aimed to explore how those in Tasmania seeking abortion access services. Specifically, we also wanted to document the interplay between how state policies, the introduction of varied health service delivery strategies, and the resulting clinic closures, have impacted patient experiences and the overarching landscape of abortion care in state.

2. Methods

In 2019, we conducted interviews with 20 women, transgender folks, and gender non-binary people who were residents of Tasmania and had at least one abortion since 2010. We based our interview guide on guides we had previously developed for use with Canadian and Australian abortion patients [20-22]. In order to be eligible for the study, we required that participants: had at least one abortion while residing in Tasmania since 2010, be sufficiently fluent in English to answer interview questions, and have access to a telephone and/or Skype. We offered all participants a AUD40 (USD27) grocery gift card as a thank you for their time.

2.1 Recruitment

We used a multi-modal community-based recruitment strategy. This included liaising with community groups and organizations to share information about our study, posting on social media (such as Facebook and Instagram), and posting on the online classifieds site Gumtree. KL, a Canadian PhD student in Population Health with training in medical anthropology, was responsible for recruitment and received regular input from AF and LW. After verifying eligibility, KL scheduled a mutually convenient time to talk with anyone who expressed interest in participating in the study.

2.2 Data collection

KL conducted all of the interviews while living in Australia, which took place over the telephone or Skype and lasted between 60 and 90 minutes. LW is an Australian-American cultural anthropologist and AF is an American medical anthropologist and medical doctor. Both have extensive experience conducting qualitative research on abortion provided regular feedback throughout the data collection process.

We began each interview by asking open-ended questions related to the participant's background information and general sexual and reproductive health history. This included a discussion of the participant's pregnancy and abortion history. We then turned to the respondent's abortion experience, which included an exploration of the circumstances surrounding the index pregnancy, the abortion decision-making process, and the steps involved in locating a provider. Next, we discussed the details of the participant's abortion experience(s), including what it was like to find and access a provider and reflections on the overall process. We ended the interview by asking about the participant's opinions about the provision of mifepristone through different health service delivery formats and how services and services in Tasmania could be improved. We asked participants to provide information about all of their abortions that took place while they lived in-state during the study period. With the permission of participants, we audio-recorded all interviews and then transcribed them. KL took notes during and memoed shortly after each interview, a process that allowed for early identification of key ideas, ongoing reflection on participant-researcher dynamics, and the co-construction of information [23-24].

2.3 Data analysis

We began formally reviewing data as we collected them and our regular team meetings allowed us to debrief on the interviews and discuss themes as they emerged. We believed we had reached thematic saturation, the point at which no new themes emerged, after 16 interviews and conducted four additional interviews as confirmation. Drawing on interview transcripts, notes, and memos, we conducted content and thematic analyses of the interactions using both a priori (predetermined) codes and categories based on the research questions and inductive analysis techniques to identify emergent ideas.

We used ATLAS.ti version 8.1.3 to manage our data and KL created an initial codebook and served as the principal coder. AF listened to several audio recordings and a subset of full transcripts and reviewed the codebook and a selection of coded transcripts. Our thematic analysis centered on grouping categories of information, drawing connections between ideas, and understanding relationships. We resolved rare disagreements through discussion.

The Human Research Ethics Committee at Macquarie University approved this study. We organize our results around key themes and use illustrative quotes to support the findings. We have also included several narrative vignettes, derived from a close review of individual interviews, to provide both thick description and a more robust picture of individual abortion experiences. We have removed/masked all identifying information and assigned pseudonyms to participants. We use the September 30, 2019 exchange rate when AUD1 equaled USD0.67 throughout.

3. Results

3.1 Participant characteristics

We spoke with 20 people who obtained at least one abortion while living in Tasmania between 2010 and 2019 (inclusive). All but two of our participants identified as women and used she/her pronouns. Our participants ranged in age from 21 to 37 at the time of the interview and they reported on 22 abortion experiences that took place between 5 and 13.4 weeks' gestation. Most of the abortions that our participants discussed were aspiration/surgical procedures (n=14). The majority of participants identified as White (n=17). Participants in our sample resided in all the three main regions of the state at the time they sought abortion care.

3.2 Barriers to abortion access in Tasmania have persisted before and after the clinic closures

Across the study period, participants reported on numerous barriers that made accessing abortion care challenging. Consistent with Emma's experience (Fig.1), many participants spoke about cost. In Australia, there is usually a direct out-of-pocket cost associated with obtaining abortion care, but the price can vary significantly depending on where a patient accesses the service. All but a few of our participants reported paying a direct out-of-pocket cost for their abortion, and this ranged from AUD0 to AUD2,000 AUD (USD0-1,340), with a mean of AUD356 (USD239).

The few participants who did not have a direct cost associated with their abortion reported that they received financial assistance through a variety of state-specific schemes. However many other participants were unaware of or unable to access this funding. Cassie had her abortion in 2013 when she was 19 years old. She said, "I was basically poor and homeless. My sister and her partner were kind enough to pay for me. It was $800 [USD536], but I think I got $500 (USD335) back on Medicare. It was very expensive to come up with upfront."

Some participants also faced wait times of up to 5 weeks to access care. We calculated the wait time as the amount of time that passed between when the participant first initiated the process of obtaining an abortion and when they were able to access services. The average wait time for participants was 16 days. For Jane, aged 30, who had her abortion in 2013, the long wait time associated with obtaining care locally contributed to her decision to travel to the mainland. She said, "We went to Melbourne because the wait in Hobart was a few weeks. But I made the appointment in Hobart [first] because I wasn't sure if I could get into Melbourne faster." She spent over AUD200 (USD134 USD) flying to Melbourne for her

appointment and incurred additional expenses for accommodation, plus AUD400 (USD268 USD) for the abortion itself.

Participants described long wait times as having negative emotional impacts and increasing logistical challenges. While waiting for their abortion appointment, many of our participants spoke about experiencing pregnancy-related symptoms that interfered with their ability to work and continue with their daily lives. Alice, aged 37, said "I had to wait to have the abortion and I was really sick at work. It was hard. Sometimes when you're pregnant, it's like moving through syrup: it's really slow to move. I didn't have any support." Many participants noted that they would have been interested in ways to help manage their pregnancy symptoms during the waiting period, but this was not typically discussed by clinicians at any point in their care.

3.3 The clinic closures have increased inconsistency in the landscape of abortion care Tasmania

When there were freestanding abortion clinics operating in Tasmania, participants reported on a relatively straightforward process of figuring out where they could obtain an abortion in the state. Thalia, age 28 who had her abortion in 2011, described the overall process by saying "It felt really easy." This is not to say that participants who accessed care when the clinics were operating did not experience barriers to care. Rather, having a clear referral pathway specifically facilitated the process of locating a provider.

However, as Ella's experience illustrates (Fig. 2), following the closure of the clinics, participants reported that locating a provider was a confusing process that was characterized by significant inconsistencies. Jade, aged 24, described the process of trying to find an in-state provider in 2018, following the closure of all three clinics, as having few options. "I don't think there was much choice. I think…at least at that point in time, he was pretty much

the only gynecologist [who prescribed medication abortion]. From what I can remember, because it was in this weird period where there wasn't a lot of providers…I wanted a [medication abortion] because I thought that was my only option."

Ella's story also highlights that the shifting availability of abortion in Tasmania was not necessarily linked to a lack of capable providers. As she explained, "None of the general hospitals do them [abortions]…even though they can and know how to, they don't offer it." However, how a procedure is categorized – whether as an "elective" procedure or one that is "medically indicated," whether as an abortion or as miscarriage management/post-abortion care – influences the willingness of providers and the availability of services, despite the fact that these procedures involve the same clinical skillset.

Unlike Ella, some participants reported that they were able to have their abortions in settings that do not formally provide so-called "elective" terminations, thereby highlighting the malleability of these labels. For example, Rachel, age 27, was originally told that she would have to travel several hours outside of her community and pay up to AUD600 (USD402) out-of-pocket for her abortion in 2017. However, she explained: "They ended up telling me they had a contact…that occasionally can do it for special circumstances, and she referred me [there]." Rachel was ultimately able to have her abortion close to home and did not incur a direct cost for the procedure. Although being able to access care close to home was of significant benefit to Rachel, she also reported that the process required her to repeat her story several times to multiple people. She recalled this as distressing, saying "I remember feeling ashamed, embarrassed [to repeat how I made my decision]…It wasn't an easy thing to discuss and I'd cry a lot. I remember crying a lot." Rachel's case also highlights the inconsistency in the availability of care across the state. Those residing outside of Hobart reported on compounded barriers in accessing abortion care.

3.2 The lack of a clear referral pathway increases the influence of gatekeepers

Across the entire study period, very few participants reported that they self-referred for their abortion. This was true even after the liberalization of Tasmanian abortion law in 2013 meant that a referral was no longer required, as evidenced by Julie's story (Fig. 3). For the vast majority of participants, a general practitioner (GP) was the first point of contact; some contacted other agencies such as youth or sexual health centers. Nadia, age 31 who accessed care in 2014, originally visited her GP after confirming her pregnancy at home, but then said, "It turned out I didn't need a referral [to the abortion clinic]. With lots of specialists you need a referral, but I didn't."

Even though the first point of contact remained the same, the process of locating a provider became more convoluted for participants following the closures of the clinics. This was exemplified by the experience of Sedona, who was given information about a closed clinic after contacting a GP in 2015. "[The GP] sent me to the [abortion clinic]. I went there the next day at 9am when they opened. He told me to go in the next day…[but] the place didn't exist. It was a café." The clinic that the doctor recommended had closed more than a year earlier. Sedona spoke about this experience as being humiliating.

The shifting and precarious availability of abortion care in Tasmania appears to result in access to care being heavily influenced by gatekeepers. Alice, aged 37, succinctly summarized the issue by saying, "People in positions of power influence everything. You need them." Indeed, participants discussed widely varied experiences navigating the health care system, and this was often dependent on the how the participant's first point of contact responded to their request for a termination (see Fig. 3). Some participants were able to access particular state-specific funding schemes or were linked with services that provided logistical and/or financial support. In contrast, several participants reported that GPs were generally unhelpful or conscientiously objected to providing information about abortion care.

This was an especially salient issue for participants who lived in communities outside of Hobart where there were fewer options for both generalized and abortion care.

3.5 There is a public perception that abortion is unavailable in Tasmania

Even though none of our participants were trying to locate an abortion provider at the time of the interview, the majority consistently brought up – without prompting – that abortion services were currently unavailable in Tasmania. As Thalia said, "I think it's sad [abortion] is not available in Tasmania anymore. Nobody I know agrees with it being taken away. It doesn't make sense to me that it's not an option." Jane said, "I know everyone has to go to the mainland."

Participants were unclear as to where specifically they had gathered this information, but it was a commonly held belief. Indeed, participants also expressed that this represented a shift in the availability of abortion care in the state. Many participants expressed that abortions used to be easier to access and that inaction on the part of the state government was at least partly to blame for the current situation. As explained by Jade: "I probably just would have felt a bit more supported [if] the government or whoever is like a bit more pro-choice and [abortion is] not this sort of demonic thing…but you know, they're getting rid of most of the surgical clinics in Tassie [Tasmania]. And that was a government thing."

Participants expressed strong support for making aspiration/surgical abortion services available in public hospitals across the state. Some also felt that at least one freestanding clinic needed to return to Tasmania, but there was concern that this could lead to inequitable access to care across the entire state. Many participants were also enthusiastic about the integration of medication abortion into general practice and expressed frustration at its current lack of availability. Beth explained, "It would've been really nice if my regular doctor could have [prescribed medication abortion]. If you can write a script [prescription], you can

write a script. But apparently with that specific thing it can only be dispensed by [a] few pharmacists because they don't have it in stock. At the time I was like, 'Why can't I just go to my GP and get this from any pharmacy?' It's bullshit. Why do I have to do all these appointments when I could have just gone, gotten the tablets and went home?"

4. Discussion

Worldwide, there is a documented interest towards expanding demedicalized and innovative health service delivery strategies for the provision of medication abortion [25, 26]. The story of Tasmania highlights that while these models can be useful for increasing access, they can also have unintended consequences. The closures of the freestanding abortion clinics in Tasmania appear to have had a significant and detrimental impact on the experiences of patients accessing abortion care. As noted by our participants, it is common in Australia for GPs to serve as a primary point of contact for referrals to various health care services [27]. However, the lack of a clear referral pathway has led to a landscape of abortion care that is both precarious and characterized by inconsistent availability. Thus, even if there is a political will to shift abortion from the clinic into patient's hands [28], it is imperative that those seeking care have clear pathways for finding services. These findings may be especially salient in the Canadian context where mifepristone has recently become available and there is documented interest for providing the medication via telemedicine [29]. Indeed, the more widespread availability of medication abortion has already resulted in some significant shifts in abortion care in Canada [30].

Amongst those who have experience trying to access abortion care in this context, there appears to be broad support for the integration of abortion care into public hospitals

across the state, which is a strategy that has the potential to alleviate some of the current inequities in access. However, it is unclear as to whether this model of care would allow patients to self-refer for their abortion. The liberalization of the state abortion law in 2013 formally eliminated the referral requirement to receive an abortion, but the patchwork landscape of abortion care in Tasmania currently means that many patients are still *de facto* obligated to get a referral to find a provider. Given the overarching structure of the Australian health care system, it is unclear whether self-referral for abortion is a feasible option [27]. However, in the absence of self-referral, direct engagement with clinicians and working to create a clear referral pathway is a strategy that could help to alleviate patient barriers in accessing care. Educating GPs about the variety of funding schemes available in-state to offer financial assistance to those seeking abortion care could also be beneficial.

Our findings suggest that the belief that abortion care is currently unavailable in the state is common. Media attention about the issue is important and has been integral in putting pressure on law- and policymakers to improve access to fundamental reproductive health services for Tasmanians. However, the focus on the clinic closures and lack of available services may be contributing to inaccurate information about the true availability of in-state abortion care. Direct engagement with the public is one strategy that that could be used to challenge this narrative. It is critical that Tasmanians be made aware of what services are available. Further, increasing information about medication abortion appears to be warranted and may facilitate broader conversations about the availability of services in-state. Clarity around the current status of the promised low-cost provider in Hobart would also be beneficial to the public.

4.1 Limitations

Qualitative methods provide an excellent mechanism for in-depth exploration of participants' experiences, beliefs, and behaviors. However, the method does not yield representative and generalizable results. Although multimodal recruitment of a purposive sample of people who had terminated a pregnancy across Tasmania gives us confidence that the themes we identified are significant, we are unable to assess the degree to which these experiences represent broader trends.

4.2 Conclusions

While barriers to accessing abortion care have long persisted in Tasmania, the closure of the freestanding clinics and the Tabbot Foundation have exacerbated the challenges that patients face in locating a provider and accessing care. The case of Tasmania reminds us that as we expand service delivery pathways for abortion care, there can be unintended consequences which negatively impact those seeking care. These concerns should foreground discussions about expanding access to medication abortion. Finally, strategies to engage with a variety of clinicians, including general practitioners, and the public directly, appear warranted in Tasmania.

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Figure 1: Emma's story

Emma was in her early 30s and living in the northwest of Tasmania when she became pregnant in 2015. Upon confirming her pregnancy, Emma's first thought was not about her options and whether or not she would continue the pregnancy. She was certain about her decision to terminate even before she took the test. Instead, the positive pregnancy test prompted intense feelings of anxiety because Emma was not sure how she would come up with the money to pay for the procedure or if she would be able to take time off work.

Emma contacted a local sexual health clinic that helped her arrange a medication abortion in a town about an hour away from where she was living. For Emma, a medication abortion seemed preferable because she could have her abortion at home, but it was also a less expensive option. She ended up paying about $100 (USD67 USD) out-of-pocket for the pills and had to pay her rent late as a result. Emma did not feel comfortable disclosing her pregnancy to anyone or asking to borrow money for fear of judgment about her pregnancy and her decision.

In order to have her medication abortion, Emma had to drive herself over an hour away on two separate occasions: once for the initial prescription and once for a mandatory follow-up appointment. She incurred additional indirect costs associated with travelling and lost significant wages from the days she had to take off work. Still, Emma was grateful that the option was available to her because she would not have been able to travel to Hobart and pay for an aspiration procedure. Emma also recalls that the doctor who prescribed her medication abortion was frustrated for her and felt strongly that she should not have had to travel as far as she did.

Figure 2: Ella's story

Ella became pregnant for the first time in 2018 at the age of 20. As soon as she found out she was pregnant, Ella started researching where she could get an abortion in-state. Because of extensive media coverage, she knew that the last freestanding abortion clinic in Tasmania had closed just a few months earlier. Still, she was very certain in her decision and said there was never a question about whether or not she would continue with the pregnancy.

Ella's first point of contact was with a local health care provider who was well-known in the community as a provider that "bulk billed" – meaning she would not have to pay out-of-pocket for services accessed there. After discussing her options, Ella had a strong preference for an aspiration procedure and spent more than two weeks trying to locate a provider in state. After an exhaustive process of making calls to multiple potential providers, Ella decided she was willing to travel across the state. However, she was quoted prices of between AUD1200 and AUD2000 AUD (USD804-1340 USD and this was more than she was able to pay. She also looked into flying to the mainland for her abortion, but the cost of travel was prohibitive. Although there was some funding available to help with the cost of travel, the system ended up being too challenging for her to navigate. Ella said the process of trying to locate a provider made her feel "stupid and vulnerable" because she was refused care on multiple occasions and unable to afford the options that were available to her.

With some financial assistance from her mother, Ella ultimately paid AUD350 AUD (USD235) for a medication abortion. However, a couple of weeks after taking the pills, Ella said she was still feeling sick and unwell. A routine follow-up appointment included an ultrasound that revealed she had retained products from the medication abortion. To her surprise, Ella was easily able to make an appointment at her local hospital to have a uterine evacuation. Ella had previously tried to schedule her abortion at this hospital but was told they did not offer abortions. Although she was grateful that it was straightforward for her to schedule her appointment at the hospital, Ella felt like the whole process of trying to obtain an abortion in Tasmania was long, drawn out, and hypocritical.

Figure 3: Julie's story

Julie was in her last year of high school when she became pregnant for the first time. When she found out she was pregnant, she was overcome with fear that her boyfriend would be mad at her. Julie then made an appointment with a general practitioner (GP) to discuss her options and initiate the process of obtaining an abortion. However, the GP that she met with did not provide her with any information or the referral she requested. Julie described the GP as "the most unhelpful person I've ever met in my life." This negative interaction impacted her so significantly that while she knew she wanted to have an abortion, she felt disempowered to move forward with the process of locating or scheduling a provider.

Julie ended up discussing her pregnancy with a trusted school counselor who supported her in her decision. The counselor helped Julie get in contact with an organization that provided her with a referral and financial support. Beyond this, the counselor offered Julie a safe space to talk about her experience, helped her to schedule appointments, and also wrote notes to teachers to excuse Julie from class as she navigated the different appointment times.

Julie noted that she does not know how she would have gotten her abortion without the help of the school counselor. As well, the financial support that she received meant Julie was able to make the decision about her pregnancy on her own and only solicit input from the people she wanted to share information about her pregnancy with. She was worried that the cost of the procedure would force her to disclose her pregnancy to family members who would not support her decision and that this would ultimately impact if, when, and how she was able to have her abortion.

Chapter 10:

Competitive Framing Processes of Abortion in Tasmania: Mobilization, Imputation, and Health Care

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Competitive Framing Processes of Abortion in Tasmania: Mobilization, Imputation, and Health Care

Abstract:

The landscape of abortion care in the Australian island-state of Tasmania has undergone a significant shift in the last decade. This article uses a lens of reproductive governance to draw on field work that I conducted in the state, which included in-depth interviews with people who had accessed abortion care and key stakeholders, as well as a media audit. I explore the history of abortion in Tasmania and focus on the different discursive frames that surround abortion in the state to highlight how abortion has both effectively mobilized grassroots activism but also been deployed as a political tool to silence health care professionals and service providers. In this way, abortion is not simply a legal medical procedure that is available in Tasmania, but rather a concept and symbol that circulates virtually and continues to have significant impacts on people's lives.

Keywords: abortion, reproductive governance

Introduction

Leading up the 2018 state elections in Tasmania, head of the Australian Greens party, Richard di Natale, raised abortion as an election issue when he said, "People are absolutely appalled that in one of our states women are not getting access to safe terminations, and what I know is that in any decent society we ensure that all women have access to those choices and right now people in Tasmania are being deprived of that," (Dawson and Symons 2018).

The availability of abortion care in Tasmania is complex. However, di Natale's statement seemed to imply that abortion was either completely unavailable in Tasmania or that people were resorting to unsafe abortion methods. Following the highly publicized closure of the state's last abortion clinic in late 2017, the media has reported widely on Tasmanians travelling out of state to access care (Bailey 2018a; Wahlquist 2018). Yet, there are in fact several abortion providers in the state, and there is no evidence to suggest that Tasmanians are resorting to unsafe abortion methods to terminate a pregnancy. Di Natale's call to action about abortion access in Tasmania was ultimately effective in bringing attention to the barriers faced by Tasmanians in accessing timely and affordable abortion care. Yet, it is also indicative of how reproductive rights are often used as a sort of political football to invoke outcry and encourage constituent participation. Abortion in particular has underpinned a number of governmental acts and interventions across the state over the last decade.

Tasmania is Australia's smallest, least populated, and only island state (Australian Bureau of Statistic 2019). Its economy has historically relied on fishing, mining, logging, and agriculture, and the shifting global demands for these products has, in many ways, been challenging for the region to keep up with. Today, Tasmania is ranked as poorest state in the country, and the second poorest region overall only after the Northern Territory (Australian Bureau of Statistics 2019; Baird 2015). Now, tourism – most of which centers on the over 50% of state land that is designated as protected state forests, national parks, and reserves – is

a driving economic force in the region (Ooi and Hardy 2020). Still, the state's connection to the environment and wilderness continues to forefront not just economic decisions, but is interspersed in day-to-day interpersonal conversations.

"The state government has made it clear that they are not in the business of supporting those who oppose their interests." The person I was speaking with was referring specifically to the right-of-center Liberal state government of Tasmania, Australia, and did not agree to be identified because they felt it could jeopardize their connections in state politics. It felt poignant that our conversation was punctuated by protest chants, as groups of people holding homemade anti-logging signs, decrying recent actions by the Liberal government, made their way down the street to a rally that was being held later that afternoon.

While there are examples of the state's efforts to curtail environmental activism – including with the introduction of the country's strictest anti-protest laws (Maloney 2019) – I was surprised by this comment in the context of our conversation. We were talking about access to abortion care in the state and potential strategies to make the medical procedure more accessible. Abortion in Australia is both safe and common, and opinion polls indicate that the country also has generally favorable views towards the procedure (Simpson 2017; O'Rourke, Belton, and Mulligan 2016). It is liberally provided in every state and territory (de Costa et al. 2015).

For these reasons, it seemed unusual to me that the Liberal Party would perceive groups working to make reproductive health care more accessible as opposition, let alone as opposition to the political party as a whole. The Liberal Government of Tasmania has not publicly stated that it opposes abortion; instead, it has made few very comments on the issue in general. However, abortion continues to be used as a sort of political football with reproductive health policies often representing key differences between Australia's political parties.

In July 2019, I contacted the Tasmanian Health Service, a state government department, and asked if someone would speak to me for a part of my PhD dissertation research exploring the provision of abortion care in Australia, generally, and Tasmania, specifically. After initially being told that I would be put in touch with someone to set up an interview, I later received a reply stating "As this is a very controversial topic for the Tasmanian Health Service (THS) I have been advised that the THS should not make comment." Abortion is a common, legal, and available medical procedure in Tasmania that is apparently too controversial to discuss.

While the government's silence on the issue could be construed as inaction, it is in fact a very purposeful act. The stated intention of the government's refusal to speak about abortion is to quell controversy, but this strategy appears to have had the opposite effect. Rather than depoliticizing the issue, the silence surrounding abortion has effectively mobilized activists, sparked protests, and allowed competing parties to dominate the conversation about abortion care in the state.

In this context, abortion is not merely a common, in-demand medical procedure that people want, seek, and obtain. Rather, abortion functions as a tool that is used to both silence some voices, while simultaneously catalyzing debate around women's rights and bodily autonomy and the relationship between individual sexuality and the state.

In 2019, with support from the Department of Anthropology at Macquarie University, I travelled to the state of Tasmania to document and explore how abortion services were being provided and advertised in the state. While media reports were suggesting that anyone seeking abortion care was forced to travel to the mainland, I had spoken with Tasmanians who had recently terminated a pregnancy in the state. There was clearly a disconnect between what was being reported on in the media, how politicians were framing the issue, and the lived reality of those trying to access care. I wanted to better understand what abortion

represented to different parties who were affected by the narratives surrounding, and access to, abortion.

In this chapter, I draw on my fieldwork experience, interviews and media reports using a lens of reproductive governance to analyze the relationship and interaction between abortion as an actual medical procedure and abortion as a concept and symbol that circulates virtually. Below, I begin with a discussion of the data collection methods that I used as a part of this project. I then provide a brief overview of some of the anthropological literature that has contributed to the development and evolution of the concepts of stratified reproduction, the politics of reproduction, and reproductive governance. Next, I discuss the shifting landscape of abortion care in Tasmania over the last decade before I analyze different representations of abortion in this context.

Methods

My analysis draws on multiple data sources. I conducted formal in-depth interviews with key stakeholders. During my time in state, ten stakeholders agreed to participate in a formal interview. I spoke with people who held a variety of roles, including abortion providers, advocates, and representatives from community organizations and government. I also had informal conversations with additional stakeholders during my time in Tasmania and at a reproductive health conference in 2019 in Brisbane, Queensland. Further, I conducted additional in-depth interviews with 20 Tasmanians who had accessed abortion care since 2010. I have previously published on the results of these interviews with abortion patients and offered an in-depth discussion of those findings (LaRoche, Wynn, and Foster 2020).

I also engaged in more informal conversations about access to abortion and reproductive health as I travelled around the state on Tasmania's Redline bus system. I spent time in each region of the state, and spent most of my time with reproductive rights activists

and attending local pro-choice events. I also conducted a media audit to explore and understand how the media has been reported on abortion related issues over the last decade. In February 2020, I returned to Tasmania to engage in dissemination activities based on the findings of this research and I had additional meetings with policymakers and stakeholders across the state.

Reproductive Governance

The myriad ways in which we can frame "the abortion issue" means that a variety of discursive frames are applied to the subject. Indeed, abortion occupies a unique space within political, medical, religious, personal, and social conversations. Is abortion an issue of individual bodily autonomy, reproductive justice, public health, women's rights, fetal rights, or religious freedom? Abortion occupies a contested space (Ginsburg 1989). Ginsburg notes that despite being a safe, common, and legal procedure, abortion exists within a "gray area on the borders of acceptable social and medical terrain" (Ginsburg 1989, 2).

Anthropologists have made critical contributions to our understanding of different kinds of reproductive disruptions, including abortion, infertility, and pregnancy loss (Rapp 2011; Willen 2005; Inhorn and Birenbaum-Carmeli 2008). Our reactions to reproductive disruptions are rooted in historically and culturally specific understandings and constructions of race, gender, motherhood, femininity, and kinship (Singer 2018; Cromer 2019; Inhorn 2006). Yet, abortion in particular often triggers wider social debates about gender roles, the inevitability of motherhood (Kumar, Hessini, and Mitchell 2009), and shifting definitions of personhood and human rights (Howes-Mischel 2016; Mishtal 2019).

In 1986, Shellee Colen wrote about her research on West Indian childcare workers in New York City, who were working for white, US-born employers (Colen 1986). She coined the term "stratified reproduction" to refer to inequalities in social and physical reproductive

tasks, which are influenced by a variety of social, economic, and political forces (Colen 1986; 1995). Building on this, in their seminal volume, *Conceiving the New World Order: The Global Politics of Reproduction,* Faye Ginsburg and Rayna Rapp defined stratified reproduction as "the power relations by which some categories of people are empowered to nurture and reproduce, while others are disempowered" (Ginsburg and Rapp 1995, 3).

Ginsburg and Rapp further discussed the "politics of reproduction" as representing a key shift in the direction of the field. While anthropologists had once been predominantly interested in exploring how the practices surrounding fertility, birth, and child care differed between settings and contexts, Ginsburg and Rapp posited that the topic of human reproduction is central to social theory and sits squarely at the nexus of politics and power (Ginsburg and Rapp 1995). Indeed, "access to comprehensive health care and abortion stands at the heart of contemporary political transformations and struggles" (Rapp 1999, 5).

Building on this framework, Lynn Morgan and Elizabeth Roberts developed the concept of reproductive governance as an analytic tool to highlight and trace how reproduction is mobilized and activated at particular historical moments (Morgan and Roberts 2012; Morgan 2019). Specifically, they use reproductive governance to refer to "the mechanisms through which different historical configurations of actors – such as state, religious, and international financial institutions, NGOs [non-governmental organizations], and social movements – use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor, and control reproductive behaviours and population practices" (Morgan and Roberts 2012, 243).

To date, anthropologists have used the framework of reproductive governance in two major ways (Morgan 2019). First, they have analyzed the emergence of new social subjects, such as adoptable embryos and fetal persons (Mishtal 2019; Howes-Mischel 2016). Second, they have examined the intersection between reproductive governance and a human rights

framework, which has been used to advocate both for and against the availability of access to reproductive healthcare including abortion (De Zordo, Mishtal, and Anton 2017; Morgan and Roberts 2012; Morgan 2014).

Writing in 2019, Morgan reflected on how much has changed since she and coauthor Roberts first wrote about reproductive governance in 2012 (Morgan 2019). Indeed, reproduction has been featured prominently in the global political landscape, including in trade agreements, transnational activist movements, and international human rights courts. There has also been a growing trend towards the judicialization of reproductive rights (Morgan 2019). In examining how and when reproduction is mobilized at particular moments, the differing narratives that emerge from different sources on the issue reinforce our understanding of abortion as a symbol that can be either utilised or silenced to advance particular agendas. The shifting landscape of abortion care in Tasmania provides a salient case through which to use the lens of reproductive governance to explore how silence and the appearance of inaction can be deployed as purposeful political action.

Abortion in Tasmania

Across Australia, there has been no federal ruling on abortion. Instead, liberalisation and decriminalisation have been advanced one jurisdiction at a time through legislative reform. In 1969, a ruling in the Victorian Supreme Court, *R v Davidson*, which is also commonly known as the Menhennit Ruling, was the first state-specific piece of legislation in the country that defined certain circumstances under which abortion could be considered lawful (Warhurst and Merrill 1982). The Menhennit Ruling in Victoria spurred on a trend towards the liberalisation of abortion across the country. Tasmania was one of several states that adopted the provisions for a lawful abortion as defined by Menhennit, but did not make

an official change to legislation for a number of years (Baird 2017; Warhurst and Merrill 1982).

Although safe abortion care became available in Tasmania in the late 1960s, there were no formal protections enshrined in the law until 2001 with an amendment to the criminal code (Baird 2017). These amendments offered additional clarification about the circumstances under which an abortion could be considered lawful, but also put in place several restrictions. The law required that abortion seekers receive mandatory counselling, and that two separate physicians sign off on the eligibility of the procedure. From a legal standpoint, there was no upper gestational age limit on when procedures could be performed. Yet, according to testimony at an October 2013 parliamentary inquiry, at least some physicians continued to have concerns that being involved in the provision of abortion care at any point in the pregnancy could result in criminal sanctions (Smith 2014).

Shortly after the first amendments to the criminal code in 2001, a private abortion provider from the mainland opened a fortnightly clinic in the state's two main cities, Hobart and Launceston (Baird 2017). A second private clinic also started operating in Hobart on the opposite weeks. All three clinics offered instrumentation procedures and were served by "fly-in-fly-out" doctors who visited the state from mainland Victoria once every two weeks.

After its own extended legal saga, mifepristone, part of the recommended regimen for medication abortion by the World Health Organization (WHO), had been approved for general importation in Australia in 2012 (Baird 2015; WHO, 2012). This allowed medication abortion to make its way into the state, and there was one physician who provided both medication and aspiration procedures along the Northwest Coast up until his retirement in 2016.

In 2013, Tasmania's Minister of Health and representative of the left-of-center Labor Party, Michelle O'Byrne, proposed the *Reproductive Health (Access to Terminations) Bill*

2013 (Michelle O'Byrne 2013). The bill passed and went into effect in November 2013; it decriminalised abortions up to 16 weeks and instituted safe access zones within 150 metres of any facility that provided abortion care, thereby restricting proximate protestors. The bill also included an "obligation to refer", meaning that if a patient sought an abortion or pregnancy options counselling from a physician with a conscientious objection to abortion, the physician was obligated to refer the patient to another practitioner who is known not to have a conscientious objection (Sifris 2015). At the time, the bill represented some of the most progressive abortion legislation in all of Australia.

In 2014, Tasmania held its quadrennial statewide election. Going into the election, the Labor Party – which had spearheaded the decriminalisation of abortion in the state and had consistently prioritized reproductive health as a part of its platform - had been in power for 16 years (Hurst 2014). The Liberals won the election with a decisive majority and have retained power since (Lehman 2015).

The same year marked the beginning of the closures of the abortion clinics that were operating across the state, starting with the Fertility Control Clinic at Moonah in Hobart. Media reports stated that the closure was due to the fact that the service had become financially unviable due to administrative requirements and shifting, state-based standards for accreditation of the facility. Faced with a bill of over $100,000 in renovations in order to keep the clinic open, Dr. Kathy Lewis decided to close the clinic (Smith 2014). The reasons behind the closure are reminiscent of targeted anti-abortion regulations that have proliferated elsewhere around the world. Indeed, the changing criteria for licensure and associated renovation costs are strategies that have been used to justify the closure of abortion clinics under the guise of patient safety (Guttmacher 2020). Media reports said that at the time she closed the clinic, Dr. Lewis had been providing "hundreds" of abortions out of the clinic each year (Smith 2014).

Additionally, there were at least some reports at the time that the availability of medication abortion with mifepristone – which had become widely available across Australia in 2012 - had reduced demand for instrumentation procedures, which further jeopardized the economic sustainability of the clinic (Crawley 2014; Baird 2017).

In 2020, I spoke with a representative of the Labor Party as they reflected on how the incoming Liberal Government had coincided with the closure of the first Hobart clinic. This member did not want to be identified, but they had been involved in the party leading up to, and following, the *Access to Terminations Bill 2013*. We were having lunch at a bright, newly opened café in the northern part of the state when they told me, "You know, at the time we really didn't think it was connected. We didn't see the changes to accreditation standards for medical facilities] as something that was targeted at closing abortion clinics specifically." The member recounted that at least one other facility – a dental office – had also closed. However, the closure of the abortion clinic received significantly more media attention and was effective in instilling both concern and outrage in large portions of the public. In retrospect, while the member did not go so far as to say that the Liberals had altered accreditation standards for facilities with the intention of closing the abortion clinic, they said we could never be sure. "Maybe we should have pushed back more on it then. Maybe."

In 2015, Dr. Paul Hyland, the physician who ran the two remaining abortion clinics in the state, launched the world's first national telemedicine program for abortion with mifepristone and misoprostol, calling it the Tabbot Foundation. Hyland launched the Foundation with the hope that it would increase access to safe, high quality abortion across the country, but especially in settings where there were few or no providers.

The name of the organization is a portmanteau. Hyland named the foundation after former Liberal Prime Minister Tony Abbott who was vocal about his personal anti-abortion

stance (Aubusson 2017). Abbott had prominently described abortion as "the easy way out", and in the same March 2004 speech at Adelaide University, went on to say, "Why isn't the fact that 100,000 women choose to end their pregnancies regarded as a national tragedy approaching the scale, say, of Aboriginal life expectancy being 20 years less than that of the general community?" (*The Age* 2004).

The Tabbot Model allowed Australians to obtain mifepristone to terminate an early pregnancy without having to meet face-to-face with a physician who was eligible to prescribe the medication. Instead, abortion seekers contacted the organization, had a telephone call with a provider, and were linked with local ultrasound and bloodwork laboratories to determine their gestational age and eligibility for abortion with the mifepristone regimen. Tabbot then mailed the medication directly to patients and arranged for them to receive local follow-up care. In addition, another key tenet of the Tabbot Model was that services were capped at a price of $495 (not including fees for ultrasound and bloodwork). While $495 is a considerable amount of money for many people to come up with to pay out-of-pocket, Tabbot offered a transparent pricing model that was significantly lower and more straightforward than many other abortion providers across Australia (LaRoche, Wynn, and Foster 2020).

The Tabbot Foundation provided medication abortion to people across the Australia, but reports indicated that a high proportion of Tabbot clients in the first 18 months of operation – up to 35% - were living in Tasmania when they accessed care (Hyland, Raymond, and Chong 2018). The disproportionate number of Tasmanians accessing abortion care through this model seemed to suggest that there was either a lack of accessible or available services across the state.

Yet, in 2016, the Launceston clinic, the only clinic in the Northern part of the state, closed (Baker 2016). Further, the same year, the aforementioned physician who had been

providing care along the Northwest Coast, retired. In late 2017, Tasmania's last remaining abortion clinic in Hobart closed its doors.

Finally, in an unexpected announcement in March 2019, the Tabbot Foundation said that it would stop providing services. Tabbot pledged to provide care to the last 20 patients who had registered with the service but stated that after that point, services would stop (Rushton 2019). Stakeholders in the state – who did not agree to be identified – described the closure to me as "shocking" and on very short notice. They relayed to me that they were completely caught off guard by the closure and had previously been under the impression that they would have received advanced notice about such an abrupt end to the organisation.

I was similarly surprised by the announcement. I had spoken with Dr. Hyland just a few months earlier at the end of 2018 and he gave me no indication about the looming closure of the Tabbot Foundation. He recounted to me that the proportion of Tasmanians accessing care through the service had increased significantly after the clinic closures. However, in retrospect, it has occurred to me that perhaps our conversation did in fact presage the closing of the organization. From Melbourne, Dr. Hyland spoke to me over the phone about the tension between the expansion of medication abortion and telemedicine services and the services provided at freestanding clinics. He relayed that the introduction of so-called "tele-abortion" had diminished the demand for in-clinic surgical abortion services in Tasmania to such an extent that the freestanding clinic model of care was not financially sustainable.

He admitted to creating a challenging situation for himself from a business perspective; by launching Tabbot, he had made his own business model economically unviable. For a number of years, Dr. Hyland had been the primary abortion provider in the state, and he was now continuing this role through Tabbot by providing medication abortion to Tasmanians. Yet, in both cases, Dr. Hyland received no support from the government in

the way that services provided through a public hospital would be. He explained, "We had no grants to run our business or benefactors as [similar services] have in the United States" (Rushton 2019). His points raised questions about whether – and to what extent – the government is responsible for ensuring that legal, necessary health care is available to its citizens.

Publicly, Dr. Hyland cited a lack of financial sustainability for the telemedicine model as the reason for the closure of Tabbot (Rushton 2019). As a private business, it was not a profitable enterprise and would have required government subsidies to continue to operate. He also emphasized that the closure was not associated with a declining demand for abortion in either Tasmania or Australia (Rushton 2019).

Abortion as Mobilization

The first clinic closure in 2014 had prompted widespread media reports about an "abortion crisis" in the state and whether or not people would still be able to obtain services (Crawley 2014). The cascade of closures that followed between 2016 and 2018, in such quick succession, felt especially dire. It effectively mobilized a campaign of grassroots activism across the state and the founding of an advocacy organization called Not Ovary-Acting Tasmania in 2018.

Jess Ferguson, a resident of Hobart who had experience organizing advocacy efforts around environmental issues and sexual and gender based violence, co-founded the organisation with Jax (formerly Holly) Ewin. Jess said, "It just felt like there was such a big gap in Tasmania because no one was focusing on this. Something needed to be done."

Not Ovary-Acting was founded as – and remains – a quintessential kind of grassroots organizing. Jess and Jax have never had a formal space to plan demonstrations or hold events, so they started planning in the back room of the flower shop that Jax owned and Jess worked

at. The shop is small with dark walls, and unsurprisingly fragrant due to the number of brightly colored flowers that it houses. After hours, they moved the flowers out of the way, as much as they could, and strategized, made signs, sent emails and made phone calls, and held gatherings of people to discuss ideas and next steps.

The Liberals retained a majority government in the 2018 state election, which felt like a blow to many who had hoped that a change in the state legislature could have rectified the growing unsettlement about reproductive health care in the state (Morton 2018). While the Labor Party had campaigned on increased access to reproductive health services, including abortion, as a key part of their platform, the Liberals had not explicitly addressed the issue. Not Ovary-Acting responded by organizing the first of several large protests on Hobart's Parliament lawns. The initial protest gathered more than 200 people – a big turnout for Hobart - and helped amass over 7000 signatures on a petition asking the Liberals to "bring back abortion clinics in Tasmania". In a form of craftivism, Not Ovary-Acting also constructed a signed chain of paper uteruses that they planned to present to the Premier, Will Hodgman (Figure 1).

Figure 1. Protestors gather on Hobart's Parliament Lawns and hold a signed petition in the form of a uterus chain to present to the Premier. Image by Tim Cooke, used with permission.

Amid this mounting pressure and media coverage about the lack of available abortion care, Premier Hodgman and the Liberal Party stated that there was a private gynecologist in Hobart who was providing both medication and instrumentation abortion procedures. In addition, they pledged increased funding for Tasmanian abortion seekers to fly to the mainland to receive care as part of the Patient Travel Assistance Scheme (PTAS). Premier Hodgman said the Department of Health and Human Services was "working very actively on that" but did not provide further details or clarification (Shine 2018).

Both Jess and Not Ovary-Acting had been featured frequently in media reports about abortion in Tasmania. When I was reading about the issue from the mainland, her name kept coming up. When I arrived in the state, she was one of the first people that I wanted to speak with. I felt that Jess would be able to help me to better understand the current provision of abortion services and interpret the government's response – or lack thereof. My initial research aims were to document whether or not abortion was available, and I hoped to track and map abortion seekers' journeys of finding and accessing care. However, it did not take long for the larger, overarching context of how abortion was being both deployed and silenced to forefront my investigation in the state.

From my hostel in Hobart, I found several social media profiles with the name Jess Ferguson. From what I could see from the very small profile pictures, I chose one that seemed like it had a reasonable chance of being the Jess that I wanted to talk to. I reached out introducing myself and asked to connect. The person that responded was indeed the Jess Ferguson that I had wanted to speak with, and to my surprise she quickly agreed to meet with me to talk more about her work, Not Ovary-Acting, and my research. I met Jess for the first time at a popular Vietnamese restaurant in North Hobart on a Saturday evening in July 2019. The place was packed and we ended up sitting with our pho bowls in an outdoor seating area that faced the busy street.

Despite the awkwardness inherent in meeting someone in person after exchanging only a few cursory Facebook messages, Jess is someone that could make anyone feel at ease. She got straight to the point in describing why she felt the Liberal Party's response to the clinic closures was woefully inadequate. "First of all, the private provider that they talk about in Hobart charges up to $2500. Who has that kind of money? That's too much."

I had heard this before in interviews with people who had managed to get an abortion in the state after the clinics closed. While they had all described receiving high quality, patient-centered care from the same private gynecologist, it was a struggle to afford it. This had significant negative implications for their lives, such as being unable to pay rent on time or having to ask an employer for an advance. For a number of abortion seekers, this had in turn prompted them to become involved with reproductive rights activism.

Jess also explained that the Patient Transfer Assistance Scheme (PTAS) requires patients pay for medical services up front and are then later reimbursed. In addition to the up-front cost barrier, Jess relayed that she heard many people were hesitant to seek reimbursement through the fund because it was not confidential. PTAS is managed by the state government that is perceived as being unsupportive of reproductive rights. Therefore, filling out forms for PTAS for reimbursement for an abortion was a quite literal "way to get your name on a list," she said. "Besides, not everyone can just pick [up] for a weekend and go to Melbourne."

Premier Hodgman refused to meet with Not Ovary-Acting members when they had planned to present him with the paper uterus chain. In response, the now-Deputy Leader of the Labor Party, Michelle O'Byrne ended up taking the uterus chain to Parliament and presenting it to the Premier during a parliamentary session. Not Ovary-Acting held additional rallies on the Parliament lawns, and has continued to organize around reproductive health related initiatives in the state.

But the lack of abortion access in the state has not just mobilized Not Ovary-Acting and individual abortion seekers. In July 2019, a spate of anti-abortion billboards were erected around Tasmania, and a number of them were concentrated in Hobart. The billboards prominently pictured a pair of hands in the shape of a heart, cupping a pregnant belly, beside the words "A heart beats at four weeks." Underneath, in blue lettering, the signs listed a website – notbornyet.com – which is run by the anti-abortion group Emily's Voice.

One of the signs was put above a North Hobart establishment called the Republic Cafe, or the Repub, as it is more commonly known. The Repub received such strong backlash over the billboard, including multiple calls to boycott the venue entirely, that they felt compelled to post notices around the venue clarifying their position. Laminated sheets of white printer paper were taped up inside and outside the bar (Figure 2). They read, "NOTICE: We do not control the billboard above our building. We do not control women's bodies. This venue is pro-choice."

Figure 2. One of the signs posted around the North Hobart bar, The Republic Cafe, after an anti-abortion billboard was erected on top of the building.

The billboard came down from above the North Hobart bar just a few days after it had gone up. Staff from the Repub told me that the bar management had complained to the company that owned the billboard space and said that since the advertisement from Emily's Voice had gone up, it was having a detrimental effect on their revenue. After the billboard came down, Not Ovary-Acting planned and hosted a series of events at the Repub in an act of solidarity and an attempt to offset the revenue loss from when the billboard went up.

Abortion as an Imputation of Misconduct

Although there are several sexual and reproductive health organizations, most of which are based in Hobart, that have an interest in increasing access to abortion in the state, they are limited in what they can say about the issue publicly. These organizations receive a significant portion of their annual operating budget from the state government, which has effectively muzzled their ability to advocate for abortion rights in Tasmania. They fear losing funding and not being able to provide any kind of services if they speak too loudly about the issue. While the stakeholders who quietly conveyed this fear to me acknowledged that they were unclear about how realistic the threat of losing their funding was, they said it still felt very real and that they had become "much quieter about abortion" since the 2014 election. Indeed, despite the fact that I heard this same story over and over, from many different kinds of sources, no one agreed to have their name or organization attached to statements acknowledging this.

Similarly, a 2018 investigation by the Australian Broadcasting Corporation (ABC) reported that "… some doctors performing publicly funded terminations will not complain openly about the restrictions placed on providing abortions for fear of Health Minister Michael Ferguson shutting off funding or ordering services to be stopped. Those in the state service also fear losing their jobs if they speak out" (Ogilvie 2018).

Not Ovary-Acting was created to re-focus the conversation on abortion and reproductive health in Tasmania. As a grassroots group that does not receive funding from the government, Not Ovary-Acting has been free to critique the Liberal response without fear of repercussions. Yet, Jess also revealed to me that organizations are sometimes hesitant to engage with her about abortion activism. While Not Ovary-Acting has successfully organized various demonstrations and events, and continued to focus media attention on the issue, the organization has not served as a voice for the muzzled organizations in the way that she had originally hoped. Jess has the perception that the groups who fear losing funding feel that voicing their true opinions through her and Not Ovary-Acting would not provide enough degrees of separation for concealment. They still fear repercussions. Indeed, the threat from the government is felt so deeply by those in the state that it has created an overarching landscape of silence on the issue as a whole.

Along these lines, abortion functions as its imputation of misconduct service providers across the state who receive government funding. The Liberals' lack of a clear plan to make abortion care accessible in the state appears to be in fact a very deliberate action to move the conversation away from abortion entirely.

"Sometimes I feel like I'm screaming into the void," Jess told me. After a series of meetings with various informants across the state to discuss upcoming actions that Not Ovary-Acting wanted to put together, she and I were talking about the next election. We had been told that in order for any real change to happen, we would need to wait for the next election and hope for a change in government. In the time that we had spent together, I had often seen Jess frustrated and angered by the government's policies and responses that she perceived as hindering access to fundamental reproductive rights. Although it did not last for long, this was the first time I saw her really defeated. The government's outward silence on

the issue felt like a power play to exert dominance, and it was more frustrating than if they had responded openly with an anti-abortion policy.

During my time in Tasmania in 2019, there was an overwhelming perception that abortion was completely unavailable in the state. This was something that people brought up with me frequently in the context of our conversations about reproductive health care in the state more generally. They talked about it without prompting and many framed the issue as something that the government had taken away in a purposeful act. The abortion seekers described feeling unsupported by their government and that the lack of abortion care was indicative of how the administration valued women and gender minority people more broadly. The struggles that they faced in accessing abortion care was not just a policy decision that they disagreed with; it felt like a personal attack. One woman named Grace summarized this sentiment well when she said, "It needs to be a government-supported service just to show that the government supports women in this and anyone's choice."

Yet, based on what I had been told repeatedly, it also appeared that the Liberal government felt that providing or advocating for accessible abortion care was an attack on the political party as a whole. In this way, abortion represents much more than a common, legal, necessary medical procedure to the state government. The actions (and inactions) of the state legislature have made it clear that improving access to the procedure is not a priority, but also something that should not be talked about at all.

Abortion as Necessary Health Care

We were cooking dinner in a mutual friend's kitchen, listening to a playlist of 90s dance-pop hits, when Lindy told me about her abortion in 2019. She described her pregnancy as unplanned, unexpected, and definitely unwanted. The decision to have an abortion had not been a hard one for Lindy to make because she had "never really been into the idea of having

children of my own". She knew what abortion was, she felt certain in her decision, and she knew – somewhat – where to go to initiate the process of getting the abortion pills in her city. In many ways, Lindy was better informed than most of the people that I had spoken with about their experiences of accessing abortion care in Tasmania. "I knew because I've always been a punk. And then I got into environmental protest stuff. When you're a part of more progressive communities like that, things like abortion get talked about, you know?"

The strength and certainty with which Lindy talked about her decision and experience meant that I was a bit surprised when she started to tear up as she talked more about the process of obtaining care. She told me about the seven different appointments she had to go to and feeling like she was being bounced around between care providers. She told me about the "totally shitty" comments the ultrasound technician had made to her about her pregnancy, and how it made her defensive and distrustful of the entire process. Lindy felt especially betrayed by those comments about her "baby" when having a dating ultrasound done because she had been referred specifically to that ultrasound clinic by her abortion provider.

And she talked about the waiting time and how she felt like she was being forced to be pregnant for so much longer than she wanted to be. To Lindy, abortion was not just an abstract, political concept that was used to advance an agenda or particular viewpoint. Rather, it was a real, necessary part of the health care system that she had to jump through hoops to access. Even with all of the tools and support that she had to access care, the process of getting the medication abortion pills into her hands was exceedingly difficult. That felt different and highly exceptional to Lindy when she compared it to other kinds of health care she had received.

In its contested space, abortion in Tasmania symbolizes more than merely a medical procedure. But it is critical that abortion seekers like Lindy undergird the analysis of how abortion has been deployed, silenced, and mobilized. At the center of competing policies and

discursive frames are real people who need a real medical service, and who experience real suffering and consequences when they are barred from accessing care.

In 2019, in the same hushed conversations about the fear of various organizations losing funding, stakeholders insinuated to me that the criteria for an abortion to eligible to be completed at the hospital had shifted over the years. Formally, hospitals in Tasmania have never offered "elective" abortion care. Instead, hospitals offer abortion services only in cases of life endangerment or in cases of severe fetal illness or damage, or for cases where abortion is "medically indicated". This remains the formal policy in the state despite ongoing calls by the media, advocacy groups, and various members of the legislative council to incorporate abortion into the public health care system at the Royal Hobart Hospital since the first clinic closed in 2014 (Bailey 2018b; Ogilvie 2018; Coulter 2019).

Yet, it seems to be common – but quiet – knowledge that clinicians used to be able to make a case for patients with exceptional circumstances to have their terminations completed in the public system. Clinicians had the ability to "call in a favor" of sorts and advocate for their patients. I heard stories from abortion seekers who could not afford a termination from a private provider and who were then rerouted through the public system, even though they did not strictly meet the criteria for a "medically indicated" abortion.

These stories indicate that the provision of abortion care has long represented a contested, yet symbolic, space within the state's health care system. The fluidity with which the same procedure can be categorized as either "elective" or "medically indicated" highlights the malleability of these labels. However, this no longer appears to be the case. Stakeholders told me that such favors no longer existed and that the bar to meet the criteria of an abortion that was medically indicated had only become more stringent. Once again, abortion seekers are the ones who bear the consequences.

Conclusion

In Tasmania, the government's apparent silence about abortion policy and access may have the outward appearance of inaction and indecisiveness, but it is in fact a purposeful decision that has elevated abortion to a symbolic status beyond that of a simple, legal, medical procedure. When we view the actions of the Liberal government through a lens of reproductive governance, we are reminded that reproduction is inextricably linked with power. As such, the refusal of the state government to comment on abortion at all is an instance of the Liberals exerting this power.

My research contributes to the growing body of literature that uses reproductive governance as a framework to understand how abortion is deployed as a political tool. Abortion in Tasmania has effectively mobilized entire communities and grassroots activists while simultaneously being used to silence service providers and health care professionals. The juxtaposition of these two spaces that abortion has come to inhabit is stark. At the same time, it is abortion seekers who shoulder the consequences of the government's silence.

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Chapter 11:

General Discussion

General Discussion

This thesis aimed to extend the literature about the potential of mifepristone to expand access to abortion services by documenting and exploring the introduction of the medication in Canada and Australia. Specifically, I wanted to examine the ways in which different regulatory settings and policies condition access to care and focus on the experiences of abortion patients in both countries. Although the effectiveness and acceptability of mifepristone as an abortifacient are well established (Chen & Creinin, 2015; Goldstone et al., 2012; Jones & Henshaw, 2002), both Canada and Australia have only recently registered the regimen. Beyond this, each country has implemented some innovative strategies for how the medication can be dispensed and prescribed.

In Canada's case, mifepristone was initially approved with a number of restrictions that were described by clinicians and advocates, almost universally, as unusually restrictive and out of step with the provision of health care in Canada more broadly (Kirkey, 2016; Picard, 2016). Further, while the public funding of health care in Canada means that instrumentation procedures are usually covered by provincial and territorial health insurance schemes, the lack of a national drug plan means that there was no cost coverage for mifepristone upon its introduction (Population Institute Canada, 2017). Mifepristone fell into a regulatory grey area. If it was classified as a medication, the lack of cost coverage was consistent with broader trends for the Canadian health care system. Yet, if it was classified as abortion care, the lack of cost coverage was decidedly exceptional, as the *Canada Health Act* considers abortion to be a "medically necessary" service which mandates cost coverage for patients (Kaposy, 2009).

Individual provinces and territories implemented cost coverage one by one (LaRoche & Foster, 2020). When compared to other countries globally, Health Canada, the national regulatory agency responsible for pharmaceuticals and health technologies, amended the

product monograph to align with the global body of evidence in an expedited timeline from the drug's introduction (Health Canada, 2018, 2019). The regulations surrounding the mifepristone and misoprostol combination pack Mifegymiso® are now some of the most evidence-based regulations worldwide. While barriers to integrating mifepristone into primary care and expanding access to abortion care across Canada continue to abound, the introduction of mifepristone in Canada is promising. Some family practices have integrated medication abortion into their practice and in certain provinces, nurse practitioners are able to autonomously prescribe the regimen (College of Nurses of Ontario, 2017).

In Australia, mifepristone has been listed on the national Pharmaceutical Benefits Scheme (PBS) since 2013, which has reduced the cost for some abortion seekers (Baird, 2015). However, as this thesis demonstrates, listing mifepristone on the PBS has not necessarily made the drug more accessible or eliminated the cost for the majority of patients. There are a range of forces that that shape people's access to health care, and focusing solely on singular or legislative interventions is not inherently synonymous with improved access or patient experience.

Still, medication abortion with mifepristone is available in some family practices and in a number of settings across Australia, and patients are able to fill their prescription for MS-2 Step at a pharmacy (Baird, 2015; de Costa et al., 2019). Australia was also the first country in the world to implement a national telemedicine program for medication abortion (Hyland et al., 2018; Raymond et al., 2016). Although this national telemedicine service shut down only a few years after its inception, it still represents an important development in examining the feasibility and acceptability of providing medication abortion with this strategy. In late 2019, a New South Wales-based physician announced that she was launching a new national telemedicine service for Australia (Clun, 2019).

The recent introduction of mifepristone in both Canada and Australia make the data collected as a part of this thesis particularly timely. Specifically, the introduction of mifepristone in Canada provided a key opportunity to document the experiences of people across the country deciding to use and accessing Mifegymiso® in the midst of a shifting regulatory environment. In response to conversations with stakeholders, we wanted to help providers and policy makers gain an in-depth understanding of patients' experiences with the regimen and learn about ways that Mifegymiso® users think that services can be improved. For a number of reasons, including population density and general trends in how health care is delivered in both countries, Australia provides an appropriate comparison to examine how the introduction of mifepristone influences patient's experiences. Similarly, we wanted to gather data in the Australian context that could be useful in informing policy and practice.

The papers contained within this thesis represent some of the first in-depth, qualitative exploration of patients' experiences with mifepristone in both Canada and Australia. There is a growing acknowledgement that patient stories are crucial for informing regulatory change, as qualitative research can both humanize and contextualize the impact of policy and law on people's lives (Woodruff & Roberts, 2019).

This general discussion section of the dissertation serves to review the primary findings and situate them within the broader literature of medication abortion, reproductive health, and public health. First, I begin with an overview of each manuscript and a brief discussion of the primary findings. Second, I integrate the primary findings from the dissertation while exploring the policy and practical implications of the study. Finally, I conclude with a discussion of limitations, next steps, and future directions.

Overview of Manuscripts and Primary Findings

Manuscript 1 is a peer-reviewed chapter in the forthcoming edited volume *Abortion, politics, and the pill that promised the change everything: The global journey of mifepristone*. This paper draws on a media audit, document analysis, and in-depth interviews with key informants to describe the factors that contributed to mifepristone's delayed introduction in Canada, as well as the length of Health Canada's review process of the drug. This chapter provides key contextual information about mifepristone in Canada and is one of the first in-depth records of this period of abortion history in Canada. This represents an important contribution to the literature as the majority of research that has been conducted on the history of abortion in Canada has focused on the era prior to decriminalization (Brodie et al., 1992; McLaren, 1978).

A number of factors contributed to mifepristone's delayed registration in Canada. The lack of a pharmaceutical champion significantly delayed the registration of mifepristone when compared with other Global North countries and the neighbouring United States. The mifepristone review was one of the longest drug review processes in Health Canada's history and the initial restrictions put in place by the regulatory agency were met with significant public outcry. Yet, Health Canada amended the regulations surrounding mifepristone quite quickly, with the first major revisions to the Product Monograph and Risk Management Plan issued less than a year after the drug was available in Canada. While different stakeholders had different perceptions on the Health Canada review process, those most closely involved with the review maintain that the length of the process was not influenced by political or anti-abortion motivations. Instead, they described the length of the review as a function of the Health Canada process.

Manuscript 2 has been published in the journal *Contraception*. It uses in-depth interviews to document the experiences of 64 people who used Mifegymiso® to terminate a

pregnancy across Canada. Participants reported on obtaining abortion care in seven different provinces: Alberta, British Columbia, Manitoba, Newfoundland, Nova Scotia, Ontario, and Quebec. This paper represents the first rigorous exploration of abortion seekers across Canada deciding to use and accessing Mifegymiso® in the midst of a shifting regulatory environment. That the study found that medication abortion with mifepristone was highly acceptable to patients is consistent with an established body of global literature (Chen & Creinin, 2015; Sanhueza Smith et al., 2014). However, it was still important to document this in the Canadian context.

Additionally, these interviews generated useful insights into how information about medication abortion can be improved across the country. This is important because participants in this study who felt well-informed about medication abortion reflected more positively on their experiences. In contrast, those who felt uninformed or underinformed characterized their experience less positively. Specifically, study participants wanted more information about pain and pain management, bleeding patterns and the products of conception, and how long the abortion process was likely to last. Many respondents also emphasized the importance of personal stories and reflected that this was a preferred way to receive information about the abortion process. The fact that study participants identified the importance of patient stories further underscores the importance of this qualitative study. We plan to proactively share these findings with abortion providers and key stakeholders in Canada, including giving a presentation and preparing a report to be distributed at the National Abortion Federation Canadian Providers' Meeting 2020.

Manuscript 3 is a qualitative case study that looks at the experiences of Ottawa residents obtaining abortion care before (Phase 1) and after (Phase 2) mifepristone became available. It has been published in the peer-reviewed journal *FACETS*. Notably, after the introduction of medication abortion, participants described obtaining care from more

providers and in a wider variety of health care settings. In Phase 2 of this study, no participants reported obtaining care from a new surgical provider. Thus, it appears that the introduction of Mifegymiso® has increased the number of service delivery points for abortion care in the city. In general, participants in Phase 2 reported that they did not wait as long in order to access abortion care as Phase 1 participants did. The nature of this study does not allow us to say definitively that the introduction of medication abortion is responsible for reduced wait times in Ottawa. However, it is logical to consider that an increase in providers would respond to demand for services and that this would have implications for wait times. These two findings are important to document because they are reflective of what reproductive health advocates have long hoped the impact of mifepristone could be. This study suggests that when the regulations surrounding mifepristone are based in evidence it facilitates the provision of abortion care in a wider variety of settings.

Yet, Manuscript 3 also serves as a cautionary tale about the impact of overmedicalizing the process for medication abortion seekers. Patients who obtained medication abortion care in Ottawa reported that the process required significantly more encounters than obtaining an aspiration or surgical abortion. This paper can be used to inform efforts to streamline medication abortion services in Ottawa, as well as develop strategies to effectively communicate what is involved with a medication abortion to abortion seekers and patients.

Manuscript 4 draws on data collected as a part of the Canada Abortion Study, a national qualitative study about the experiences of Canadians accessing abortion care prior to the introduction of mifepristone, and focuses on the experiences of mothers. This manuscript is currently under review at the journal *Women's Health Issues*. While research has long indicated that a high proportion of abortion seekers are already parents, little in-depth research concentrates on the motivations and experiences of this group (Abrams, 2015;

Jerman et al., 2016). This paper discusses the abortion experiences of Canadian residents who had already given birth and made the decision to terminate a subsequent pregnancy. It illuminates specific barriers faced by parents when trying to obtain abortion care and discusses how the introduction of mifepristone could potentially mediate some of these challenges.

Manuscript 5 centres on the experiences of Australians using mifepristone to terminate a pregnancy and it has been published in the peer-reviewed journal *Contraception*. This study serves as a companion piece to Manuscript 3, as it used the same overarching recruitment, data collection, and analytic strategies. I interviewed 22 Australian abortion patients who had used mifepristone since 2009; participants were from every Australian state as well as the Australian Capital Territory. This study documented numerous barriers to accessing medication abortion care in Australia, and highlighted that primary care providers appear to be uniquely positioned to aid abortion seekers in locating a provider in a timely manner. Despite the fact that mifepristone is listed on the Pharmaceutical Benefits Scheme in Australia, most participants still reported incurring a significant, direct cost for the medication. The cost associated with medication abortion also highlighted a tension of expectations, such that participants who paid more for their procedures sometimes were disappointed in the quality of care that they received. The findings from this manuscript highlight that engagement with primary care providers appears warranted across the country in order to improve patients' experiences in finding timely, non-judgmental abortion care.

Manuscript 6 has been accepted for publication at the Australian journal *Public Health Research and Practice*. This paper describes an emergent finding from the interviews that I conducted as a part of Manuscript 5. Participants who accessed care in settings where abortion was still listed on the criminal code at the time they used mifepristone discussed, at length and without prompting, how the criminalized status of abortion negatively impacted

their experiences. These discussions prompted us to include formalized questions about the legal status of abortion in the remaining interviews.

Despite the fact that abortion is liberally available across much of Australia, patients accessing care in criminalized settings recounted that the laws obliged them to justify their decision in some way and interrupted the clinician-patient relationship. Participants also identified legal reform as an important strategy for reducing abortion stigma. The findings from this study were particularly timely as they coincided with the introduction of a bill in the New South Wales Parliament to decriminalize abortion up to 22 weeks' gestation (NSW Health, 2019). Although the findings from this study were not published at the time at the bill was read and debated in the NSW Parliament, I proactively shared the findings the advocacy group *Our Bodies Our Choices* (OBOC). OBOC spearheaded much of the decriminalization campaign in the state. The bill to decriminalize abortion in NSW ultimately passed, and advocacy efforts in South Australia and Western Australia are ongoing to update the state criminal codes.

Manuscript 7 is under review at the journal *Contraception* and is a qualitative study that documents the shifting landscape of abortion care in Tasmania over the last decade. While the state was once serviced by three specialized, freestanding abortion clinics, they have all closed since the introduction of mifepristone. This study uses in-depth interviews with 20 people who obtained abortion care in the state between 2010 and 2019. Participants reported on barriers to obtaining care both before and after the clinic closures; however, the existence of the freestanding clinics facilitated a clear referral pathway for patients. Since the clinics have closed, participants reported on increased inconsistency in the landscape of abortion care in the state. For example, some people were permitted to obtain care in certain settings under specific circumstances, while other participants were not able to do the same. As well, in these interviews, participants frequently brought up, without prompting, the idea

that abortion care is currently unavailable in the state of Tasmania. This appears to be a commonly held belief and represents a concerning trend because abortion care is still available in the state, but is harder for abortion seekers to find. The findings from this study suggest that strategies to engage with a variety of clinicians, as well as the public directly, could facilitate the experiences of abortion seekers locating a provider.

In February 2020, I returned to Tasmania to engage in dissemination activities and formal advocacy in the state related to the findings discussed in this paper. I had meetings with the Deputy Leader of the state Labor Party and the Shadow Minister of Health to discuss the findings of my research. I also coordinated with local advocacy groups and discussed my research with the newspaper the Launceston Examiner and the national broadcasting program ABC News.

Manuscript 8 is formatted for the journal *Medical Anthropology Quarterly*. During my time in state, I formally interviewed a number of stakeholders in a variety of roles, including abortion providers, advocates, and representatives from community organizations and government. I also engaged in more informal conversations about access to abortion and reproductive health as I travelled around the state on Tasmania's Redline bus system, and conducted a media audit of abortion related issues in the state. In this article, I draw on my fieldwork experience, interviews with stakeholders and abortion patients, and media reports to detail the history of abortion care in Tasmania over the last decade.

In this paper, I use a lens of reproductive governance to explore the competing discursive frames of abortion in the state, including how this common medical procedure has come to mobilize local advocates while simultaneously being used to silence health care workers and service providers. I argue that what appears to be government inaction about abortion care is in fact a purposeful decision to elevate abortion to a symbolic status beyond that of a simple, legal, medical procedure. This paper also contributes to the growing body of

literature that uses reproductive governance as a framework to understand how abortion is deployed as a political tool.

Integration of Primary Findings

Mifepristone Can be Provided in a Variety of Settings and is Acceptable to Patients

This dissertation builds on and contributes to an established, global body of literature that finds that medication abortion with mifepristone is both safe and highly acceptable to patients (Chen & Creinin, 2015; Sanhueza Smith et al., 2014). This has been demonstrated consistently with both qualitative and quantitative investigations (Fielding, 2002; Grindlay et al., 2013; Swica et al., 2013). However, the qualitative evidence base is still quite small (Wainwright et al., 2016) and this study thus makes a unique, distinctive contribution to the literature by presenting some of the first in-depth, qualitative exploration of the acceptability of medication abortion to abortion patients in Canada and Australia. The (Canadian) National Collaborating Centre for Healthy Public Policy states that when evaluating policy, "the goal is to combine the available evidence with the most context-specific understanding possible" (The National Collaborating Centre for Healthy Public Policy, 2010, p. 7). The ability to generate such context-specific insights is one of the key strengths of qualitative methods and anthropological approaches to research and also what makes the findings from this study particularly pertinent for informing and evaluating policy change.

Globally, quantitative studies have found a high degree of acceptability regarding the at-home, self-administration of misoprostol – the second pill in the medication abortion regimen – among abortion patients (Løkeland et al., 2014; Ngo et al., 2011; Sanhueza Smith et al., 2014). The at-home administration of misoprostol has a number of advantages. It can simplify the medication abortion regimen by requiring fewer clinic visits, provide abortion seekers with greater control over the timing of their abortion, and allow social support

networks to be present during the abortion process should the abortion patient choose (Elul et al., 2001; Fiala et al., 2004; Ngo et al., 2011). Different studies have documented acceptability rates of taking the second part of the medication regimen at home that range from 84% to 99%, and there is no difference in the rate of complete abortions depending on whether the misoprostol is administered in-clinic or at-home (Ngo et al., 2011).

Consistently, research has demonstrated that medication abortion users describe that this method of abortion gives them increased autonomy over their decision and discuss how being at home is both a comfortable and preferable option (Fiala et al., 2004; Fielding, 2002; Newton et al., 2016a, 2016b). This was consistent with the findings from the studies conducted as a part of this dissertation, as many mifepristone users in this study commented on how they find medication abortion to be more "natural" and "private". The similarities between the way that people talk about these experiences, and their preferences and priorities for medication abortion, are interesting because there is a high degree of consistency in patients' reported descriptions across contexts. When analysing the interviews that I conducted as a part of this study, I found remarkable similarity in patients' decision-making to use medication abortion in Canada and Australia. Participants in both countries also reflected very similarly on their experiences after the fact.

There is less research available about the experiences of patients self-administering and taking both parts of the medication abortion regimen at home, but the evidence available demonstrates that this is also acceptable to patients and providers (Conkling et al., 2015; Swica et al., 2013). The regulatory status of mifepristone in Canada and Australia, where both parts of the regimen can be dispensed by a pharmacist and taken at home by the patient, means that the investigation of patients' medication abortion experiences in these countries contributes to an emerging and important body of literature. The qualitative data collected as a part of this dissertation found that when abortion seekers are given the option of taking both

parts of the regimen at home, it provides them with increased flexibility in scheduling and control over the timing of their abortion, which they reflected positively on. This kind of flexibility with scheduling may be more relevant or important to certain groups of abortion seekers, such as people who have to contend with childcare arrangements.

When participants reflected positively overall on their medication abortion experiences, they generally described feeling well-informed and knowing what to expect. In contrast, those who characterized their medication abortion experiences more negatively, or specifically noted that they would not recommend the regimen to a friend, also reported that they did not feel as well-informed about the process. They often felt underinformed about the pain and possible pain management strategies for medication abortion, and were more likely to report that they experienced more pain than they had anticipated. In contrast, participants who described the pain of their medication abortion as "10 out of 10" were still likely to recommend the medication abortion regimen to others if they had been well informed and expected that level of pain before it occurred. This echoes findings from other quantitative studies that found that abortion patients were more likely to characterize their medication abortion experience as positive if they had less pain and bleeding than they expected (Teal et al., 2007)

The qualitative nature of this study provides more context-specific data to this general phenomenon. In both Canada and Australia, patients identified key areas about the medication abortion process that they would have preferred to receive more information about. While there were similarities across the two countries, Canadians emphasized that they wanted more information about pain and the products of conception. In both settings, patients wanted more information about how long the bleeding was likely to last and more information about obtaining appropriate follow-up care if the medication abortion process failed. The reports from patients could suggest that there are differences in the counselling

practices of clinicians between the two countries, perhaps due to the fact that medication abortion with mifepristone has been available for longer in Australia and health care providers may have had more opportunities to receive feedback from medication abortion patients.

Although different participants had different personal preferences for service delivery settings and strategies, there was not a notable difference in medication abortion satisfaction based on where or how participants obtained services. This includes Australian participants who were able to obtain telemedicine services through the Tabbot Foundation when it was still in operation.

While different health service delivery settings and strategies appear to be broadly acceptable to abortion patients in both Canada and Australia, many participants described a desire for more streamlined care. While I discuss this finding most explicitly in Manuscript 3, the case study of Ottawa residents' experiences obtaining abortion care before and after mifepristone became available, it was a notable finding across all of the interviews that I conducted in both countries. As currently structured, medication abortion generally requires patients have more encounters with a variety of providers across the health care system than clinic-based instrumentation procedures. For some, this represents a more convenient and preferable option for how to obtain care, but for others, the number of encounters associated with obtaining medication abortion was prohibitive.

In Australia, where it is more common for abortion seekers to pay a direct out-of-pocket cost for their procedure, the number of encounters with different kinds of health care providers contributed to the high variability in patient's reported cost. Even if the cost of the medication abortion regimen itself is covered or highly subsidized, many Australian residents paid to receive ultrasounds or bloodwork. Thus, while participants in this dissertation were open to receiving care in a variety of settings, there were sometimes unexpected costs that

were not anticipated or clearly communicated which is an additional barrier to obtaining timely care.

There is a Need to Engage with a Broad Range of Health Care Providers

In Canada, amendments to the Mifegymiso® Product Monograph and Risk Management Scheme appear to have addressed several barriers for abortion seekers. The piecemeal roll out of universal cost coverage has also made strides to improve equitable access to the regimen. These advancements are promising and should not be understated. While the changes are welcome, they have been challenging for physicians, pharmacists, and health care providers to keep up with and interpret. Thus, engaging with clinicians – including those who do not directly provide abortion care – is necessary as we move towards decentralized and demedicalized models of care.

Indeed, Mifegymiso® users in Canada reported that medication abortion typically involved interacting with a wider variety of health care providers than obtaining an instrumentation procedure at a freestanding clinic. This included family doctors, technicians at blood laboratories, sonographers, and pharmacists. Interestingly, in Canada, participants did not generally report that these interactions were negative or stigmatizing. Rather, in the cases where participants characterized these interactions in more a negative way, they described the health care provider as being generally uninformed about abortion, or perhaps being unaware that they were seeking the service as a part of abortion care.

Many Canadian participants described that when they obtained medication abortion in a primary care setting, the prescribing clinician sent them to a specific blood laboratory or ultrasound clinic. This seems to indicate that Mifegymiso® providers are likely initiating some sort of a vetting process to ensure they refer their patients to a place where they can

obtain timely, nonjudgmental care. This assumption is also consistent with what I have heard from abortion providers in informal conversations at professional meetings.

Similarly, a key finding that emerged from the interviews in Australia was the crucial role that general practitioners play in helping abortion seekers successfully locate care. In both settings, efforts to streamline care are warranted, but engagement with a broad swathe of health care providers is also necessary to ensure abortion seekers can access timely and non-judgmental services.

Abortion care has historically been siloed from other kinds of health care, which means that this kind of broad engagement represents an important new frontier for the field. The freestanding clinic model simultaneously protects abortion patients and providers from violence and harassment while perpetuating the separation of family planning from other kinds of routine health care. This has permitted many primary care providers to remain uninformed about abortion care, and family planning services more generally, because they conceptualize abortion as something outside of their practice. The lack of discussion about abortion in routine undergraduate medical education in Canada and Australia further exacerbates this issue (Baird, 2015; Dawson et al., 2016; Roy et al., 2006; Steinauer et al., 2009). As abortion with medications becomes more commonplace in primary care settings, efforts to engage with the curricula for medical education will be necessary in both Canada and Australia.

Further, as a wider variety of health care professionals such as nurse practitioners (NPs) and certified nurse midwives become eligible to prescribe mifepristone, it is critical that we provide training opportunities to these professions as well. In Canada, NPs are eligible to prescribe Mifegymiso® and in the province of Ontario, midwives are actively working to have medication abortion included in their scope of practice though the College of Midwives of Ontario (CART-GRAC, 2019). The global body of evidence supports the idea

that mifepristone can be safely and effectively provided by many different kinds of clinicians (Dawson et al., 2016; Foster et al., 2015), and as such abortion training needs to be included early and routinely in the education of these health professionals. The routine incorporation of abortion into medical, nursing, and midwifery curricula could also have implications for normalizing abortion as a health care procedure rather than a stigmatized personal decision. Importantly, in the studies that form this dissertation, medication abortion patients in both countries were highly receptive to receiving care from a range of providers.

The findings from this dissertation indicate that engagement with a variety of health care professionals is necessary a number of main reasons: 1) to provide information to and support clinicians who are providing medication abortion; 2) to encourage more providers to incorporate medication abortion into their practices in order to shift care from urban city centres to more places; 3) to make sure that clinicians who do not provide medication abortion can provide timely, accurate, and nonjudgmental referrals for their patients; and 4) to ensure that interactions that abortion seekers have with other health care providers throughout the abortion process are also high quality and non-judgmental.

Strategies for Supporting Clinicians who are Already Providing Mifepristone and Those Who Want to Provide Mifepristone

As one way to facilitate the communication between general practitioners and other health care providers, researchers at the University of British Columbia, Canada, have launched a website called the Canadian Abortion Providers Support-Communauté de pratique canadienne sur l'avortement (CAPS-CPCA). This site endeavours to serve as an online community of practice for Mifegymiso® prescribers across the country (Norman et al., 2019). The website has interactive aspects to promote the sharing of best practice resources and encourages dialogue between members. It is also has a feature that allows users to locate

the closest pharmacy that stocks mifepristone based on postal codes. In order to access this website, registration is required and users must be approved by the site administrator. The program is open to all kinds of health care providers, including general practitioners, OB/GYNs, pharmacists, and more.

An evaluation of the effectiveness and impact of the CAPS-CPCA online program is underway (Norman et al., 2019). Undoubtedly, the CAPS-CPCA program serves as a useful resource that provides beneficial, evidence-based information to registrants. This program predominantly addresses the first two reasons why it is important to engage with a broad swathe of health care professionals: to support existing providers and to encourage more health care practitioners to incorporate medication abortion into their practice.

Further, the National Abortion Federation (NAF) Canada has made significant efforts to offer trainings and workshops about abortion care and medication abortion by offering continuing medical education (CME) credits to physicians. With the introduction of mifepristone into primary care settings across the country, NAF has recognized that their previous criteria for membership could be prohibitive for clinicians in these settings that provide abortion care at a much lower frequency than clinicians located in specialized, freestanding clinics. In response to the shifting landscape of abortion care across Canada, NAF has introduced new membership categories which provide expanded training opportunities for a broader array of abortion providers (National Abortion Federation, n.d.). NAF Canada's responsiveness to the evolving needs of Canadian abortion providers is one key strategy to promote engagement with a wider variety of health care providers. It is also a beneficial strategy to supporting clinicians who are already providing mifepristone and those who may be interested in incorporating the regimen into their practice in the future.

Still, both of these strategies by CAPS-CPCA and NAF Canada are dependent on clinicians seeking out additional information and training opportunities. The fact that these

resources are available is of significant benefit, but they are not required or routine. Once again, this highlights why abortion training should be integrated early on in the educational trajectories of many kinds of health care providers.

In Australia, the restrictions that continue to surround mifepristone, such as the requirements that clinicians complete a mandatory training course and that pharmacies must register to dispense the medication, are additional barriers to making medication abortion available in more places across the country. Australian physicians and advocates have long argued that these restrictions do not provide additional protections or benefits to patients, but rather limit the potential of the drug to make abortion care available in more places (de Costa et al., 2019; de Costa & Douglas, 2015). Further, these regulations signal that prescribing abortion medications is somehow different than prescribing other medications (O'Rourke et al., 2016).

In the Australian state of Victoria, the state government and the Centre for Excellence in Rural Sexual Health developed a training program for primary care providers and nurse practitioners to facilitate the decentralization of abortion care in rural areas (Hulme-Chambers et al., 2018). Research conducted with training program participants indicated that among health care providers in rural areas, there was generally strong support for the decentralization of abortion care. However, program participants also identified the lack of a state-wide strategy for service provision as a significant barrier to routinely incorporating medication abortion with mifepristone into a wider variety of settings (Hulme-Chambers et al., 2018). These findings could have implications for other parts of the country and highlight the importance of widespread, strategic interventions towards decentralizing abortion care.

Across Canada, evidence-based policy change and the roll out of mifepristone was aided by statements from various provincial medical colleges and professional societies (College of Nurses of Ontario, 2017; College of Pharmacists of British Columbia, 2017;

College of Physicians & Surgeons of Nova Scotia, 2017; College of Physicians and Surgeons of Ontario, 2017). While the Health Canada product monograph implemented regulations about the provision of care on a federal level, ultimately, clinicians' professional responsibilities are defined by their colleges. The colleges are also responsible for sanctions related to non-compliance with these rules. This highlights that professional societies are an important avenue for future advocacy efforts and that direct engagement with the colleges could be a promising and relevant opportunity to engage with a variety of clinicians.

Strategies For Creating a Clear Referral Pathway

Global research has demonstrated that there is a need to improve referral pathways for obtaining abortion care, in order to both reduce wait times and streamline patients' efforts to locate a provider (Dawson et al., 2016; Kumar et al., 2004; Wiebe & Sandhu, 2008). For example, in the 1980s, a centralized referral service for abortion was established in Edinburgh, Scotland, and research demonstrated that it lead to a significant reduction in wait times (Glasier & Thong, 1991).

In the United States, a non-profit organization called Provide has been developed specifically to help create better referral pathways for abortion seekers. Provide works in partnership with a variety of health and social services providers to "build a health system that is equipped to respond to women's health care needs around unintended pregnancy and abortion" (Provide, n.d.). The program's goal is not to help primary care providers incorporate medication abortion into their practice, but rather to offer training and technical assistance to give accurate, informed, non-judgmental referrals for pregnancy and abortion related care. An evaluation of Provide training programs found that the vast majority of program participants were very satisfied with their training experience, and also that

participants reported a significant increase in their intention to provide non-judgmental pregnancy options counselling and referrals for abortion care (O'Donnell et al., 2018).

The findings from this dissertation suggest that a similar initiative may have particular relevance across Australia where primary care providers often serve as abortion seekers' first point of contact. The idea of a centralized referral hub may be especially salient in the Tasmanian context due to the state's small population, island status, and the stated privacy concerns of providers. Indeed, as a part of their federal election campaign, the national Labor party pledged to establish a Tasmanian Reproductive Health Hub if they won the election (Hayes, 2018). While Labor did not win the election and ultimately was not able to deliver on their promise, the need for clear referral pathway for abortion care was identified and is still desperately needed.

The Australian state of Victoria has recently implemented a centralized referral service for state residents seeking contraception, abortion, and other reproductive health related care called 1 800 My Options (Women's Health Victoria, n.d.). The resource is a database that is updated regularly and those seeking care have the option of finding a service using a web- or phone-based platform. One particular benefit of this model of referral services is that when clinicians register to be listed on the 1 800 My Options database, they can choose whether to have their contact information listed publicly or privately. For those clinicians that choose to have their information kept private, their contact information will only be made available to abortion seekers under certain circumstances. While it would be ideal for all providers to have their information listed publicly so as streamline the process of locating a provider, this model of referral may assuage clinicians' fears about privacy and safety and may ultimately encourage more health care providers to register with the database service. In my conversations with Australian and Tasmanian stakeholders, there was broad support for the expansion of this kind of database service to other states and territories.

In some ways, there appears to be a disjuncture between advocating for the decentralization of abortion care and acknowledging the benefits of the model of a centralized referral hub. However, the reality of decentralization is that it does not occur all at once but rather as a piecemeal process. As abortion moves into some primary care settings but not others, it can be confusing for abortion seekers to navigate. Further, abortion seekers may be fearful about asking for an abortion at a place that does not necessarily advertise itself as offering that service. The studies in this dissertation suggest that abortion clinics are often well known within communities and can thus facilitate the process of timely obtaining care. In this way, a centralized referral hub can complement a decentralized model of abortion care.

Strategies for Engaging With Other Kinds of Health Care Providers That May be a Part of the Medication Abortion Process

The findings from this dissertation suggest that engagement with other health care providers, such as technicians who work at blood laboratories, pharmacists, and sonographers at ultrasound clinics, could be another important strategy to improve the overall experiences of abortion patients. Medication abortion means that these health care professionals of many stripes often play a role in the abortion process, even though it is unlikely that they would consider themselves to be abortion providers. As such, broader engagement strategies, rather than those that focus on reaching clinicians that identify as abortion providers or potential abortion providers appear warranted. Importantly, one strategy for reaching a wider audience with this kind of engagement could be to create training and outreach programs for these professions that focus on providing patient-centred care in general, rather than specifically on abortion care. Patient-centred health care strategies are increasingly supported by evidence

and encourage clinicians to work as a part of community teams across disciplines (Bauman, Hardy, & Harris, 2003).

Conscientious Objection is a Growing Issue as Abortion Care is Decentralized

The role of primary care and other health care providers in abortion care is directly linked with issues related to conscientious objection, where a health care provider may be opposed to providing a particular service or kind of care because of personal, moral, or religious objections (Keogh et al., 2019). Although so-called "conscience clause" legislation does not stipulate which kinds of care that clinicians have the right to refuse involvement in, most discussions in medicine and bioethics about this issue center on the provision of contraception, abortion, and medical assistance in dying (Fiala & Arthur, 2017; Savulescu, 2006). Increasingly, this legislation has also been used to refuse care to people on the lesbian, gay, bisexual, trans, and queer (LGBTQ+) spectrum (Ronit & Emanuel, 2017).

This is a timely and evolving issue in both Canada and Australia with variations between states, provinces, and territories. In Canada, a recent decision by the Ontario Division Court ruled that a requirement of "effective referral" was a reasonable limit for the religious freedoms of doctors (Glauser, 2018). The College of Physicians and Surgeons of Ontario (CPSO) defines an effective referral as a clinician "taking positive action to ensure the patient is connected to a non-objecting, available, and accessible physician, other health-care professional, or agency" (2015, para. 2). CPSO further stipulates that physicians must not expose patients to adverse clinical outcomes as a result of effective referral, and that physicians are obligated to provide care in emergency situations when it is necessary to prevent imminent harm (CPSO, 2015).

This ruling underwent a court challenge but was ultimately upheld. A highly controversial bill in Alberta, *Bill 207*, has recently received an abundance of media attention

but ultimately failed to reach a second reading (Heidenreich, 2019). If it had passed, *Bill 207* would have allowed medical practitioners to refuse services, such as abortion and medical assistance in dying, without the obligation to refer a patient to another practitioner (Bellefontaine, 2019). There was also concern that the bill could codify the discrimination of transgender people if a clinician expressed a moral objection to providing them care, which would deny this vulnerable population immediate access to health services. Further, *Bill 207* would have protected clinicians from lawsuits or sanctions by their medical association if they refused to provide care or referrals to patients based on their personal beliefs.

The official position of the Canadian Medical Association (CMA), according to their policy on induced abortion, is that "there should be no delay in the provision of abortion services" (Blackmer, 2007, p. 1310). However, the same CMA policy statement holds that physicians have a right to exercise conscientious objection and should inform patients of this so that they can find another health care provider (Canadian Medical Association, 1988).

These two statements appear to contradict one another. In many smaller, rural and more remote communities there may only be one health care provider, which raises the question about what this means for patients seeking care. According to the CPSO definition of an effective referral and a ruling by the Court of Appeal for Ontario, "where an irreconcilable conflict arises between a physician's interest and a patient's interest, physicians' professional obligations and fiduciary duty require that the interest of the patient prevails" (CPSO, 2015, para. 7). Yet, most policies that require practitioners to provide a referral to patients do not stipulate whether this referral has to be accessible to the patient. The time-sensitive nature of abortion care further exacerbates this issue, as there are significant concerns for patients seeking care at later gestational ages.

In Australia, the recent Act that decriminalized abortion in NSW in October 2019 included a number of specific provisions about conscientious objection. If a patient enquires

about abortion care to a clinician who has religious objections, the health care practitioner is required to transfer the patient to another registered health care practitioner who does not have a conscientious objection to abortion, or provide information (that may be approved by the state Health Secretary) about how the patient can locate and find another provider (NSW Health, 2019). This is similar to provisions in place in Queensland, Victoria, and Tasmania. However, since decriminalization occurred in Queensland, the state government has raised concerns about an increasing number of clinicians who have refused to treat patients for abortion-related care (Hendrie, 2019).

Several Australian participants raised issues of conscientious objection when discussing their experiences accessing medication abortion. While much of the mainstream dialogue in the media surrounding conscientious objection centres on the religious rights and freedoms of clinicians, the stories from Australian participants highlight how in refusal to treat scenarios, the burden falls on the patient seeking care. Even if regulations are in place that require clinicians to provide a referral, the repercussions for health care providers that fail to comply with this are unclear and often ill-defined for abortion seekers. Indeed, in order for a health care provider to face professional repercussions for failing to uphold her/his/their professional obligations of referral, it requires the patient to make a complaint. Many patients lack the knowledge of the inner-workings of the health care system and are unable to navigate this dynamic. It is also not always clear who patients can complain to in cases where clinicians do not fulfil their obligations and it may not be something that abortion seekers even consider at the time (Keogh et al., 2019). The Australians that I spoke with who encountered clinicians who refused to treat them did not, for the most part, seem interested in filing complaints or taking professional action against the clinician. Instead, they stated that their priority was to find someone who could either help them to locate abortion care or provide it in a timely manner.

Further, in the cases of Australian abortion seekers who met with clinicians who refused to treat them but followed the regulation for referral, this still resulted in a delay in care for patients. Participants reported that being denied services for abortion felt exceptional and stigmatizing and was inconsistent with their broader experiences with the Australian health care system. These stories further highlight how in regional and rural areas, what constitutes an "effective referral" is not always clear and that patients and clinicians may have different definitions of this. For study participants, a referral to a service that they could not realistically access in a timely or affordable way did not constitute an effective referral, even if the health care provider had technically fulfilled their obligation. Issues of health care providers refusing to treat for abortion related care highlights the ever-compounding barriers faced by abortion seekers who live outside of major metropolitan areas.

Laws, Policy, and the Media All Play Significant Roles in Crafting the Abortion Discourse and Shaping the Experiences of Those Seeking Care

Encouraging stakeholders to incorporate high-quality evidence into policy decisions has long been a goal of public health research, yet there is often a discrepancy between policy and practice. That is to say that policy change is important but not always sufficient to tangibly improve access to, or the quality of, care. The implementation of policy can also have unintended consequences that may appear in unexpected downstream ways (The National Collaborating Centre for Healthy Public Policy, 2010).

For these reasons, it is important that policy change is considered as one part of, rather than the whole of, a strategy to increase health equity and improve access to abortion services. It is imperative to deliberately contextualize the implementation, effectiveness, feasibility, and other factors of a policy from the perspectives of local stakeholders. Too often, the voices of patients and the people actually accessing health care are absent from

these discussions. Taken together, the findings from this study in Canada and Australia reinforce why it is important to have a deep, contextualized knowledge of patients' experiences accessing care in order to understand the true implications of policy. The different components of this thesis have been useful in generating context-specific recommendations about improving access to, and information about, medication abortion in Canada and Australia. This dissertation combines research that focused on specific contexts, like Ottawa and Tasmania, with broader, national investigations across two countries.

The case of the criminalization of abortion in Australia reflects an additional dynamic in the interplay between policy and patient experiences by underscoring the role of law and regulation in creating, and perpetuating, public discourse. Despite the fact that abortion is liberally available across Australia, its ongoing criminalization has negative impacts for patients seeking care. Indeed, the legal status of abortion was often brought up, without prompting, by participants who accessed care in criminalized settings. Further, abortion patients themselves identified decriminalization as a critical step towards reducing abortion stigma. The recent legislative reform in Queensland and New South Wales have given momentum to other state-specific campaigns in South Australia and Western Australia. Still, in Tasmania, where abortion was removed from the criminal code in 2013, the change in legal status has not been associated with increased or more equitable access (Baird, 2017).

In both Canada and Australia, participants brought up the media as important sources of information for learning about medication abortion, the availability of services in their province, state, or territory, and in the case of Tasmania, the clinic closures. The way that participants in Canada used media coverage to advocate for themselves with health care providers emphasizes the importance of medically accurate media coverage about reproductive health care. In Tasmania, the refusal of the state government to make definitive statements about the availability of abortion care in state has allowed the media to largely

control the narrative and, in some cases, perpetuate misinformation. These findings also highlight that engagement with journalists is a potential strategy that reproductive health advocates can employ to increase information for abortion seekers.

More broadly, the findings from the studies that form this dissertation also underscore how policies that are not specifically related to abortion condition access to care. For example, in Canada, the Canadian Blood Services guidelines about providing WinRho to Rh-negative patients with early medication abortion detrimentally impact the ability of medication abortion providers to streamline care. In Australia, policies about reimbursement and the health care system more broadly have significant impact on abortion seekers and their ability to afford care.

The Introduction of Medication Abortion Can Have Unintended Downstream Effects

The shifting landscape of abortion care in Tasmania highlights the potential for unintended, downstream effects of introducing mifepristone and effectively decentralizing abortion care. As abortion becomes available in more places, it is crucial that both abortion providers and advocates have discussions about the feasibility of continuing to provide care in clinic-based settings. These conversations should foreground the ongoing conversations about making abortion care available in more places with mifepristone so as to ensure that the rapid clinic closures that occurred in Tasmania are not repeated elsewhere. The case of Tasmania may be particularly relevant for other small and/or island-based settings in Canada like the Maritime provinces of Newfoundland, Nova Scotia, and Prince Edward Island, in addition to other small and remote population settings around the world. Indeed, shortly after the introduction of Mifegymiso® in Canada, one clinic in British Columbia, the only abortion-providing facility on Vancouver Island, stopped providing instrumentation

procedures due to the demand for medication abortion (Grant, 2019). This has implications for strategizing about the decentralization of abortion care across a variety of contexts.

Future Directions

This is a qualitative dissertation, which means that the methods used throughout the thesis do not yield representative or generalizable results. Instead, qualitative methods provide an excellent mechanism for in-depth exploration of participants' experiences, beliefs, and behaviours. While I am confident that the findings from the studies that comprise this dissertation have import beyond the immediate scope of the study, I am unable to assess the degree to which they represent broader trends. The findings have also generated further research questions, which may be explored through qualitative, quantitative, or mixed-methods approaches.

Namely, more research is needed to specifically explore the integration of mifepristone in rural and remote settings in both Canada and Australia. While the findings from these studies suggest that it should be both feasible and acceptable to patients in these areas to obtain medication abortion from a variety of health care providers, future investigations should aim to document the perspectives of patients and providers in rural, remote, and regional areas specifically. The promise of mifepristone lies in its ability to bridge the urban-rural divide of centralized abortion care. In both Canada and Australia, there seems to be potential for mifepristone to achieve this promise, but further investigation is necessary. The studies that comprise this dissertation included participants from a broad range of geographic areas in each country, but few participants were residing in rural, regional, or remote areas at the time they attempted to obtain care. Further research about the feasibility of experimenting with demedicalized strategies would also be a welcome addition to the literature.

As conscientious objection is a timely issue in both Canada and Australia, future research should prioritize the documentation of patients' experiences with being refused care. Much of the narrative that dominates the discussion of conscientious objection centres on respecting the rights and beliefs of clinicians, but there is comparatively little literature about the effects of these policies on patients seeking care. The findings from these studies suggest that patients being refused care is not an uncommon phenomena and future research should explore these dynamics with an emphasis on patients' perceptions.

There is also a need for future research to explore how we can best encourage policy makers to incorporate evidence into their decision-making. A recent study published in the journal *Contraception* found that evidence was not associated with driving American state legislators' policymaking on abortion (Woodruff & Roberts, 2019). However, this same study found that personal stories appeared more convincing to legislators, which means that qualitative research may be particularly relevant for driving policy change related to reproductive health. However, both the Australian and Canadian context for health care, generally, and abortion, specifically, are quite different than in the US. There is a need for research that explores how evidence is weighed by policymakers in these countries.

Finally, we received funding from the Women's College Hospital Toronto to collaborate with Planned Parenthood Ottawa (PPO) on a research project that examines the barriers and facilitators clinicians experience with incorporating medication abortion with mifepristone into their practice. PPO has launched an initiative called the Medical Abortion Access Project (MAAP), which aims to provide support to Ottawa-area clinicians to incorporate medication abortion into their practice. I am part of a team in the process of conducting a qualitative evaluation of this project in order to understand if this model could be transferable to other settings. As discussed above, a similar study and evaluation could be

useful in rural and remote areas in order to explore if clinicians in these areas have different views, concerns, or experiences with mifepristone than urban providers.

Additional Manuscripts

We are in the process of writing an additional two manuscripts related to the data that we collected as a part of this PhD research. First, drawing on the 64 interviews conducted with Canadian Mifegymiso® users, we are preparing a paper that compares patients' experiences accessing care through different health service delivery settings. The people that we spoke with as a part of this component of the study obtained care in a variety of settings, including high-volume, freestanding abortion clinics; community health and sexual health clinics; family practices; hospitals; and other kinds of health care settings, like an ultrasound clinic that also prescribes Mifegymiso®. In Manuscript 2, we mention that participants expressed a high level of acceptability for obtaining care in these different settings and from different kinds of providers. This forthcoming manuscript will further explore this finding and include an in-depth analysis of how participants' experiences varied across service delivery settings.

The second manuscript that we are in the process of drafting draws on the key informant interviews that I conducted with a variety of stakeholders across Canada. This paper will serve to document the perceptions of key stakeholders to the Health Canada review process of mifepristone and the amendments to the product monograph. We anticipate that this paper will serve to clarify misinformation that emerged during the Health Canada review process of Mifegymiso® and may be useful for future efforts to introduce reproductive health technologies in Canada.

Limitations

In the interviews with both Canadian and Australian abortion patients, in some cases, participants were recalling an abortion experience that occurred up to 10 years earlier. Just as with any data that is self-reported, our participants' accounts may be subject to recall bias. As well, these studies specifically aimed to document the experiences of those who were ultimately able to obtain abortion care; we cannot comment on the experiences of abortion seekers for whom the barriers associated with obtaining care were ultimately insurmountable. For the most part, the studies also focused on recruiting abortion patients who had used medication abortion. While Manuscript 3 did include a small number of abortion patients who had instrumentation procedures but would have preferred a medication option, we cannot assess the extent to which this is indicative of wider trends. Future research may want to prioritize exploring the experiences of abortion seekers who wanted a medication abortion but were unable to obtain it.

In both Canada and Australia, the majority of participants included in the study were White and non-Indigenous. We used a community-based recruitment strategy and made efforts to recruit a diverse group of participants. It is important that we acknowledge the broadly homogenous racial and ethnic makeup of the participants in these studies, but racial and ethnic identities of our participants are reflective of broader demographic trends in both countries. Future research should prioritize engagement specifically with communities of colour and visible minorities to understand if they have similar experiences with and preferences for medication abortion. Further, both Canada and Australia are countries where the structural violence of settler colonialism is ubiquitous, and the lasting effects of colonial violence cannot be separated from research conducted in either setting.

The history of contraception and abortion is inseparable from the population control movement, which was closely associated with eugenics (Ladd-Taylor, 2014; Powderly,

1995). In both Canada and Australia, many vulnerable groups, including the disabled and Indigenous peoples, have been subject to state-sponsored sterilization programs (Amy & Rowlands, 2018; Brady et al., 2001). In 2017, a group of nearly 100 Indigenous women launched a class action lawsuit in Saskatoon, Saskatchewan against both the provincial and federal government because they say they were coerced into tubal ligation while they were in labour (Howard-Hassmann, 2019). This is but one example of how racism and colonialism in both Canada and Australia are not merely a legacy, but ongoing issues today that continue to impact racialized and Indigenous communities. This context ultimately influences the level of trust that these communities have in the health care system in general and it may also affect their perceptions of medication abortion. Future research should explore this issue.

Additionally, transgender men and gender non-conforming people have unique health needs (MacKinnon et al., 2019), and the provision of sexual and reproductive health care, including abortion, is no exception to this. While I did interview a number of participants who did not identify as women, I did not gather enough data to reach thematic saturation for these populations or to adequately explore how the abortion experiences of transgender and gender non-binary people may be similar or different from those of cisgender women. Future research that focuses explicitly on the experiences of abortion patients (with both medication and instrumentation methods) who are not cisgender women is warranted.

Conclusions

Medication abortion with mifepristone appears to be highly acceptable to abortion patients in both Canada and Australia. As well, participants were receptive to receiving abortion care in a variety of health service delivery settings, from different kinds of care providers, and through telemedicine if it made care more accessible and available. Participants who felt better informed about what to expect with the medication abortion

process reflected more positively on their experience, which underscores the importance of making accurate information available to abortion seekers.

The studies that comprise this dissertation suggest that when mifepristone is regulated consistently with the extensive body of evidence available about the drug's safety and efficacy, these evidence-based regulations can facilitate making abortion available in more settings and improving the patient experience. Still, it is important to take into account how other kinds of policies and legislation can affect abortion access, even if these regulations do not appear to be directly linked with reproductive health.

In both Canada and Australia, barriers to accessing timely, affordable, and non-judgmental abortion care persist. Engagement with a broad array of clinicians and health care providers and creating clear referral pathways for decentralized models of abortion could be beneficial in addressing some of these barriers. As well, efforts to streamline the medication abortion process and ensure that clinicians do not overmedicalize the process appear warranted.

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Appendices

Appendix A

Approval from the University of Ottawa Research Ethics Board (Canada Abortion Study)

26/08/2019

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

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	S-04-18-551
Titre du projet / Project Title	Documenting people's experiences using mifepristone
Type de projet / Project Type	Recherche de professeur / Professor's research project
Statut du projet / Project Status	Renouvelé / Renewed
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	26/08/2019
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	15/07/2020

Équipe de recherche / Research Team

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

Conditions spéciales ou commentaires / Special conditions or comments

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26/08/2019

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

University of Ottawa
Office of Research Ethics and Integrity

Le Comité d'éthique de la recherche (CÉR) de l'Université d'Ottawa, opérant conformément à l'*Énoncé de politique des Trois conseils* (2014) et toutes autres lois et tous règlements applicables, a examiné et approuvé la demande d'éthique du projet de recherche ci-nommé.

L'approbation est valide pour la durée indiquée plus haut et est sujette aux conditions énumérées dans la section intitulée "Conditions Spéciales ou Commentaires". Le formulaire « Renouvellement ou Fermeture de Projet » doit être complété quatre semaines avant la date d'échéance indiquée ci-haut afin de demander un renouvellement de cette approbation éthique ou afin de fermer le dossier.

Toutes modifications apportées au projet doivent être approuvées par le CÉR avant leur mise en place, sauf si le participant doit être retiré en raison d'un danger immédiat ou s'il s'agit d'un changement ayant trait à des éléments administratifs ou logistiques du projet. Les chercheurs doivent aviser le CÉR dans les plus brefs délais de tout changement pouvant augmenter le niveau de risque aux participants ou pouvant affecter considérablement le déroulement du projet, rapporter tout évènement imprévu ou indésirable et soumettre toute nouvelle information pouvant nuire à la conduite du projet ou à la sécurité des participants.

The University of Ottawa Research Ethics Board, which operates in accordance with the *Tri-Council Policy Statement* (2014) and other applicable laws and regulations, has examined and approved the ethics application for the above-named research project.

Ethics approval is valid for the period indicated above and is subject to the conditions listed in the section entitled "Special Conditions or Comments". The "Renewal/Project Closure" form must be completedfour weeks before the above-referenced expiry date to request a renewal of this ethics approval or closure of the file.

Any changes made to the project must be approved by the REB before being implemented, except when necessary to remove participants from immediate endangerment or when the modification(s) only pertain to administrative or logistical components of the project. Investigators must also promptly alert the REB of any changes that increase the risk to participant(s), any changes that considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project or the safety of the participant(s).

[redacted]
Riana MARCOTTE
Responsable d'éthique en recherche / Protocol Officer
Pour/For **Barbara GRAVES** Président(e) du/ Chair of the **Comité d'éthique de la recherche en sciences sociales et humanités / Social Sciences and Humanities Research Ethics Board**

550, rue Cumberland, pièce 154 550 Cumberland Street, Room 154
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Appendix B

Approval from the University of Ottawa Research Ethics Board (Key Informant Interviews)

File Number: 03-18-11 **Date (mm/dd/yyyy):** 03/28/2018

Université d'Ottawa University of Ottawa
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Ethics Approval Notice

Social Sciences and Humanities REB

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

First Name	Last Name	Affiliation	Role
Angel	Foster	Health Sciences / Others	Supervisor
Kathryn	LaRoche	Health Sciences / Others	Student Researcher

File Number: 03-18-11

Type of Project: PhD Thesis

Title: Exploring the role of advocacy in the approval of mifepristone in Canada

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
03/28/2018	03/27/2019	Approval

Special Conditions / Comments:
N/A

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www.recherche.uottawa.ca/deontologie/ www.research.uottawa.ca/ethics/

File Number: 03-18-11 **Date (mm/dd/yyyy):** 03/28/2018

Université d'Ottawa University of Ottawa
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement (2010) and other applicable laws and regulations in Ontario, has examined and approved the ethics application for the above named research project. Ethics approval is valid for the period indicated above and subject to the conditions listed in the section entitled "Special Conditions / Comments".

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

Please submit an annual report to the Ethics Office four weeks before the above-referenced expiry date to request a renewal of this ethics approval. To close the file, a final report must be submitted. These documents can be found at: https://research.uottawa.ca/ethics/forms.

If you have any questions, please do not hesitate to contact the Ethics Office at [redacted] or by e-mail at: [redacted]

Signature:

[redacted]
Gabriel Petitti
Protocol Officer for Ethics in Research
For Barbara Graves, Chair of the Social Sciences and Humanities REB

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Appendix C

Approval from Macquarie University Human Research Ethics Committee

Office of the Deputy Vice-Chancellor (Research)

Research Services
Research Hub, 17 Wally's Walk
Macquarie University
NSW 2109 Australia
T: +61 (2) 9850 7987
http://www.research.mq.edu.au/
ABN 90 952 801 237
CRICOS Provider No 00002J

MACQUARIE University
SYDNEY·AUSTRALIA

30/01/2019

Dear Associate Professor Lisa Wynn,

Reference No:5201934916955

Title: 3491 Exploring Australian patients' experiences with medication abortion via telemedicine

Thank you for submitting the above application for ethical and scientific review. Macquarie University Human Research Ethics Committee HREC Humanities & Social Sciences considered your application.

I am pleased to advise that ethical and scientific approval has been granted for this project to be conducted by Associate Professor Lisa Wynn and other personnel: Kathryn LaRoche**.**

Approval Date: 30/01/2019

This research meets the requirements set out in the *National Statement on Ethical Conduct in Human Research* (2007, updated July 2018) (the *National Statement*).

Standard Conditions of Approval:

1. Continuing compliance with the requirements of the *National Statement,* which is available at the following website: http://www.nhmrc.gov.au/book/national-statement-ethical-conduct-human-research
2. This approval is valid for five (5) years, subject to the submission of annual reports. Please submit your reports on the anniversary of the approval for this protocol.
3. All adverse events, including events which might affect the continued ethical and scientific acceptability of the project, must be reported to the HREC within 72 hours.
4. Proposed changes to the protocol and associated documents must be submitted to the Committee for approval before implementation.

It is the responsibility of the Chief investigator to retain a copy of all documentation related to this project and to forward a copy of this approval letter to all personnel listed on the project.

Should you have any queries regarding your project, please contact the Ethics Secretariat on 9850 4194 or by email ethics.secretariat@mq.edu.au

The HREC Terms of Reference and Standard Operating Procedures are available from the Research Office website at: https://www.mq.edu.au/research/ethics-integrity-and-policies/ethics/human-ethics

The HREC Humanities & Social Sciences wishes you every success in your research.

Yours sincerely,

[redacted]
Dr Karolyn White
Chair, HREC Humanities & Social Sciences

This HREC is constituted and operates in accordance with the National Health and *Medical Research Council's (NHMRC)National Statement on Ethical Conduct in Human Research (2007, updated July 2018*) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*