Exploring accompaniment in abortion care: A multi-methods study

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Abstract

Accompaniment models have been used globally to help address barriers to abortion access. Access to abortion is an important issue facing individuals in Canada today. In Canada, abortion doulas provide accompaniment services, even though they are not formally integrated into the abortion care system. This thesis explores the concept of accompaniment in the context of abortion care and provides insight into the experiences and perspectives of abortion doulas active in Canada. This is accomplished through a scoping review and in-depth interviews with abortion doulas across Canada.

Results suggest that accompaniment models are beneficial to abortion care and can improve accessibility. Further, abortion doula support helps abortion seekers overcome barriers to care and empower those providing the support. Abortion doulas have many suggestions for improvements to the abortion care system in Canada and have valuable insights into the barriers which exist today. Abortion care can be improved by integrating abortion doula support into the abortion care system, but further research is needed to develop and evaluate interventions. This research is a starting point and aims to contribute to the literature in an under-researched area.

Résumé

Des modèles d'accompagnement ont été utilisés dans le monde entier pour aider à lever les obstacles à l'accès à l'avortement. L'accès à l'avortement est une question importante auquel les individus au Canada sont confrontés. Au Canada, les doulas spécialisées dans l'avortement fournissent des services d'accompagnement, même si elles ne sont pas officiellement intégrées au système de soins lié à l'avortement. Cette thèse explore le concept d'accompagnement dans le contexte des soins liés à l'avortement et donnera un aperçu des expériences ainsi que les points

de vue des doulas spécialisées dans ce domaine au Canada. Afin de démontrer ceci, la thèse s'appuie sur un examen de la portée de l'étude et sur des entretiens approfondis avec des doulas spécialisées dans l'avortement au Canada.

Les résultats suggèrent que les modèles d'accompagnement sont bénéfiques aux soins liés à l'avortement et peuvent en améliorer l'accessibilité. De plus, le soutien des doulas aide les personnes qui cherchent à se faire avorter à surmonter les obstacles aux soins et renforce l'autonomie de celles qui offrent ce soutien. Les doulas d'avortement ont de nombreuses suggestions pour améliorer le système de soins en matière d'avortements au Canada et ont des idées précieuses au sujet d’es obstacles qui existent aujourd'hui. Les soins liés à l'avortement peuvent être améliorés en intégrant le soutien des doulas dans le système de soins liés à l'avortement, mais d'autres recherches sont nécessaires afin de développer et évaluer les interventions. Cette recherche est un point de départ et vise à apporter une contribution à la littérature sur un domaine peu étudié.

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Acronyms and abbreviations

ARCC	Abortion Rights Coalition of Canada
CBC	Canadian Broadcasting Corporation
CEDAW	Committee on the Elimination of Discrimination against Women
CESCR	The Committee on Economic, Social and Cultural Rights
CFPC	The College of Family Physicians of Canada
CHEO	Children's Hospital of Eastern Ontario
CMPA	The Canadian Medical Protective Association
CNO	College of Nurses of Ontario
CRR	Center for Reproductive Rights
IPPF	International Planned Parenthood Federation
NAF	National Abortion Federation
PI	Principal investigator
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
REB	Research ethics board
SOGC	Society of Obstetricians and Gynaecologists of Canada
WHO	World Health Organization

Definition of terms

Accompaniment: A process or system where individuals and networks provide instruction and guidance throughout the abortion process, connect people in their time of need, and support individuals to reduce potential harm (Erdman et al., 2018).

Conscientious objection: Refusing to obey a particular order or rule or to do a particular type of work for moral or religious reasons (Cambridge Dictionary, 2023). Sometimes referred to as "belief-based denial" of care.

Doula: An individual with training or experience in pregnancy, labour and delivery, postpartum, or abortion support. Doulas that are familiar with all reproductive health scenarios are referred to as full spectrum doulas.

Known person or partner: An individual who is known by the person having the abortion and has a pre-established relationship with the abortion seeker.

Midwife: A registered midwife with formal education in midwifery.

Volunteer group or community organizations: Organized groups of people with specific goals. In this case the goal is to increase access to and improve abortion care. These groups/organizations may or may not be registered legal entities.

Chapter 1: Introduction

1.1 Background

1.1.1 Introduction to abortion

In 2016, the Centre for Reproductive Rights (CRR) collected information on the distribution of abortion laws globally and their impact (CRR, 2022). They found that 59% of women of reproductive age live in countries that allow abortion under most circumstances (CRR, 2022). While most women live in countries where abortion is legal, 41% of women live under restrictive laws including 6% who live in countries where abortion is illegal under any circumstance (CRR, 2022). In countries with restrictive abortion laws, unsafe abortions are more common and lead to preventable maternal death and disability (Grimes et al., 2006; Haddad & Nour, 2009). Hence, why legality and accessibility of abortion are important to consider.

Reproductive health and abortion are highly politicized topics globally (Berer, 2017; Blystad et al., 2020). Abortion is often subject to controversies and challenges stemming from questions about human and reproductive health rights, gender and sex, equity and equality, morality and religion, the legal and moral status of the fetus, and societal and cultural norms (Blystad et al., 2020). Reproductive health rights and the status of abortion often evoke strong opinions and reactions from social and political groups, commonly resulting in division (Blystad et al., 2020; Ferris et al., 1998). In addition, abortion status and urgency can be influenced by global events and crises (Dias Amaral & Sakellariou, 2021; Fetters et al., 2020; M. Kumar et al., 2020). This complicated landscape of multiple stakeholders often makes it challenging to achieve progress (Berer, 2017; Johnstone, 2017).

Despite the challenges, in Canada abortion is decriminalized and both medication and instrumentation abortion care are available (Burnett, 2019). However, Canadian abortion law is

far from untouchable (Saurette & Gordon, 2013). Since its decriminalization, approximately 47 bills with anti-abortion implications have been introduced into the House of Commons (ARCC, 2021; Saurette & Gordon, 2013). Although none have passed, abortion status is constantly challenged by anti-choice discourse and there remains a need for pro-choice groups and individuals to engage with these ongoing efforts (Cannold, 2002; Duerksen & Lawson, 2017). Anti-choice groups have presented a wide variety of arguments aimed at reintroducing abortion into the criminal code and reducing abortion access in Canada (Cannold, 2002; Duerksen & Lawson, 2017; Saurette & Gordon, 2016). These groups continue to develop new strategies to reduce abortion access and attack abortion rights (Saurette & Gordon, 2013, 2016). These strategies are often founded in medically inaccurate information and usually aim to discourage the abortion-seeker from getting the abortion (Richardson & Nash, 2006).

According to Leslie Cannold, anti-abortion rhetoric can be divided into two categories: fetus-centered and woman-centered (Cannold, 2002). The more traditional form of anti-abortion discourse, fetal-centered, is known to target legislative change and often has religious associations (Johnson, 2014; Rose, 2011; Saurette & Gordon, 2013). Further, it frames women who access abortions as selfish, irrational, and irresponsible (Cannold, 2002; Duerksen & Lawson, 2017). More recent, and increasingly common, anti-abortion discourse uses a woman-centered approach, claiming that abortion fundamentally harms women and that they are coerced into getting an abortion (Duerksen & Lawson, 2017; Roberti, 2021). This shift in discourse is a technique used to build momentum and attract supporters (Rose, 2011). Understanding anti-abortion mobilization in Canada is key to preparing and defending the future of abortion legality and access (Saurette & Gordon, 2013).

In Canada, discussions regarding abortion status require constant engagement (Johnstone, 2017; Saurette & Gordon, 2013). The regulatory status and accessibility of abortion is greatly influenced by technological advancements, political factors and policy development, pro- and anti-choice arguments and advocacy, and social perceptions (Ferris et al., 1998; Johnstone, 2012; Schwartz & Tatalovich, 2009). These factors then impact the experiences of abortion-seekers and the accessibility of abortion care (Altshuler & Whaley, 2018; LaRoche & Foster, 2018, 2020).

1.1.2 The importance of access to abortion

The global need for abortion is consistent and is not influenced by legal status or availability (New, 2018). It is widely known that restricting abortion does not reduce the number of abortions or the abortion rate; rather, restrictions increase the rate of unsafe abortion (CRR, 2011). Globally, approximately 20 million women have an unsafe abortion each year (Shah & Åhman, 2009). These unsafe abortions cause significant maternal mortality and disability (Shah & Åhman, 2009). In fact, unsafe abortion is responsible for approximately 70,000 maternal deaths and 5 million temporary or permanent disabilities each year (Shah & Åhman, 2009). These deaths are generally considered to be preventable (Haddad & Nour, 2009). Access to abortion is essential to protecting every individual's right to life and preventing avoidable death (CRR, 2011; Shah & Åhman, 2009). By restricting abortion access, pregnancy capable people are forced to seek alternative methods of ending their pregnancy, putting their lives at risk (CRR, 2011). Any context where the individual must put her/his/their life at risk to access a health service is, by definition, a violation of the right to life. By supporting accessible abortion services, governments and organizations create an environment where the right to life is respected (CRR, 2011). Access to abortion services is also a crucial aspect in respecting an

individual's right to health (ARCC, 2018). In 2000, the Committee on Economic, Social and Cultural Rights (CESCR) expanded the right to health to include "the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference" (CESCR, 2000). This includes being able to access safe abortion services without being obstructed (CESCR, 2000). Therefore, access to abortion services is essential to respecting the right to life and health.

Access to abortion has long been considered a human and reproductive rights issue. However, it is important to note that abortion access is also an equality issue. The right to gender equality is an accepted and fundamental part of human rights law (CRR, 2011). In 1999, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) claimed that "laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures" were barriers to health care for women (CEDAW, 1999). Thus, to criminalize or make abortion inaccessible, is to discriminate against women. Further, evidence shows that individuals from marginalized or vulnerable groups are more likely to need abortion services (Todd-Gher & Shah, 2020). Therefore, preventing abortion access creates inequities in the health care system and perpetuates existing inequalities in society. Overall, access to abortion is vital to respecting human rights and promoting equality.

1.1.3 Accompaniment in abortion care

The term accompaniment is broad and has different meanings depending on the environment. In the context of abortion care, accompaniment is defined as a process where individuals or networks provide information and direction throughout the abortion process and connect and support individuals to reduce potential harm (Erdman et al., 2018). Accompaniment is typically provided by a support person or group and is used worldwide to improve the

accessibility of abortion care and services (Bercu, Filippa, Jayaweera, et al., 2022; Wollum et al., 2022). The type of accompaniment provided is generally influenced by the local context and needs of the community. For example, in Argentina, abortion beyond a gestational age of 12 weeks is severely restricted (Guttmacher Institute, 2018). However, feminist groups provide in-person accompaniment support to help abortion seekers self-manage their abortions at home (Bercu et al., 2021). In these cases, the accompaniment providers facilitate access to safe abortion and reduce the need for, and harmful effects of, unsafe abortion.

Accompaniment in the context of abortion care is a relatively new concept in the literature, with most research occurring within the past decade. Accompaniment models have been more formally studied as methods of improving access to abortion in legally restricted settings, with the bulk of research set in the global South (Drovetta, 2015; Zurbriggen et al., 2018). In this context, the most common type of accompaniment is provided by feminist volunteer groups (Bercu et al., 2021; Krauss, 2019; Moseson et al., 2022; Singer, 2019; Wollum et al., 2022; Zurbriggen et al., 2018). For example, researchers associated with Ibis Reproductive Health have explored how feminist accompaniment impacts the effectiveness of self-managed medication abortion (Moseson et al., 2020, 2022), emotions related to abortion (Wollum et al., 2022), and general experiences and perspectives of both abortion seekers and those providing support (Bercu, et al., 2022; Garnsey et al., 2022). Throughout their work, researchers have found that non-clinical accompaniment support can help people understand when and how to access care (Moseson et al., 2022), reduce negative feelings regarding stigma (Wollum et al., 2022), and be well-received by abortion-seekers (Garnsey et al., 2022).

In North America, accompaniment provided by abortion doulas and known individuals (such as parents or partners) are the most common types of accompaniment (Altshuler et al.,

2016; Chor et al., 2012; Nguyen et al., 2018). Despite the paucity of research,, current literature from the United States claims that abortion doulas play an important role in the abortion experience (Whaley, 2014), and their presence allow abortion providers to focus on more technical aspects of care without worrying about the patient's emotional needs (Chor et al., 2015). Further, associations between doula accompaniment and more positive patient experiences have been cited and people who received abortion support highly recommended it (Bond, 2015; Stabnick, 2021). Some research suggests that doula support could lead to better health outcomes (Stabnick, 2021). Overall, the literature suggests that integrating abortion doula support can help produce safer and more patient-centered care (Chor et al., 2015). However, these findings require further research to be corroborated.

In the literature, accompaniment appears to have the potential to positively impact abortion care and overall accessibility (Action Canada, 2020b, 2020a; CBC, 2019; Chor et al., 2018; Kurji et al., 2019; Vosters, 2012; Whitten, 2019). However, there has been little research exploring how accompaniment models can influence abortion care in Canada. The small amount of existing peer-reviewed literature in Canada focuses primarily on accompaniment provided by a known person (Altshuler et al., 2016; Nguyen et al., 2018) and little is known about external support people or groups, including abortion doulas. Information about abortion doulas in Canada is currently spread through news articles and other forms of media. These sources report that abortion doulas could be key in improving access to abortion in Canada (Al-Hakim, 2018). Media reports claim that abortion doulas help abortion seekers overcome geographic and financial barriers (Butler, 2022; CBC, 2019; CBC, 2022), navigate the health care system (Onyenacho, 2021), and provide them with emotional and practical support (Neustaeter, 2022). Increasingly, abortion doulas are being discussed in the context of abortion care in Canada.

While awareness of abortion doulas is increasing, there remains a large knowledge gap regarding how accompaniment provided by abortion doulas could impact abortion care in Canada. Further research is required to help understand abortion doulas in the Canadian context.

1.1.4 History of abortion care in Canada

One in three Canadian women will have an abortion over their reproductive lifetimes (Norman, 2012) and over 100,000 abortions are performed each year (ARCC, 2022a; Government of Canada, 2017). This makes abortion one of the most commonly experienced medical procedures for women[1] of reproductive age (Raymond et al., 2002). It is also one of the most important. In Canada, nearly 50% of pregnancies are unintended and 37% of documented pregnancies end in abortion (Bearak et al., 2022; Guttmacher Institute, n.d., 2020).

Over the past 55 years, abortion legality and access has changed significantly (Burnett, 2019). Prior to 1969, abortion was completely illegal in Canada (National Abortion Federation (NAF) Canada, 2022). At the time, the maximum penalty for an abortion provider was life imprisonment, with the abortion seeker getting up to two years in prison (Burnett, 2019; Long et al., 2022; NAF Canada, 2022). Then, in 1969, because of an amendment to the criminal code, abortion became legal in Canada if the pregnancy threatened the health or life of the woman (Burnett, 2019; Long et al., 2022; NAF Canada, 2022). Although abortion was legal, many barriers to access remained (Burnett, 2019). The process abortion seekers had to navigate to access services was time consuming, resulting in delayed abortion care (Burnett et al., 2019; Burnett, 2019). There was also no legislation enforcing abortion provision and as a result, many

[1] While I use the term "women" here to reflect the language used in the original reference, it is important to note that any person with the capacity for pregnancy, regardless of gender identification, is someone who may need, seek, and obtain an abortion.

hospitals chose not to provide abortion services and they would not refer abortion seekers to someone who offered care (Burnett et al., 2019; Burnett, 2019).

In 1975, Dr. Robin Badgley was appointed to chair a committee with the goal of examining the functionality of Canada's abortion care law (Burnett, 2019). The committee found many inequities and barriers in the system (Thomas, 1977). For example, the committee discovered that the average wait time between initial consultation and abortion procedure was eight weeks (Thomas, 1977). While the committee made no specific recommendations, it indicated that the system was not working equitably and changes needed to be made (Thomas, 1977). Abortion remained criminalized until 1988 when the supreme court struck down Section 251 of the Criminal Code in *R v. Morgentaler* (Burnett, 2019). Chief Justice of Canada, Brian Dickson, wrote "Forcing a woman by threat of criminal sanction, to carry a fetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person" (Canada, 1988). This landmark decision allowed abortion to be treated as any other medical procedure (NAF Canada, 2022). Abortion is defined as a medically necessary service, but is regulated at the provincial and territorial level (NAF Canada, 2022). Although there have been attempts to re-criminalize abortion, it remains decriminalized and Canada continues to have one of the strongest legal frameworks in the world (Burnett, 2019).

1.1.5 Current issues impacting abortion care in Canada

Although there are no criminal legal restrictions on abortion in Canada, abortion seekers still encounter a wide range of barriers (Doran & Nancarrow, 2015; Shaw & Norman, 2020; United Nations, 2016). The most relevant challenges can be grouped into three categories: 1)

geographic disparities in service availability; 2) societal and cultural norms and belief systems; and 3) existing systems of inequity.

The first of these categories covers a wide range of issues related to how abortion care is organized in Canada. This includes geographic, regulatory, financial, and time related barriers to access. One of the most significant barriers relevant in the contemporary context is the regulation of medication abortion (Action Canada, 2019b; Devane et al., 2019; Wagner et al., 2020). While the gold standard of medication abortion, Mifegymiso®, was approved in 2015 and became available in 2017, complicated provincial and territorial regulations limit its promise and reach (Devane et al., 2019; LaRoche et al., 2022). Research has demonstrated that accessing abortion care in Canada is significantly more challenging for those living in rural communities (Cano & Foster, 2016; Cohen, 2019; Devane et al., 2019; Norman et al., 2013; D. Shaw & Norman, 2020). In some provinces, abortion provision is only available in urban centers, even though 30 to 40 percent of the population reside in a rural community (Action Canada, 2019b; Shaw, 2006). Full integration of medication abortion into the health system, including in rural areas, could reduce geographic barriers and increase abortion access in Canada (Action Canada, 2019b; Cano & Foster, 2016; Devane et al., 2019; LaRoche et al., 2022; Norman et al., 2013; Wagner et al., 2020).

Provincial and territorial regulatory difference cause uneven access to abortion in Canada (Norman et al., 2016; Sethna & Doull, 2013; Shaw, 2006). Abortion seekers needing care, especially at later gestational ages, may have to travel out of their province of residence, or out of the country, to access services (Johnstone & Macfarlane, 2015; Sethna & Doull, 2012). Domestic and international travel pose undue financial hardship on abortion seekers who may already be under pressure to front the costs of abortion care if they are not fully covered through

provincial or territorial insurance schemes (Johnstone & Macfarlane, 2015; Reardin, 2022). Accessing abortion care can require women, transgender men, and gender non-binary individuals with the capacity for pregnancy (womxn) to take time off work, pay for travel, or pay for childcare, increasing the cost of the abortion (Cano & Foster, 2016; Doran & Nancarrow, 2015; Reardin, 2022). In some cases, there are anti-choice physicians and groups that intentionally mislead abortion seekers with the intention of delaying or preventing them from getting an abortion locally (Action Canada, 2019a; Kaposy, 2010; Sethna & Doull, 2012).

Societal and cultural norms and belief systems can contribute to delays in accessing abortion care or prevent womxn from accessing abortion altogether (ARCC, 2022b; Keer et al., 2022). For example, conscientious objection allows medical providers to refuse provision of medical services on the basis of personal moral or religious belief (Lindeman, 2021; Schuklenk & Smalling, 2017). Often, the denying party either has no obligation to provide a referral or does not provide the referral, despite the obligation (Kaposy, 2010; Lindeman, 2021; Rodgers & Downie, 2006). This practice creates delays in the abortion-seeking process and contributes to abortion stigma (Faúndes et al., 2013; Fiala & Arthur, 2014). Stigma toward abortion also hampers access to information about abortion care (Action Canada, 2018, 2019a; Kumar et al., 2009; Viau, 2022) and can be emotionally and physically harmful (Morrison, 2022). Existing stigma can be perpetuated by anti-abortion, or anti-choice, discourse (Cullen & Korolczuk, 2019; Purcell et al., 2014). In fact, stigmatizing abortion is central to the anti-choice argument (Cullen & Korolczuk, 2019). By construing abortion as shameful or immoral, anti-choice rhetoric attempts to dissuade abortion-seekers from accessing care (Baird & Millar, 2019; Chełstowska, 2011; Cullen & Korolczuk, 2019). However, current evidence on the impact of abortion seekers' encounters with anti-choice groups shows that anti-choice encounters did not make the abortion

seeker change their decision, but rather made them feel frustrated, upset, stigmatized, and unsafe (Doran & Nancarrow, 2015; A. M. Foster et al., 2020; D. G. Foster et al., 2013; Sethna & Doull, 2007).

Barriers to accessing abortion are further influenced by structural oppression and existing systems of inequity in Canada and the Canadian health system (Ackerman & Stettner, 2019; Beausaert, 2014; Dyck & Lux, 2016). However, this relationship has not been broadly explored in the literature (Ackerman & Stettner, 2019). Additionally, barriers to abortion disproportionately impact vulnerable and marginalized womxn (Action Canada, 2019b; Hulme et al., 2015; Kaposy, 2010). Specifically impacting individuals living on low-incomes, womxn of color, migrants and refugees, and linguistic minorities (Action Canada, 2019b; Coen-Sanchez et al., 2022; Kaposy, 2010). Structural barriers are then compounded when these individuals live in rural or remote areas (Action Canada, 2019b; Shaw & Norman, 2020). Everyone deserves to have equal access to abortion care, yet racism, misogyny/sexism, xenophobia, classism, homophobia, transphobia, ableism, and ageism continue to directly and indirectly prevent womxn from seeking and obtaining abortion care (Action Canada, 2019b; Coen-Sanchez et al., 2022; Mandlis, 2011).

1.2 Project development

In September of 2020, I began working toward a master's degree in Interdisciplinary Health Sciences at the University of Ottawa to pursue further education in global and reproductive health rights. Earlier that summer, my supervisor and I had decided that my thesis would include an evaluation of the Safe Abortion Referral Program (SARP) in Chiang Mai, Thailand and would include 3-4 months abroad conducting fieldwork. Although the COVID-19

pandemic was ongoing, we were confident in the project and developed a plan to ensure my thesis project could be completed within the expected time frame. This involved three stages: 1) delay fieldwork; 2) change the project to be fully virtual; and 3) shift the project topic entirely. While we had planned for fieldwork to commence in the summer of 2021, it was clear that the pandemic was not yet over, and my fieldwork needed to be delayed. At the time, the University of Ottawa had put policies in place to prevent non-essential international travel, further complicating the fieldwork timeline and plan. As a result, we began planning for fieldwork to commence in the fall of 2021. However, throughout 2021 severe political instability in Myanmar had a major impact on our local collaborators in Northern Thailand. My supervisor and I decided to further postpone the fieldwork as COVID-19 was still prevalent, the country's political instability resulted in a volatile environment, and virtual interviews and work was not a reliable option. When the opportunity to conduct fieldwork became available in early 2022, I was unable to travel due to scheduling and financial conflicts. However, in anticipation of fieldwork challenges, in 2021 I conducted a scoping review on accompaniment in the context of abortion care. Throughout the process, I was struct by the lack of literature available in Canada about the topic. After deciding to pivot away from my original thesis topic, I followed my interest to study reproductive health here in Canada and decided to conduct a small exploratory study on one model of accompaniment in Canada – abortion doulas.

1.3 Rationale

Navigating abortion care involves overcoming a variety of barriers. Accompaniment models have been implemented in various countries and contexts to help reduce the impact of

these barriers. In Canada, accompaniment provided by doulas is an emerging concept. However, there has yet to be research exploring abortion doula's experiences and opinions.

This project seeks to discover what is currently known about accompaniment in the global context of abortion care and gather insight into abortion doulas experiences and opinions. Findings from this project will give a voice to the abortion doulas of Canada and lay the foundation for further research. By publishing two articles, presenting at conferences and disseminating findings back to the abortion doulas, this thesis will be able to spread more information about abortion doulas in Canada.

1.4 Specific objectives

A better understanding of accompaniment in the context of abortion care and the experiences and opinions of abortion doulas will help to address a relevant knowledge gap regarding Canada's abortion and reproductive health care system. Further, this insight can inspire researchers, policymakers, and medical professionals to recognize the role of abortion doulas in reproductive health care. Specifically, this project aims to:

1) Summate available information about accompaniment in the context of abortion care;
2) Describe the experiences, attitudes, and opinions of Canadian abortion doulas; and
3) Explore abortion doulas' perspectives on how abortion care could be improved for Canadians and how abortion doulas could be better supported.

1.5 Thesis structure

I composed a "Thesis by articles" consisting of five chapters. The first chapter provided an overview of abortion care, the importance of abortion access, the use of accompaniment

models in the context of abortion care, a brief history of abortion care in Canada, and insight into current challenges in abortion care and in Canada. Further, it describes my journey to this project and defines the project rationale. This chapter also presents my specific research objectives and outlines the thesis structure.

Chapter two introduces the methods implemented for this project and is broken down into two subsections to provide more information about each component and the different methods I employed.

The third and fourth chapters include the articles from the two components of the project. The first article (Chapter 3) is a scoping review of accompaniment in the context of abortion care and discusses how accompaniment is documented in both peer-reviewed and grey literatures. We have formatted this article for submission to *BMJ Reproductive and Sexual Health*. The second article (Chapter 4) details the experiences of abortion doulas in Canada and their recommendations on how to improve access to abortion while supporting both abortion seekers and doulas. We have formatted this article for submission to *Contraception*.

In the fifth and final chapter, I integrate results and discuss their significance. In this chapter I also discuss the limitations of my thesis and the future directions of this project, as well as my positionality and the role it played in data collection and interpretation. I end with a brief conclusion.

Chapter 2: Methods

Given the goal of this project, and the limited amount of literature available on this topic, I began my thesis with a comprehensive scoping review of available literature. Scoping reviews can be used to help gain understanding of the scope of existing literature and knowledge (Arksey & O'Malley, 2005; Pham et al., 2014). Additionally, scoping reviews are useful when attempting to identify knowledge gaps and inform potential projects (Pham et al., 2014).

Afterwards, I used an action-oriented research framework to conduct in-depth interviews with the goal of delving deeper into abortion doulas' experiences in Canada. This method of data collection was the most appropriate because I aimed to explore a new topic in depth and gather information about experiences (Boyce & Neale, 2006).

This chapter provides details about my own training and preparation taken before beginning this project and specifics about each component of my thesis. Specifically, in this chapter I describe the methods for both the scoping review (component I) and the in-depth interviews (component II). I then conclude by exploring the ethical considerations of this project and the conceptual framework I employed.

2.1 Training and preparation

Over the past five years, several experiences have prepared me to successfully complete this research project. From 2016-2020 I completed an honours undergraduate degree in health sciences at Carleton University. This experience provided me with background knowledge in scientific writing, social determinants of health, and research methods. Additionally, as required for this degree, I completed a year-long field placement at the Children's Hospital of Eastern Ontario (CHEO). While at CHEO, I was involved in various research projects, one of which

included working with marginalized populations and health advocacy. Not only did this placement provide me with research experience and the opportunity to improve my academic writing skills, but it also fostered my passion for health advocacy.

In 2021, as a part of a directed study, I completed multiple interviews for the United States Medication Abortion Study. My supervisor, Dr. Angel M. Foster, designed this study to understand better the experiences of those who used medication abortion (mifepristone) for early abortion in the United States. This project included interviews with womxn from over 30 states and provided me with a hands-on opportunity learn about qualitative research, including interview techniques, memo writing, and transcription.

Further, I completed a multi-day qualitative research methods training course and successfully completed the necessary coursework required of the MSc in Interdisciplinary Health Sciences program. These experiences broadened my exposure to the field of qualitative research and enabled me to improve my interviewing and memo writing skills.

While working on my master's degree, I was given the opportunity to work on an additional project led by Dr. Foster which explored the use of misoprostol in Uganda. This experience inspired me to build on this topic for my thesis project and gave me experience in searching and writing scoping reviews.

2.2 Component I

2.2.1 Methodological framework

In component I of my thesis, I conducted a scoping review adhering to the methodological framework proposed by Arksey and O'Malley and revised by Levac, Colquhoun, and O'Brien (Arksey & O'Malley, 2005; Levac et al., 2010). This framework involves six stages

(five mandatory, one optional): 1) identify the research question; 2) identify relevant studies; 3) study selection; 4) charting the data; 5) collating, summarizing, and reporting the results; and 6) consultation (Arksey & O'Malley, 2005). While I completed the five mandatory stages of this framework, I did not complete the sixth, optional, stage: consultation. The sixth stage of this framework involves consulting with practitioners and consumers so they can provide additional references as well as context for the scoping review findings (Arksey & O'Malley, 2005). While this stage adds value and purpose to the scoping review, I chose not to complete this stage because it was not feasible at the time. I used the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) scoping review extension guidelines to organize the review (Tricco et al., 2018). In accordance with the guidelines, I included all 20 necessary components. However, given the nature of the scoping review, I did not complete a critical appraisal of individual sources of evidence and therefore chose not to complete the optional items 12 and 16.

2.2.2 Search strategy

To begin the scoping review, I performed a preliminary search for existing scoping reviews, systematic reviews, primary research papers, and research syntheses as a way of becoming more aware of the terminology used in this context, avoiding unnecessary duplication, and ensuring the review was comprehensive. This included searches of Ovid PubMed/MEDLINE, OSF, CINAHL, Embase, PROSPERO, Cochrane Database of Systematic Reviews, Google Scholar, BJM Open, BMC Systematic Reviews, Epistemonikos, and the JBI Evidence Synthesis. I conducted this search with terms previously identified as relevant to this context such as accompaniment, companionship, escort, associate, abortion care, reproductive

care, termination of pregnancy, medical/medication abortion, and surgical abortion. While there was some literature discussing accompaniment, there were few studies that explored this topic in the context of abortion care. Moreover, there was no consistent language used to describe accompaniment. Based on our preliminary findings, I executed the main search in five databases (Medline, PsychInfo, JSTOR, ProQuest, and Scopus) using the terms abortion, doula, accompaniment, companion, and escort. Afterward, another reviewer (Dr. Anvita Dixit) and I examined the reference lists of all retained articles. Lastly, we performed a grey literature search by first agreeing on a list of organizations and websites to examine and then independently searching through each item for additional literature.

2.2.3 Eligibility criteria

The goal of this review was to explore what is currently known about accompaniment in the context of abortion care on a global level. Therefore, we included literature from all types of media without language or population restriction, published between 2010 and 2020 (inclusive). We included items that were specifically focused on accompaniment in abortion care, and we excluded items if they focused on general social support, social status, relationship status, family relationships or if they focused on miscarriage, pregnancy, adoption, giving birth, or any other non-abortion related reproductive health topic. We did not exclude literature based on country, language, research method used, peer-review status, or source type.

2.2.4 Study selection

To select the literature, I screened titles and abstracts from the database search and used Covidence to organize all literature moved to the full text review. Then Dr. Dixit and I independently screened full texts using the predetermined inclusion and exclusion criteria and examined reference lists for additional articles. We both agreed on the inclusion of items, and we resolved disagreement through discussion. Dr. Foster was available to adjudicate in the event of continued disagreement, but this was not necessary. We then completed the grey literature search independently.

2.2.5 Data charting

Both Dr. Dixit and I extracted data from included literature using a predetermined format in Google Sheets. Specifically, we extracted the type of media, research aims, the country of study, research methods used (if applicable), overall conclusions, and type of accompaniment discussed. Afterwards, we used ATLAS.ti software to analyze the included literature and extract data.

2.3 Component II

2.3.1 Study design and data collection

This component of the project consisted of in-depth interviews with abortion doulas working in Canada. One team member (Lauren Lagoutte) is heavily involved with networks of abortion doulas and was able to leverage these relationships to distribute information about our study. She contacted organizations and individuals, providing them with our approved study poster and information about the project. This included details about the Principal Investigator (Dr. Foster), a description of the format and goals of the project, the expected time commitment

it would require, and that the participant would receive a CAD40 gift card to amazon.ca for their participation.

We scheduled Zoom (audio)/phone interviews with each participant who responded between March and June 2022 (inclusive). After receiving their consent, I recorded each interview which a team of volunteers then transcribed (between April and September of 2022). I took notes during the interviews and wrote formal memos immediately after. There was a total of nine interviews, lasting an average of 80 minutes.

I used a semi-structured interview guide to steer the conversation without limiting the participant's responses. This format allowed me to cover a breadth of previously identified topics while giving the participant room to discuss the experience and topics they felt were important. Between 2012 and 2015, the PI conducted a large-scale qualitative study examining Canadian women's abortion experiences. This project was a platform upon which many additional smaller studies were completed (Cano & Foster, 2016; Foster et al., 2017; Vogel et al., 2016). These projects provided important information about abortion in Canada and therefore served as rich sources of background for this thesis project. The PI of this project (AMF) developed the interview guide for this thesis based on the interview tools used in previous research.

The interview covered multiple domains of inquiry, beginning with details about the participant themself, their background, education, living arrangements, sources of support, welfare during the COVID-19 pandemic, and their experience in the abortion/reproductive justice field. I then proceeded to ask a series of questions about how the participant became an abortion doula, their motivations, their previous knowledge about abortion in Canada, and the role of doulas. I also inquired about specific details of their practice as an abortion doula including how often they act in that role, the number of clients they work with, their affiliations,

locations, and payment models. The next section of questions covered the participant's experiences as an abortion doula, their feelings about their experiences, details regarding their training, impact of COVID-19 on their ability to provide care, and any memorable, positive, negative, or surprising experiences they have had as an abortion doula. Subsequently, I asked them about how their role as an abortion doula has impacted their views on reproductive justice, pregnancy, abortion, feminism, and social justice. We also discussed how other abortion doulas in their community have impacted them. Next, we discussed how the participant talks about being an abortion doula with the people in their life and how their career choice has impacted these people. The participant talked about the important people in their life, how they navigate confidentiality, and discussed how their career choice has shaped other people's perspectives of reproductive justice, pregnancy, abortion (including first and second trimester abortion), policies related to abortion, and social justice. They also discussed whether they would recommend other people become abortion doulas. In the final section, I asked the participant questions about how abortion care could be improved for people in Canada and what could be done to support abortion doulas in Canada.

2.3.2 Data analysis

I took notes throughout the interview process and wrote memos immediately following each interview. Memoing is an important qualitative analytical technique which provides the researcher an opportunity to reflect on and connect with the research (Birks et al., 2008). As memoing is a flexible method without strict guidelines (Birks et al., 2008), I used it to adjust my interview style and questions as needed. Further, in conjunction with available literature, memos served as inspiration for topic and theme organization.

I managed the in-depth interview data with ATLAS.ti software. To perform the content and thematic analyses, I used both deductive and inductive techniques. I began with a deductive approach because it allowed me to engage with the existing research and relate it to my own research (Azungah, 2018). I anticipated that themes presented in the literature would appear in the interviews. For example, I expected that the participants would be heavily involved in reproductive justice because previous literature discusses the link between the full-spectrum doula movement and reproductive choice and justice (Chor et al., 2012; Mary, 2010). By using a deductive approach, I was able to recognize certain themes better and understand their context. I included an inductive approach because this method involves tracking the emerging concepts appearing in the text and allowing these themes to drive understanding of the concepts (Azungah, 2018; Thomas, 2006). This approach improved my understanding of the experiences of abortion doulas in Canada.

To implement the deductive component, I used existing literature, the project objectives, and the interview guide to develop an a priori code book. This included six primary categories: personal information, experiences becoming a doula, experiences being a doula, impact on others, impact on self, and reflections. Throughout the coding process I used an inductive approach to identify additional themes which were relevant to the research questions. This approach enabled me to recognize specific ideas emerging from the interviews and post-interview reflection allowed me to understand the relationship between these ideas and interpret their meaning. By combining the deductive and inductive approaches, I was able to capture more relevant themes which in turn strengthened my findings (Johnstone, 2004).

2.4 Ethical considerations

The first component of this project, the scoping review, did not require ethics approval since it only uses publicly available documents as evidence (Government of Canada, 2019; Suri, 2020). However, the in-depth interviews component required ethical approval as it involved directly engaging with participants (Government of Canada, 2019). I received approval for this project by submitting a modification application to a previously approved research project. The University of Ottawa's Social Sciences Research Ethics Board (REB) approved the study, and the letter of approval is in Appendix A.

2.5 Conceptual framework

The goal of this project is to better understand the role of abortion doulas in Canada's reproductive health care system and is exploratory in nature. To best facilitate this project, I first completed a scoping review and then implemented an action-oriented research project.

According to Stephen Small and Lynet Uttal, action-oriented research is "a methodological approach for doing collaborative research with practitioners and community partners that can inform practice, programs, community development, and policy while contributing to the scientific knowledge base" (Small & Uttal, 2005, p. 936). The goal of action-oriented research is to produce knowledge ,add to existing research, and develop practical solutions based on the personal experiences of local groups and communities (Bargal, 2008; Small & Uttal, 2005). This is generally done to influence change within a specific context (Small & Uttal, 2005) Among social scientists, this approach is commonly used to address contemporary social issues and to remain accountable to local communities (Small & Uttal, 2005). This involves collaboration with non-researcher participants, recognizing the importance of both technical research skills and personal experience (Small, 1995).

For this project, implementing an action-oriented research framework resulted in a more flexible research design, increased acknowledgement of the influence of systems of power, and more commitment to the needs of the local community. Specifically, this approach allowed me to develop a contextual view of the research problem (Bradbury, 2015). By implementing action-oriented research into my in-depth interviews, I was able to gain more personal insight into the experiences of abortion doulas in Canada and remain connected to the local context.

Chapter 3: Accompaniment and abortion care: A scoping review

We have prepared this article for submission to *BMJ Sexual & Reproductive Health*. The article conforms to the structural, word count, and formatting requirements of this peer-reviewed journal.

Accompaniment and abortion care: A scoping review

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Abstract

Introduction: In much of the world, abortion care is legally restricted by gestational age and indication and access to safe, high quality, abortion care is often limited. Accompaniment may provide abortion seekers with increased support, improve the quality of care, and result in positive health and psychosocial outcomes. We undertook this scoping review to explore what is known about abortion accompaniment, including existing models and outcomes.

Methods: We followed an established five-stage scoping review framework. Through a search of five databases as well as a review of grey literature and purposively identified websites we identified 63 relevant sources. We reviewed and characterized these materials, identified themes, and noted gaps and priority areas for future research.

Results: Our scoping review yielded a range of sources focusing on an array of countries, most of which were published in 2018-2020. The body of literature focuses on three categories or models of accompaniment: known person, doula or (lay) midwife, and volunteer organization or community network. The limited body of research suggests that all models of accompaniment have the potential to offer emotional, logistical, and information support and are generally well received. This is especially true of accompaniment models that draw from community networks and take place outside of the formal health system.

Discussion: Different models of accompaniment exist, and all have the potential to meet the needs of abortion seekers while increasing access to safe, high quality, non-judgmental abortion care. More research is needed to identify ways to integrate accompaniment into formal health systems.

1. Introduction

The global need for abortion is consistent. Legal restrictions on abortion do not reduce the number of abortions or the abortion rate; rather, restrictions increases the rate of unsafe abortion (CRR, 2011; New, 2018). However, even in settings where abortion is broadly legal or decriminalized, barriers to accessing timely, affordable, and non-judgmental services abound (Aiken et al., 2018; Brack et al., 2017; Doran & Nancarrow, 2015; Janiak et al., 2014; Kavanaugh et al., 2019). Externalized and internalized abortion stigma also shape access to abortion care, the dynamics between clinicians and abortion patients, and the experience of disclosure (Action Canada, 2019; Baird & Millar, 2019; Cullen & Korolczuk, 2019; Harris, 2012; Izugbara et al., 2015). This overarching context has motivated clinicians, researchers, and activists to explore a variety of models to support abortion seekers obtain safe, effective, patient-centered abortion care both inside and outside of the formal health system.

Key definitions

- A known person or partner is defined as an individual who is known by the person having the abortion and has a relationship with them.
- A doula is defined as a lay individual with non-technical training in pregnancy, labour, or abortion support. Doulas that are familiar with all reproductive health scenarios are referred to as full spectrum doulas.
- A midwife (or professional midwife) is train health care provider with technical expertise in pregnancy and childbirth. However, in much of the world the terms “lay midwife,” “traditional midwife,” or traditional birth attendant are used to denote a lay individual with non-technical training and experience in pregnancy and delivery.
- Volunteer group or community organizations are defined as organized groups of people with specific goals. In this case the goal is to increase access to and improve abortion care.

Accompaniment in the context of abortion care is a relatively new concept; the bulk of the thinking about this topic has occurred in the last decade and the concept continues to evolve. Erdman and colleagues define accompaniment as a process or system where individuals and networks provide instruction and guidance throughout the abortion process, connect people in their time of need, and support individuals to reduce potential harm (Erdman et al., 2018). This

definition includes accompaniment that occurs both inside and outside of formal health care systems and encompasses different accompaniment models.

We undertook this scoping review to better understand what is known about abortion accompaniment. Employing the broad definition by Erdman and colleagues we also aimed to characterize models of abortion accompaniment, document outcomes associated with accompaniment, and identify gaps and priority areas for future research.

2. Methods

2.1 Protocol

We used the methodological framework proposed by Arksey and O'Malley (Arksey & O'Malley, 2005) and revised by Levac, Colquhoun, and O'Brien (Levac et al., 2010) when designing this study. This five-step process began with identifying our research question. We identified several relevant studies but retained a select few based on specified criteria. Then we charted the data which enabled us to collate, summarize, and report the results. For this project we excluded the optional consultation phase given the global nature of the review. We adopted the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for scoping reviews (PRISMA-ScR) (Tricco et al., 2018) when organizing this paper.

2.2 Search strategy

We performed a preliminary search for existing scoping reviews, systematic reviews, and primary papers and research syntheses to gain familiarity with relevant terminology and ensure our review was comprehensive. Our literature review included searches of Ovid PubMed/MEDLINE, OSF, CINAHL, Embase, PROSPERO, Cochrane Database of Systematic

Reviews, Google Scholar, BJM Open, BMC Systematic Reviews, Epistemonikos, and the JBI Evidence Synthesis. We conducted our search with the terms *accompaniment*, *companionship*, *escort*, *associate*, *abortion care*, *reproductive care*, *termination of pregnancy*, *medical/medication abortion*, and *surgical abortion*. While there were multiple studies mentioning accompaniment, there were few studies focused on the topic. Moreover, we found no consistent language used to describe accompaniment in the context of abortion care. Based on our preliminary findings, we executed the main search in five databases (Medline, PsychInfo, JSTOR, ProQuest, and Scopus) using the terms *abortion*, *doula*, *accompaniment*, *companion*, and *escort*. We then examined the reference lists of all included articles. Lastly, we performed a grey literature search by first agreeing on a list of organizations and websites to examine, and then independently searching through each item for additional literature.

2.3 Eligibility criteria

We included literature from all types of media without language or population restriction, published between 2010 and 2020 (inclusive). This reflects our research goal as we aimed to determine what is currently known about accompaniment in abortion care contexts on a global level. Therefore, we included items that specifically focused on accompaniment in abortion care, and we excluded items if they focused on general social support, social status, relationship status, family relationships, miscarriage, pregnancy, adoption, childbirth, or any other non-abortion related reproductive health topic. We did not exclude literature based on country, language, research method used, or source type.

2.4 Study selection

One reviewer (SP) screened titles and abstracts from the database search and used Covidence to organize all literature moved to the full text review. Two reviewers (SP and AD) then independently screened candidate source material using the predetermined inclusion and exclusion criteria and examined references for additional articles. Both reviewers agreed on inclusion of items and any disagreement was solved through discussion. A third reviewer (AMF) was available to adjudicate disagreements, but this was unnecessary. The reviewers then completed the grey literature search independently.

2.5 Data charting

We extracted data from included literature using a predetermined format in Google Sheets. Specifically, we extracted the type of source, aims, the country of study, research methods used (if applicable), overall conclusions, and the type of accompaniment discussed. Using ATLAS.ti software to manage the data, we reviewed each source and summarized its content, making specific note of key points or issues raised. We then reviewed the corpus of sources for categories of content, themes, and missing or absent content. This process allowed us to synthesize the results and characterize the body of relevant literature.

3. Results

3.1 Search results

We identified a total of 1760 items in our database search, from which we moved 64 items to full text review. Of these items, we excluded 27 sources. Exclusion occurred because of insufficient or irrelevant discussion of accompaniment (17), accompaniment provided in a non-

abortion context (8), or dates outside of the inclusion criteria (2). After exclusion, we included 37 items in the final review. This consisted of 26 peer reviewed articles, nine documents, one news article, and one thesis. From these articles, we identified and included one additional article from the reference list search. We then performed a grey literature search to extract relevant reports, websites, and other source material not published in commercial journals. Through this process, we examined the publications and websites of 36 unique organizations and identified 25 sources for inclusion. This included eight websites, five blog posts, five website announcements, three reports, three news articles, and one training guide. All three searches yielded a total of 63 sources.

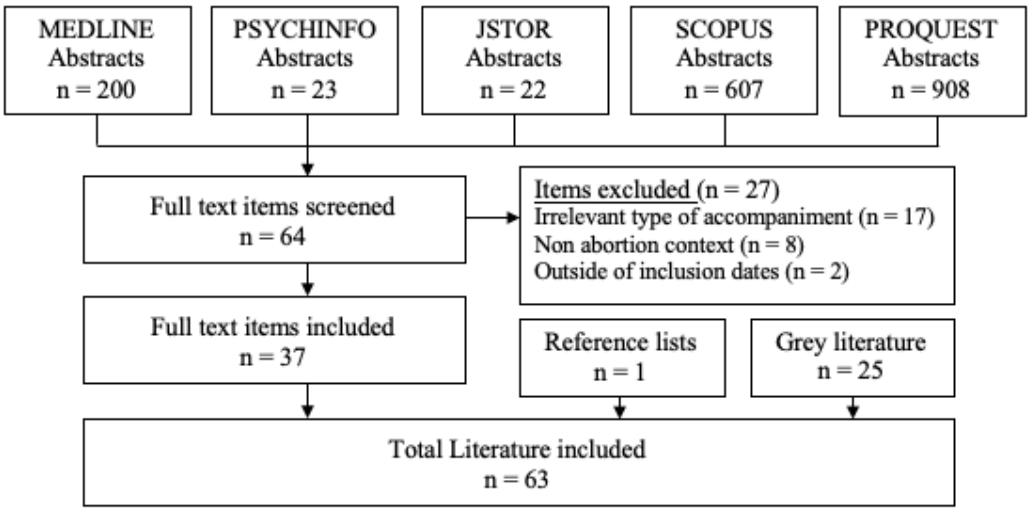

Figure 1. Overview of article selection for scoping review (PRISMA-ScR flow chart)

3.2 Literature characteristics

Most sources were set in the United States (n=18), Argentina (n=10), Mexico (n=8), or Canada (n=6). Thirteen other countries were the focus of at least on article, three studies took place in multiple countries, three items did not specify region, and one article focused on three countries but did not specify which countries were included. The included literature discussed

accompaniment provided by a volunteer group or network (n=28), by a doula or midwife (n=20), by a known person (n=12), or included all types of accompaniments (n=3). Of the peer reviewed journal articles (n=27), 12 were qualitative, 11 were quantitative, two were mixed methods, and two were reviews. We present these characteristics in Table 1. Included source materials were published throughout the eligible date range but nearly half of all sources were published in 2019 and 2020 (Fig. 2).

Table 1. Characteristics of sources in our scoping review on abortion accompaniment (N=63)

Characteristic	Frequency	Percentage (%)
Type of source material (N=63)		
Database search	n=37	
Peer reviewed article	26	41.3
Document	9	14.3
News Article	1	1.6
Thesis	1	1.6
Reference list search	n=1	
Peer reviewed article	1	1.6
Grey literature search	n=25	
Website	8	12.7
Blog post	5	7.9
Website announcement	5	7.9
Report	3	4.8
News article	3	4.8
Training guide	1	1.6
Research methods (n=27)		
Qualitative	n=12	44.4
Interviews	6	22.2
Ethnography	2	7.4
Focus groups	2	7.4
Descriptive/exploratory	1	3.7
Commentary	1	3.7
Quantitative	n=11	40.7
Cross sectional	5	18.5
Prospective	3	11.1
RCT	2	7.4
Experimental	1	3.7
Review	n=2	7.4
Mixed method	n=2	7.4

Region of focus (N=63)[1]		
USA	18 (17 specific, 1 multi country)	25.4
Argentina	10 (8 specific, 2 multi country)	14.1
Canada	8 (7 specific, 1 multi country)	11.3
Mexico	8	11.3
Unspecified	3	4.2
India	2 (1 specific, 1 multi country)	2.8
Poland	2	2.8
Sweden	2 (1 specific, 1 multi country)	2.8
The Netherlands	2	2.8
3 unspecified countries	1	1.4
Bangladesh	1	1.4
Belgium	1	1.4
Bosnia and Herzegovina	1	1.4
Chile	1 (multi country)	1.4
Ecuador	1 (multi country)	1.4
Egypt	1 (multi country)	1.4
Ethiopia	1	1.4
France	1	1.4
Iran	1	1.4
Mali	1	1.4
Nigeria	1 (multi country)	1.4
Pakistan	1	1.4
Thailand	1	1.4
Uganda	1	1.4
United Kingdom	1 (multi country)	1.4
Type of accompaniment (N=63)		
Volunteer group/community organization	28	44.4
Doula or midwife	20	31.7
Known person	12	19.0
All types of accompaniment	3	4.8

[1] Note that while there were 63 pieces of literature, some sources included multiple countries. This table lists counts each time a country was included and therefore this section's total is higher (71) than the total number of sources.

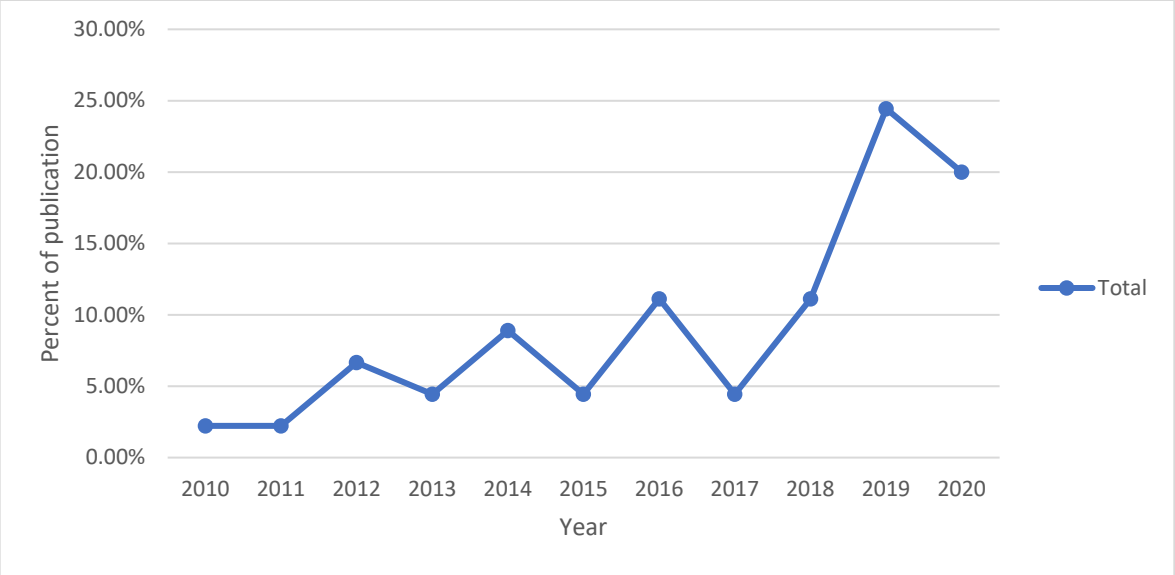

Figure 2. Distribution of included literature by percentage (%) and publication year

3.3 Accompaniment by a known person

We identified 12 studies that focused on accompaniment by a known person, mainly by a partner or parent. These studies were from the United States (3 studies), with one source each from Argentina, Bangladesh, Canada, France, India, Iran, Mexico, and Sweden. One study was a multi-country review (Canada, Egypt, India, Sweden, the United Kingdom, and the United States). A range of study designs were used including a systematic review (Altshuler et al., 2016) as well as quantitative, qualitative and mixed methods. All these sources were published in peer-reviewed articles signaling that this type of accompaniment is a relatively established area of research.

Partner accompaniment studies showed that this type of accompaniment had a positive impact on women's abortion experiences. Women from Iran, Argentina, and Sweden reported that they felt more supported by the presence of male partners (as well as family or friends) during their abortion (Kamranpour et al., 2019; Kero et al., 2010; Ramos et al., 2015; Veiga et

al., 2011). Known persons provided emotional and financial support and helped with daily activities in the wake of the abortion (Kamranpour et al., 2019; Kero et al., 2010). A Canadian study found that both the abortion seeker and the person accompanying the abortion patient reported positive experiences, but nurses in abortion providing facilities had mixed feelings because the accompanying person was often not helpful (Veiga et al., 2011).

The role and identity of men as accompanying partners emerged as a key issue in this corpus of literature. An assessment from Sweden showed that being at home made men feel more involved, while they felt excluded and unsure about their role during appointments (Kero et al., 2010). A study from the United States illustrated how anti-abortion protestors targeted male partners outside abortion providing clinics to shame them and encourage them to "control" their abortion seeking partners (Arey, 2020). Another study in the United States reported that male partners felt tension around defining their role and their masculinity in the context of their partners' abortion (Newton et al., 2020). Male partner coercion and abuse were also highlighted in some studies. For women who reported experiencing intimate partner violence in Bangladesh, husband accompaniment significantly delayed initiation of post abortion contraception (Pearson et al., 2017). In contrast, a few unmarried adolescent girls from a study in India expressed that male partner accompaniment helped with access to money (Sowmini, 2013).

Only two studies specifically focused on parental accompaniment for women under 18 years of age. Although largely accompanied by mothers, other adults including fathers, guardians, or caregivers, were reported as well. A study from France showed that an accompanying adult is a crucial source of support, particularly for decision-making. However, a few participants reported having a poor relationship with their parents and stated that the abortion was not their own choice (Le Lous et al., 2019). Another study from Mexico found that

adolescents experienced a lack of privacy and accessibility to counselling services when accompanied by parents (Clyde et al., 2013).

3.4 Accompaniment by a doula or (lay) midwife

We identified 20 sources focused on accompaniment by a doula or lay midwife. This body of literature primarily focused on the United States (12 studies) and Canada (6 studies) with one source from Poland and another multi-country study focusing on Argentina, Chile, and Ecuador. Available literature took the form of grey literature (13 sources, including six news articles, three website announcements, two wire feeds, and two websites), three quantitative and three qualitative research articles, and one review.

A few themes emerged from these sources. First, a number of sources identified a need to define accompaniment in the context of abortion care and also provide clarification on the roles of doulas and midwives (Chor et al., 2012; Whaley, 2014; Women Help Women, 2014). Second, several sources claimed that the normalization and integration of accompaniment in the context of abortion care has the potential to greatly benefit those involved (CBC, 2019; Chor et al., 2012). Indeed, several studies mentioned that this model of accompaniment benefited both the abortion seeker (more positive experience) and the doula/midwife (increased self-esteem) (Chor et al., 2015, 2016; Vosters, 2012; Whaley, 2014; Whitten, 2019). In contrast, on study reported that abortion providers had negative experiences with doulas in the clinic (Robinson et al., 2015). Third, the literature provided insight into the many ways in which incorporation of doulas and (lay) midwives could potentially improve abortion care. Specifically, sources claim that having a doula or midwife present could allow for more patient-centered care models (Chor et al., 2018),

increase the continuity of care (Vosters, 2012), and improve access to abortion services (Action Canada, 2020b, 2020a; CBC, 2019; Kurji et al., 2019; Whitten, 2019).

3.5 Accompaniment by members of a volunteer organization

Twenty-eight sources focused on accompaniment by members of volunteer or community organizations or networks. Seven of these were peer-reviewed journal articles and 21 were grey literature sources including web pages, organization documents, and blog posts. Much of this literature focused on Argentina and Mexico (7 sources each), but other sources reported on research and activities in the Netherlands and the United States (2 studies each). There was one source each from Bosnia and Herzegovina, Mali, Pakistan, Poland, Thailand, Uganda, and there was one multi-country study focused on Argentina and Nigeria. Two sources described general information documents by international organizations that did not specify a country of focus, and one study reported on a multi-country initiative but did not divulge the countries of study. Of the peer-reviewed studies three were quantitative, two of which were prospective in design, whereas four were qualitative studies, and one was a commentary for advocacy.

Overall, this body of literature indicates that accompaniment through this model are especially important in promoting and supporting safe and effective self-managed medication abortion practices (Moseson, et al., 2020). A study from Mexico showed that accompaniment through a feminist organization (Las Fuertes en Red) not only provided abortion seekers with emotional and social support, but also fostered mobilized efforts to decriminalize abortion (Singer, 2019). Vulnerable populations, like sex workers in Uganda, reported that accompaniment by a peer or community outreach educator gave them comfort (Marlow et al.,

2014) and migrant and refugee women in a humanitarian setting in Northern Thailand reported accompaniment as overwhelmingly positive (Tousaw et al., 2017).

Studies also documented the experiences of those doing the accompaniment. In Argentina, the feminist network, *Socorristas en Red*, not only provided informational, logistical, and medical support to those self-managing second trimester abortions, they also understood their wok as activism that aimed to both decriminalize and destigmatize abortion (La Revuelta, 2018a; Socorristas en Red, 2020; Zurbriggen et al., 2018). A paper drawing from ethnographic research in Mexico City discussed feminist activism and abortion accompaniment as a form of reproductive labour that could be an empowering yet challenging experience, especially if the person doing the accompaniment did not know the outcome of people's stories (Krauss, 2016, 2019).

We also found several websites and other sources dedicated to linking abortion seekers with available volunteer or community organizations providing accompaniment. This included networks in the Netherlands, (Abortion Network Amsterdam, n.d.; Abortusbuddy, 2021), the United States (Greenburg, 2011; Women Help Women, 2019), Europe (Women Help Women, n.d.-a), Mexico (Las Libres, 2014; Women Help Women, n.d.-b), and Pakistan (Irum & Monga, 2020). These websites described the volunteer organization itself and included information on accompaniment services. Blog posts and organization websites shared details of and learnings from successful accompaniment models in Argentina (La Revuelta, 2018b, 2018c), Bosnia Herzegovina (IPPF, 2016), and Mexico (Balance, 2019; Ipas, 2014) and provided training resources to expand accompaniment networks and support best practices (Ipas, 2021; La Revuelta, 2018b, 2018c; Marie Stopes International, 2020)

4. Discussion

4.1 General implications

Accompaniment in the context of abortion care has recently gained traction as a way to increase access and improve care for those seeking abortions. Known persons, doulas or midwives, and volunteer organizations constitute the three models' categories or models of accompaniment. Overall, sources site the positive impact (Chor et al., 2015, 2016; Whaley, 2014) and feasibility of accompaniment models (Moseson, Keefe-Oates, et al., 2020).

Accompaniment by partner, parent, or other known person is relatively well-documented in the literature. Involving men (and other more recently gender expansive interventions centering non-pregnant partners) has been a focus of efforts to improve prenatal care (Suandi et al., 2020), family planning service utilization (Mwaikambo et al., 2011), and delivery services (Lim et al., 2010), as well as abortion (Altshuler et al., 2016). These findings have been thoroughly examined and suggest that male partners can be allies in improving women's reproductive health care experiences, including with abortion services. However, male partner accompaniment can also be an instrument of control and a reflection of violence (Pearson et al., 2017; Sowmini, 2013); efforts to increase men's involvement in abortion care must take these realities into account. In contrast, there is a relative dearth of studies focused on parental accompaniment. Further exploration of the role of parental accompaniment in the experiences of adolescent abortion seekers appears warranted.

Literature on accompaniment from doulas and (lay) midwives has emerged recently. Evidence from several studies suggests that incorporating abortion doulas into clinic-based abortion services within the formal health system improves the experience of abortion patients, increases continuity of care, makes abortion care more patient-centered and relieves some of the

counseling and information-dissemination responsibilities from clinic staff (Chor et al., 2015, 2016, 2018; The Doula Project, 2022; Vosters, 2012; Whitten, 2019). However, these studies are heavily concentrated in the United States and in clinic settings where known persons (especially male partners) are not allowed to accompany patients. Further research is needed to explore integrated abortion doula programs in other country and health system contexts.

In contrast, most of the literature on accompaniment by volunteer organization comes from Argentina and Mexico and occurs outside of the formal health care setting. The emerging evidence from around the world suggests that a range of accompaniment and support models can facilitate access to safe and effective self-managed abortion at a range of gestational ages using misoprostol with or without mifepristone. Many of these organizations and networks are explicitly feminist in the orientation and view their work as both centering the individual abortion seeker and advancing abortion rights and reproductive justice. However, the work of these networks is only just making its way into peer-reviewed literature. Rigorous studies documenting different accompaniment models, including their orientations, operationalization, and outcomes, could facilitate replication, knowledge dissemination, and promotion of best practices.

4.2 Limitations

We attempted to use clear and consistent search terms to identify the relevant literature. However, we may have missed sources due to language and translation issues. We also intentionally omitted the study appraisal task, and thus, we are unable to comment on the quality of the research we included in the review. We made the decision to use Google rather than Google Scholar for our Internet search; this allowed us to include a range of sources from

grassroots organizations which may have made identifying more academically oriented grey literature more challenging.

5. Conclusion

Different models of accompaniment exist, and all have the potential to meet the needs of abortion seekers while increasing access to safe, high quality, non-judgmental abortion care. This scoping review has uncovered several areas of future research. First, exploring the role of parents accompanying adolescent abortion seekers. Second, identifying integration opportunities for doula accompaniment or other lay care workers into the formal health care system. Third, learning from the experiences of volunteer organizations and community networks that provide support outside the formal health care system.

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Chapter 4: "I'm actually helping somebody out there!": A qualitative study of the experiences and opinions of abortion doulas in Canada

We have prepared this article for submission to *Contraception*. The manuscript conforms to the structural, word count, and formatting requirements of this peer-reviewed journal.

"I'm actually helping somebody out there!": A qualitative study of the experiences and opinions of abortion doulas in Canada

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Abstract

Objective: We aimed to explore the experiences and perspectives of abortion doulas in Canada and solicit their recommendations on how the abortion care system could be improved.

Methods: In 2021, using a multi-modal recruitment strategy, we conducted semi-structured interviews with nine abortion doulas working in Canada. We explored our participants' journeys to becoming abortion doulas as well as their training and network affiliations, experiences with clients, and opinions on abortion services in Canada. We analyzed the interviews for content and themes using deductive and inductive techniques.

Results: Personal experiences with the abortion care system, a desire to serve their communities, and a commitment to reproductive justice inspired our participants to become abortion doulas. The abortion doulas in our study endeavored to create a non-judgmental and supportive environment for abortion seekers and described their work as both rewarding and challenging. Participants identified a number of ways in which abortion policies and services could be improved in Canada, including increasing education about abortion among providers and the public, expanding access to medication abortion care, and enforcing the Canada Health Act.

Conclusions: Abortion doulas have the potential to play an important role in helping Canadian abortion seekers navigate the health care system, improving access to abortion care, and reducing inequities related to geography and structural oppression. Conducting additional research with abortion doulas and their clients, identifying ways to support and lift up the work of abortion doulas, and exploring opportunities for integrating abortion doulas into the health system appear warranted.

Implications: Although the Supreme Court of Canada decriminalized abortion in 1988, persistent barriers to access exist. Our exploratory study suggests that abortion doulas have the potential to play an important role in providing emotional, social, and navigational support to abortion seekers. Further research to provide deeper insight into how abortion doulas could be integrated into the abortion care system appears warranted.

Key words: Abortion, Canada, doula, qualitative research, reproductive health

1. Introduction

In 1988 the Supreme Court of Canada decriminalized abortion and in 1995 the government of Canada deemed abortion a medically necessary service resulting in "universal" cost coverage [1-2]. However, the accessibility of abortion services reflects persistent inequities [3-4]. For example, clinic-based abortion services are concentrated in urban areas and near the Canada-United States border, provincial regulations in New Brunswick limit provincial funding of instrumentation abortion care to hospitals, and there are no abortion providers offering services after 16 weeks gestation east of Quebec [2, 4-8]. As a result, some abortion seekers must travel long distances or across provincial and national borders to receive care, influencing both timing and disclosure [7-9]. Further, systems of oppression, including racism, settler colonialism, and language hierarchies, and externalized and internalized stigma influence accessibility, the quality of abortion care, and the overarching care experience [7, 10-12].

In recent years, reproductive health professionals and activists have undertaken a number of efforts to help Canadian abortion seekers navigate the complicated health system landscape and provide them with financial and emotional support. This has included the development and expansion of patient support and navigation hotlines and the creation of community-based systems to connect abortion seekers with medication abortion providers [13-15]. Media accounts also suggest that abortion doulas are helping Canadian abortion seekers navigate barriers to obtaining timely, high quality, and non-judgmental care [16-19].

Abortion doulas are lay care workers who provide help and support before, during, or after an abortion. Research from the United States over the last decade suggests that abortion doulas can play an important role in promoting positive outcomes and patient-centered abortion care and are well received by abortion seekers [20-22]. However, no published research has

centered the experiences and perspectives of abortion doulas in Canada. Through this exploratory qualitative study, we aimed to better understand the work of abortion doulas in Canada and their perspectives on how the abortion care system could be improved.

2. Methods

Between March and September of 2022, we conducted in-depth, semi-structured interviews with abortion doulas working in Canada. Eligible participants were self-identified abortion doulas who worked in any geographic area of Canada, were sufficiently proficient in English or French to complete the interview, and had access to a phone/Skype/audio-Zoom. We provided all participants with a CAD40 gift card (USD30) as a thank you.

2.1 Recruitment

We used a multi-modal strategy to recruit participants. We circulated information about the study on listservs and social media platforms and shared information about the study with organizations working in the sexual and reproductive health field in Canada. We also recruited participants through our personal and professional networks. LL, an abortion doula who has practiced in several provinces, leveraged her connections with the abortion doula community and formal doula networks to distribute information about the study and recruit participants.

2.2 Data collection

SP, a master's student in Interdisciplinary Health Sciences at the University of Ottawa, conducted all interviews after conducting an initial screen, confirming eligibility and obtaining consent. Using an interview guide developed specifically for this study, SP guided the

conversation while still allowing participants to explore topics they deemed relevant. Interviews began with a discussion of the participant's demographic characteristics, educational and professional background, and motivations for becoming an abortion doula. The interviews then explored the participant's practice, including duration, time commitment, client load, affiliations, and payment models. We then moved to discussing the participant's training and experiences working with clients, the ways in which being an abortion doula has shaped the participant's views of abortion, feminism, and reproductive and social justice, and how the participant shares information about abortion work with other people her/their lives. We ended the interview by discussing ways in which abortion doulas in Canada could be supported better and how the abortion care system in could be improved.

Interviews lasted an average of 80 minutes and all took place over audio-Zoom in English. With participants' consent we recorded all interviews and a team of volunteers later transcribed them verbatim. SP took notes during the interview and memoed immediately afterward, a process that allowed for reflection on the participant-interviewer interaction and allowed us to establish thematic saturation [23]. We reached thematic saturation after eight interviews and conducted one additional interview as confirmation.

2.3 Data analysis

We analyzed the interviews for content and themes using both deductive and inductive techniques [24-26]. We established a preliminary codebook using the project objectives, interview guide, and team discussions. SP used ATLAS.ti to manage the data (transcripts, memos, and notes) and added codes and categories as they emerged during the coding and early

analytic process. In the final analytic phase, the study team identified and defined themes and then worked to understand the relationship between these ideas and interpret their meaning.

2.4 Ethical considerations

The University of Ottawa's Social Science and Humanities Research Ethics Board approved this study. After characterizing our participants, we organized our results around key themes and used illustrative quotes throughout. All but one of our participants asked that we use their real name and location in all reports and publications; we have assigned a pseudonym to the other participant.

3. Results

3.1 Participant characteristics

Nine abortion doulas from four provinces, Alberta, Quebec, Nova Scotia, and Ontario, participated in our study. Our study participants were between the ages of 26 and 48 at the time of the interview; 34 being the average age. Seven of our participants used she/her pronouns and two used she/they pronouns. Eight participants identified as white/Caucasian and one identified as Latin American. Our participants reflected a range of educational backgrounds and have been practicing as abortion doulas between 1 and 10 years.

3.2 Abortion doulas provide a wide variety of services

> If you just want to give people rides back and forth, then that's it. If you do want to do more full-on support and travel with people…we offer peer support…We'll have people email us and be like you know, I'm a mom of two, I recently had an abortion, I'd like to chat with somebody. We'll find you a mom of two who had an abortion so you can chat. Simply peer to peer. You know, if you just want to be, if you just want to fundraise, if

> you just want to talk to your friends about it. There are just so many ways you can do this work. -- Shannon, 48, Nova Scotia

Abortion doulas in our study explained that their work encompasses a wide range of services and supports. All of the abortion doulas in our study provided, or have provided, accompaniment and physical supports, such as driving abortion seekers to a clinic and traveling with a client out of province. However, many of our participants described their primary role as offering navigational support such as linking an abortion seeker with a clinic or provider, booking appointments for their clients, answering questions via text or phone, and directing clients to medically accurate information and services. As Autumn age 43 from Alberta explained, "I make sure that they get the name of the actual clinic in their area because there is just so much nonsense around these fake clinics. It's really easy to call one of them by mistake." Several of our more experienced participants explained that they now focus on training other doulas and managing the logistics of community-based organizations and abortion funds. Shannon reported,

> I coordinate, and I do education. So, there are times where I get to be a volunteer and go drive people and all of it—but that's generally not what I get to do. I'm answering questions, I'm doing trainings, I'm, you know, I'm in charge of collecting money and distributing money. So that's actually what I do.

3.3 Abortion doula work is rewarding, but can be challenging

> Being able to help them out and feel like you actually made a really big difference in somebody's life is just like, worth it, no matter what. -- Jess, 26, Nova Scotia

Our study participants repeatedly described the rewarding nature of the work. Abortion doulas, like Jess, reported finding purpose and fulfillment in supporting individual abortion seekers and members of their communities. As abortion doulas in our study were often motivated

out of a commitment to reproductive justice, many of our participants underscored the importance of living their values and all reported feeling good about their work.

However, abortion doulas in our study also noted that the work can be challenging. Lauren, a 39-year-old abortion doula working in Alberta, explained that emotional burnout and exhaustion were common among those working in this space.

> You're dealing with something that is so emotional and so personal for your clients and the fact that there are rules for different stages [of pregnancy] and the fact that how you provide support for somebody who is in a city vs someone who has to get to a city [is different]…it is exhausting work…it comes down to the frustration…the amount of time I have had to spend finding people access to the abortion pill, the inconsistency in prescribers, the inconsistencies in pharmacies that will carry the product…it is not a fun job. It is like trying to catch a ball of sand with your bare hands, if that makes sense, you might get some of it, you might get a lot of it, [but] a fair percentage is going to slip through your fingers.

Other participants cited conflicts with abortion providers and other members of the abortion care team as being a challenge. As Daniela, a 31-year-old abortion doula from Ontario, explained:

> There's been a hospital where it was really hard to advocate and be present as a doula. They were just like, "We don't care. What are you doing here?" So, that sense of like people not really getting why doulas are there and being like minimized or like told that you cannot come in…That is hard…I feel it's a really important role and I feel happy that I'm able to support people in a way that they don't feel judged that they know that their choices are valid, that you know they're cared for.

3.4 Abortion doulas provide support to individuals and their communities

> Sometimes what I'm doing is like 20 minutes of my day, I might not think about that person again, ever. But like without the…volunteer abortion role, or just volunteer role, that person wouldn't be able to have an abortion, and their life would look completely different. -- Bridget, 28, Nova Scotia

Our participants reflected on how their work helps individuals obtain the abortion care they need, want, and deserve. Abortion doulas took great pride in being of service to individual abortion seekers. As 27-year-old Monica from Ontario explained, "Being able to be there for

someone as they're going through all of those things, [being] a second sounding board or being able to have that person in the room that's not connected to you emotionally or familially or having any…personal relationship with…There's just so much value in it." But participants also discussed how their work helps their community as a whole. As 26-year-old Jess, an abortion doula working in Nova Scotia, said: "Abortion care really allows me to just impact things in a small way in my community and make it a little bit better and makes me feel like I'm not actively making things worse. I'm actually helping somebody out there!"

3.5 Abortion seekers are relieved to receive non-judgmental support

> You can be like, "I'm not ready to give up drinking and partying" and I would be like, props, good for you for knowing what you want to do with your life. [You say] "I hate kids, I don't want children". Cool, let me help you get this ASAP so that you can go back to that childfree life. "I have seven kids and I'm just so worried I can't afford it." Don't worry about it, it's totally okay like you don't need to justify…Its memorable because like 90% of people that I am talking to…even if it is through text message, you can almost feel the change in their messages, like "holy shit, this is no judgement." -- Lauren

Participants in our study reflected repeatedly on both the internalized and externalized stigma that surrounds abortion care in Canada. Abortion doulas discussed how many of their clients expected to be met with judgment and were then relieved when this didn't materialize. A number of our participants discussed how they used specific language to create a non-judgmental space where clients don't need to explain themselves. As Shannon reported:

> We just don't ask questions. And so, no one ever has to justify why they're asking us for help. And we just talk about things in as unstigmatizing language possible. "Oh, you're having an abortion? How can we help you? What do you need?"…They're like "Oh, I don't have to hedge. I don't have to give this big, long explanation of why this happened, I don't need any of that."

3.6 Abortion doulas want their work to be recognized as a way of improving abortion services and access in Canada

> You shouldn't have to jump through hoops to be able to offer abortion [support]. -- Julie, 28, Ontario

Participants reported a need for increased awareness about, and integration of, abortion doulas into the abortion care system in Canada. Several of our participants were motivated to participate in our study because they felt that research would increase the legitimacy of abortion doulas. As Mélina age 33 from Quebec said, "If there is more research, there'll be more understanding, more support, more credibility." Participants in our study also noted that abortion doulas need more financial support to continue their work and that this, in turn, will help them become more integrated with the abortion care community. As Daniela explained, "[We need] funding so that we can be paid for our work…[and be included in] conversations around health provision and abortions…[There's] something that we have to offer that is different from other folks involved in this field."

Our participants had a number of suggestions as to how to improve abortion care in Canada. First, abortion doulas indicated that there is a need to improve education about abortion among providers and the public. As Autumn said "This is just straight up shocking how Canada goes ahead and like legalizes mife [mifepristone] and nobody has bothered to educate anybody on how it's used or what… I wish that we could educate pharmacists and doctors on exactly what this is. Yes, it's legal. Yes, you can prescribe it. Yes, you can dispense it." Several participants also noted the importance of expanding access to medication abortion care, particularly through community-based services and demedicalized strategies. Mélina said "my dream would be like if we could like [have] more self-managed abortions… give the opportunity to have more rapid

access to abortion pills." Finally, a number of our participants noted the importance of enforcing the Canada Health Act. As Shannon reported "Abortion is healthcare. It is covered under the Canada Health Act, just like every other medical procedure… [we need] a change in the application of the health act."

4. Discussion

4.1 General implications

Despite their involvement in abortion care, the experiences of abortion doulas in Canada are not well documented. As a result, we currently have no information about how many abortion doulas are active, how often abortion doulas are used, or the impact of their support. Our interviews highlight that abortion doulas are excited about the prospect of research centering their perspectives and experiences and believe this could be a way to increase the legitimacy of and support for their work. Working with abortion doulas, both individuals and networks, to develop a research agenda would be an appropriate next step.

The experiences of the abortion doulas in our study suggest that these members of the care workforce are offering an important, yet undervalued, service. Helping clients navigate complex systems, offering non-judgment and non-stigmatizing support, and providing medically accurate information, fill critical needs and point to gaps in the existing abortion care system. These findings are consistent with a broader body of work on barriers to abortion access in Canada [7-9,27]. Participants in our study, even those who were spending hours each week in service to their clients, were largely volunteering their time. Exploring ways to compensate individual abortion doulas as well as doula networks is warranted and would be welcomed.

Offering financial support to abortion doulas could be a first step to integrating these frontline workers into the abortion care system. There are certainly sensitivities associated with incorporating care workers who challenge elements of the existing system into that same system. And several of our participants referenced the tensions that can exist between abortion doulas and abortion providers. However, identifying pathways for collaboration or models of integration could help meet the logistical and emotional support needs of some Canadian abortion seekers.

4.2 Limitations

Although qualitative research is not designed to be generalizable or representative, we acknowledge that this is a small exploratory study. Future research would benefit from additional perspectives, including from Francophone and Indigenous abortion doulas as well as from those who are working in Canada's territories. Further, all of the abortion doulas in our project worked with clients to obtain abortion care through the formal health system. This project did not document the experiences of those working with clients who are obtaining abortion care or self-managing their abortions outside of the abortion care system.

4.3 Conclusion

The results from our exploratory study suggest that abortion doulas have the potential to play a valuable role in helping Canadian abortion seekers obtain non-judgmental, patient-centered abortion care. Conducting additional research with abortion doulas and their clients, exploring ways to compensate abortion doulas for their work, and identifying avenues for incorporating abortion doulas into the health system appear warranted.

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Chapter 5: Discussion

This final chapter of my thesis will begin by integrating the results of the two components of this project. I will then explore the significance and implications of these findings as well as the limitations of this thesis. Afterward, I will discuss potential future directions and will reflect on my positionality as a researcher. I will end the thesis with concluding remarks.

5.1 Integration of results

The analysis from components one and two reveals three key findings. First, abortion doulas have an ill-defined position but act in accompaniment roles in Canada. Second, abortion doulas positively impact abortion-seekers and communities at large, which in turn leaves them with positive sentiments as they act in their accompaniment roles. Third, current literature has identified ways to improve abortion care in Canada which align with the perspectives of abortion doulas. This creates a pathway for meaningful change.

5.1.1 Accompaniment & the roles of abortion doulas

Abortion status and necessity can be triggered by global events (Dias Amaral & Sakellariou, 2021; Fetters et al., 2020; M. Kumar et al., 2020). For example, in March of 2020, the World Health Organization (WHO) declared SARS-CoV-2 as a global pandemic (WHO, 2020). The novel coronavirus quickly spread around the globe causing millions of deaths, taxing public health systems, and resulting in lockdowns, travel restrictions, and global job loss. Consequently, the landscape of abortion access has changed drastically around the world, including Canada (Abortion Rights Coalition of Canada, 2022; Bojovic et al., 2021; Fulcher et al., 2022; Hukku et al., 2022). The COVID-19 pandemic perpetuated existing inequalities and

resulted in additional challenges in accessing abortion care (Fulcher et al., 2022). This includes uncertainties in economic opportunities and social support, reduced clinic capacities, and travel restrictions (Abortion Rights Coalition of Canada, 2022; Hukku et al., 2022). However, participating abortion doulas did not focus on COVID-19 when describing the challenges which impacted them in their role as abortion doulas. The pandemic required abortion doulas to shift from in-person to text/virtual support, move their training programs to virtual platforms, and impacted abortion doulas personally. But the barriers they helped their clients overcome were almost always related to long-standing or deep-rooted issues, such as accessing accurate information, language barriers, or fake anti-choice clinics. While COVID-19 required abortion doulas to adapt, abortion doulas considered the challenges caused by the pandemic to be small in comparison to everyday barriers. Yet, t COVID-19 related barriers have acted as a catalyst, re-enforcing the need for safe and accessible abortion care and spurring innovative service delivery changes (Vogel & Basky, 2022; Wahl & Ennis, 2022). Further, the COVID-19 pandemic created a situation where provincial leaders and medical care providers had to declare abortion an essential service and provide resources to make it accessible (Ennis et al., 2021; Wahl & Ennis, 2022). Doulas in our study noted the importance of this action. Thus, while COVID-19 has created and exacerbated barriers to accessing abortion care, this health care crisis has also expedited access to medication abortion and has served as a reminder of the importance of abortion access, including accompaniment services.

As revealed in the scoping review, before 2021, knowledge of abortion doulas and accompaniment models was relatively minimal although slowly increasing. Since then, the global context of abortion care has shifted, making access to abortion care even more relevant and pressing. On June 24th of 2022, the United States Supreme Court overturned *Roe v. Wade*, a

longstanding legal precedent that made abortion a federal, constitutional right (Totenberg & McCammon, 2022). As a result, the landscape of abortion access has drastically changed in the United States, prompting other countries, like Canada, to examine their own approach to abortion (Vogel & Duong, 2022). In response, media outlets and politicians have begun talking about abortion with more urgency (Neustaeter, 2022b). As a result, abortion doulas, among other accompaniment models, have been discussed more frequently in the media, with many organizations and groups beginning to talk about what can be done in Canada to ensure all people have access to abortion services (Butler, 2022; CBC, 2022; Neustaeter, 2022a).

Research shows that access to abortion is critical in preventing maternal death and disability (CRR, 2011; Haddad & Nour, 2009; Shah & Åhman, 2009), protecting the right to life and health (ARCC, 2018; CRR, 2011; CESCR, 2000), and supporting equity and equality (CEDAW, 1999; CRR, 2011). Accompaniment is a model of support designed to facilitate access to safe abortion and prevent harm from unsafe abortion and from harmful effects associated with the laws and policies that restrict access to abortion services. This model of support has become increasingly relevant given the global context. In Canada, accompaniment by abortion doulas is an emerging model and suggests that doulas could have an important role to play in addressing longstanding barriers to access (Bond, 2015; Chor et al., 2015; Stabnick, 2021).

In previous work, sources have reported a lack of understanding of the role of an abortion doula[1] and how they act to help improve abortion care (Chor et al., 2012; Whaley, 2014; Women Help Women, 2014). This remains true, as there has yet to be any formal definition of an

[1] The term abortion doula is used to clarify that the doula is involved in abortion care; however, it is important to note that not all doulas who provide support in the context of abortion refer to themselves as an abortion doula. Throughout the literature the term "full spectrum doula" is also commonly used, and this body of work includes individuals who use this designation or others with the same meaning.

abortion doula or the tasks they perform. The absence of role definition and the lack of formal regulation creates an opportunity for abortion doulas to offer multiple services which can be customized to meet the specific needs of the community. As an unregulated group of allied health providers, abortion doulas have the freedom to act in the way they best see fit. This allows abortion doulas to perform different tasks and adjust their method of support as needed. This results in each community getting more tailored support, rather than a standard approach which may not adequately meet their needs. Specifically, abortion doulas impact their direct geographic community and their social groups. The role of an abortion doula involves providing practical support and information that is specific to an area or group. This requires accurate knowledge of the local context which often stems from personal experience in that area. They also play the role of support person when they physically drive their client to an appointment which requires physical proximity to the clients they help. Further, abortion doulas act in activist roles and are often involved in advocacy work, helping to address stigma around abortion and other reproductive health topics. This type of involvement in reproductive justice can impact the community by reducing the stigma or fear related to abortion.

5.1.2 The impact of accompaniment provided by abortion doulas

As discovered in the scoping review, accompaniment in the context of abortion care is globally relevant. However, the models of accompaniment implemented seem to differ depending on the needs of the region or country. In Canada, needs are centered more around accessibility than legality (Keer et al., 2022; Sabourin & Burnett, 2012). Abortion was decriminalized in Canada in 1988 in *R. v. Morgentaler* (M. Burnett, 2019). However, abortion care remains inaccessible for many (Sachdeva, 2022; United Nations, 2016). Given that the focus

of abortion doulas is to make abortion more accessible (Butler, 2022; Kaur, 2022; Neustaeter, 2022a), accompaniment provided by abortion doulas is an appropriate and valuable model.

However, there has yet to be any formal integration of accompaniment provided by abortion doulas into the Canadian reproductive health care system. This may be the case for several reasons. First, the term doula, in the literature and in general cultural knowledge, is most often associated with birth. While there has been a recent uptake of the terms "full-spectrum doula" or "abortion doula" in the media or training programs, this has not yet been reflected in the literature or common parlance. Second, abortion providers may not always accept an abortion doula's presence and may discourage them from attending (Robinson et al., 2015). Third, the lack of funding supplied to abortion care could limit its ability to take on additional personnel or pay for support services. Unfortunately, this has reduced the impact abortion doulas can have. Without integration, acceptance, and funding, it may be harder for an abortion seeker to locate an abortion doula and it may be challenging for an abortion doula to provide support.

However, a growing body of research shows that the support provided by abortion doulas is valuable and accepted (CBC, 2019; Chor et al., 2015, 2016; Whaley, 2014; Whitten, 2019). Specifically, accompaniment provided by abortion doulas can be beneficial for both the abortion seeker and for the abortion care system. In a 2015 study, one research team conducted a randomized control trial that found that 96% of people who were given doula support during their abortion would recommend that abortion doulas be routinely used during abortion procedures (Chor et al., 2015). Further, in interviews with abortion doulas, many reported having clients who expressed their gratitude. Overall, abortion doulas seem to have a positive impact on their clients and provide support which is appreciated. Indeed, because many abortion facilities preclude loved ones from accompanying abortion patients during the process for security

reasons, abortion doulas may be especially valued in these contexts. From the perspective of the reproductive health care system, accompaniment provided by abortion doulas can make abortion care more patient centered (Chor et al., 2018), increase the continuity of abortion care (Vosters, 2012), and improve access to abortion (Action Canada, 2020b, 2020a; CBC, 2019; Kurji et al., 2019; Whitten, 2019). These factors provide strong evidence for the ongoing integration of doulas and expansion of their role in reproductive health care and abortion.

Lastly, acting in the role of an abortion doula, while challenging at times, has shown to be rewarding for abortion doulas. In our interviews, abortion doulas reported feeling fulfilled by doing work which is meaningful to them. Often, abortion doulas reported being motivated by reproductive justice and were excited to be involved in making a difference in their community and province. With evidence supporting the positive impact accompaniment provided by abortion doulas has on the abortion-seeker, abortion care system, and abortion doula themselves, it becomes clear that abortion doulas provide valuable care that merits expansion.

5.1.3. Improvements in abortion care

Throughout the history of abortion in Canada, there have been many challenges and issues in the abortion care system (Burnett, 2019). Until 1988, abortion in Canada was illegal in all cases except for if the pregnancy endangered the woman's health or life. The 1988 ruling, which declared that laws criminalizing abortion violated the *Charter of Rights and Freedoms*, set the stage for public funding. Since then, abortion care has become more accessible but geographic and other barriers remain. For instance, abortion care is provincially regulated causing considerable differences in access between provinces and territories (Keer et al., 2022; Reid, 2013; Sethna & Doull, 2013) and between rural and urban areas (Cohen, 2019; Norman et

al., 2013). In addition, abortion access is highly impacted by systems of oppression, including racism and colonialism, and structural oppressions related to income and nativity resulting in marginalized groups receiving poorer access to abortion care (Action Canada, 2021; Ferreira, 2022; Shoush & Bourgeois, 2022; United Nations, 2016). Canada's reproductive health care and abortion systems need improvement.

In interviews, abortion doulas working in Canada had many recommendations for ways to improve abortion care. Given their proximity to the day-to-day challenges of accessing abortion care, these are well informed recommendations inspired by personal experience. First, abortion doulas strongly suggest proper enforcement of the Canada Health Act, less regulation of medication abortion, more awareness around training for medication abortion providers, and mandatory abortion education in medical schools. Second, they suggest having more research on and for abortion doulas, increased funding for abortion doulas and abortion provision, integration of abortion doulas into standard abortion care, utilization of more inclusive and accurate use of language around abortion, integration of abortion into standard medical practice, more discussion with politicians, and increased access for later gestational age abortion care. These suggestions are oriented toward improving access to abortion in Canada.

These suggestions matter because they represent increased access for populations and areas that traditionally have less access to reproductive rights, and health care in general (K. Burnett et al., 2020; Loignon et al., 2015; Marwaha et al., 2021; Quesnel-Vallée et al., 2011; Smart et al., 2022). For example, abortion doulas recommended increased research on and for abortion doulas. This stemmed from discussions of the lack of information and awareness of abortion doulas and how to support doulas better. However, this was also related to the abortion doulas' experiences of supporting individuals who associate with one or more "disadvantaged"

or “marginalized” social positions (or groups). There continues to be insufficient research on the demographic characteristics of people who seek abortions in Canada, including race, ethnicity, age, sexual orientation, and nativity, or which populations need the most support. Although qualitative research suggests disparities in access and outcomes, without population level information it is hard to understand inequalities, let alone address them. Abortion doulas have an important perspective on the operationalization of the abortion care system in Canada and their recommendations deserve further consideration.

Results from the scoping review suggest integrating accompaniment provided by abortion doulas into standard practice in abortion care settings should be considered. The scoping review provides support for this integration and found evidence that accompaniment could increase continuity of care (Vosters, 2012) and make abortion more patient centered (Chor et al., 2018). These are crucial elements of care which have been identified as important by the College of Family Physicians of Canada and other professional medical associations and bodies (CFPC, 2009, 2021; CMPA, 2021; CNO, 2022). The abortion doulas in our study echoed this recommendation.

5.2 Significance and implications

This is the first study examining the opinions and experiences of abortion doulas in Canada, building on recent media coverage. The overarching goal of this work is to increase awareness to the experiences and opinions of abortion doulas and to support existing efforts aimed at improving abortion care in Canada. The findings of this project provide insight into the ways in which abortion care can be improved and how abortion doulas can be better supported. Further, these findings emphasize the important gaps in health care which abortion doulas are

currently filling. Finally, this thesis has created a starting point upon which more research can be conducted.

5.3 Limitations

This study had some notable limitations. First, we were unable to recruit participants from Newfoundland and Labrador, New Brunswick, Prince Edward Island, Manitoba, Saskatchewan, or the territories. Next, we were unable to recruit participants who were non-English speakers. These individuals may have had a unique perspective on the role of an abortion doula or report different challenges in accessing abortion care. Future research would benefit from including doulas working in different languages and a broader range of geographic areas. Lastly, our recruitment methods primarily utilized group connections. While this was an effective way to gain insight into the networks of abortion doulas, it may have prevented those who are less connected from participating in this project. Those who are less connected may be working in more remote areas and may have different perspectives and insights.

5.4 Future directions

Given that importance of community involvement in action-orientation research, I plan to disseminate the results of this thesis back to the community. I also intend to actively share the findings from this research with abortion providers in Canada. I presented on the result of this project at the 2022 annual meeting of the National Abortion Federation Canada and in the at the 2023 National Abortion Federation annual meeting in the US. I am also hopeful that both manuscripts resulting from this thesis project will be published in peer-reviewed journals. The

goal of these activities is to increase knowledge and awareness of abortion doulas, and to contribute to the growing body of literature on abortion in Canada.

Future studies should explore the remaining provinces and territories of Canada to gain insight into how doula experiences and access to care differs throughout the country. Further, this body of research would benefit from exploring the experiences of those who use the services provided by the doulas, as well as the impact of abortion doulas in Canada. Additional research should also be done to corroborate the findings and recommendations explored in this thesis. Lastly, future research should explore models of accompaniment involving abortion doulas in Canada.

5.5 Positionality statement

As a researcher doing reproductive health work, it is imperative that I reflect on the ways my identity or social positions influence my understanding of abortion and reproductive justice. As a white cis-gendered woman in a country founded on settler colonialism, I acknowledge my privilege and recognize that there are many ways this may have impacted my project. Importantly, the lenses that I bring to this work are ones that likely shaped the way I engaged with the abortion doulas I interviewed and the way I interpreted findings. I tried to approach this research with humility and with the goal of learning from my interlocutors. By memoing about my experiences, I was able to reflect on my positionalities and how my own values impact my interactions with participants and collaborators, and my interpretation of the findings. However, this is an ongoing process and one that I will continue to reflect on and learn from as I disseminate the findings.

5.6 Statement of contribution

I completed this thesis in partial fulfillment of the requirements for the Master of Science in Interdisciplinary Health Sciences Program at the University of Ottawa. I was responsible for conceptualizing the study, collecting, and analyzing the data, and leading the writing of the articles which are included in this thesis.

Dr. Anvita Dixit contributed to this project by acting as a second reviewer in the scoping review and a second author in the first paper. She provided expertise and guidance during this component of the project. Several volunteers that work with my supervisor's larger research group were responsible for the transcription of the interviews included in this thesis. Maya Meeds, Arpana Wadhwani, Dina Babiker, Kaden Venugopal, Victoria Porter, Khadeeja Kalair, and Nicki El-Bouchi all contributed to this component of the project.

Lauren Lagoutte contributed to this project by leading recruitment efforts for the second study component. As both a participant and member of the research team, Lauren provided needed insight into abortion doula networks and roles. She was critical in understanding and interpreting the findings and formulating recommendations and is the second author of the first paper.

Finally, Dr. Angel M. Foster provided overall supervision and guidance during all phases of the project. She is the PI of a larger multi-country study explore the role of abortion support workers (including doulas, hotline staff, and abortion fund volunteers) and the second component of my thesis is part of this effort.

5.7 Conclusions

This project collected and summarized existing information about accompaniment and accompaniment models, described the experiences, attitudes and opinions of Canadian abortion doulas, and explored abortion doulas' perspectives on how to improve abortion care in Canada and abortion doulas support systems.

The findings of this project demonstrate that accompaniment models can support improved abortion access and that abortion doulas are well received by abortion seekers. However, abortion doulas have not been formally integrated into the Canadian abortion care system. Abortion doulas feel positively about their ability to help others and take pride in contributing to their communities. Their intimate knowledge of the challenges that Canadian abortion seekers face, gives them insight into ways systems of care can be improved. Finally, this project supports the exploration of ways to act on the recommendations of abortion doulas and identify ways to incorporate them and their work into abortion care in Canada.

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01/02/2023

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Bureau d'éthique et d'intégrité de la recherche

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CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	S-02-19-3079
Titre du projet / Project Title	Evaluating the impact of working to support abortion patients: A qualitative study hotline staffer, community activists, and doulas in North America
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)	04/03/2019
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	03/03/2024

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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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).

Coordonateur / COORDINATOR
Coordonnateur de l'éthique / Ethics Coordinator
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**

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