

Exploring the Journeys of People Accessing Abortion Care in Ontario, Canada

by

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### **Author's Declaration**

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

## Abstract

**Background:** Abortion has been a contentious socio-political issue throughout Canada's history. Despite the decriminalization of abortion in 1988 and the approval of medication abortion in 2015, challenges to accessing abortion in Ontario still exist. There is a dearth of research on people's experiences of accessing abortion, especially in an Ontario context.

**Research Questions:** What are the experiences of people accessing and receiving an abortion in Ontario? When reflecting on their abortion care journeys, how do people who have obtained an abortion perceive their care encounters? How can the provision of abortion care be improved in the Ontario health care system?

**Methods:** This research project used a qualitative research design, drawing on 16 in-depth, semi-structured narrative interviews from racially and gender diverse participants across Ontario. Participants were recruited through social media accounts of reproductive care organizations. Individuals were eligible to participate in the study if they had received a procedural and/or medication abortion in Ontario in the last 3 years (2020-2023). Interviews were conducted virtually or over the telephone and lasted 1-1.5 hours. This study also employed a novel technique of healthcare journey mapping during interviews to visually depict key healthcare encounters. Narrative-thematic analysis was used to capture themes from participants' stories.

**Findings:** Five individuals' stories and abortion care journey maps are highlighted, demonstrating multiple routes to accessing care and the differential complexity of navigating care. In the next chapter, participants' accounts are structured into four main themes by story plot element. Most participants encountered difficulties and/or stress accessing care, which posed as the first complicating action in their journeys. The next complicating action stemmed from their interactions with abortion care professionals during diagnostics and assessment of the pregnancy. A range of interactions with care professionals were narrated, fluctuating between services being perceived as restrictive, rushed, and shame-inducing to caring, connective, and, non-judgemental. All participants received at least one abortion, categorized as the plot climax of their story. Participants often found the process of receiving an abortion emotional and/or physically painful. Lastly, the degree of "resolution" of participants' stories was impacted by the quality of post-abortion care they received for their ongoing physical or emotional needs.

**Conclusions:** This study is one of the first to blend narrative inquiry with the novel technique of healthcare journey mapping to people's experiences of abortion care, identifying the gaps in services to provide clients with non-judgemental care. By highlighting a few abortion care maps and stories, it suggests that space needs to be carved out in the healthcare system to provide individualized care sensitive to clients' emotional, physical, and spiritual needs. It makes several recommendations as to how abortion practice and policy can be improved to be more trauma-informed, abortion-focused, and client-centered.

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## Chapter 1: Introduction

Abortion is a contentious socio-political issue in Canada. Since its decriminalization in Canada in 1988, abortion care has been considered a medical necessity in Ontario, with its incorporation into healthcare funding and services (Johnstone, 2017). However, throughout the late 1980s to current day, the decision to decriminalize abortion has been unsuccessfully contested by bills brought forward by members of parliament and private members (Abortion Rights Coalition of Canada [ARCC], 2023; Bashevkin, 2023; Johnstone, 2017). The recent decision in the United States to overturn *Roe v. Wade* prompted pro-choice advocates in Canada to hold rallies in the street (CBC News, 2022) while academics discussed that this could increase vocalization of anti-abortion sentiment in Canada (Macfarlane, 2022; Vogel & Duong, 2022). As of late, some Canadian Conservative politicians have been supporting pro-life rallies and introducing petitions in Parliament to restrict abortion access while, in response, Federal cabinet minister Soraya Martinez Ferrada publicly shared her abortion story in parliament (Ekelund & Skulski, 2024; MacCharles, 2024).

This thesis is informed by the reproductive justice movement which advocates for the dismantling of systemic barriers that obstruct a person's right to not have children, right to parent, and right to have children (Luna & Luker, 2013). As suggested by the literature, it is likely that the socio-political contentiousness of abortion contributes to people feeling stigmatized, shamed, judged, and pressured to hide their experiences throughout their abortion journeys (LaRoche & Foster, 2018; Norris et al., 2011; Shaw, 2012). Research has also suggested that stigma may impact a person's clinical quality and course of care (Seewald et al., 2019; Sorhaindo & Lavelanet, 2022). However, there are few Canadian studies that explore people's perceptions of their abortion care encounters from a reproductive justice lens.

Furthermore, it has been well-established in the literature that there is considerable variation in access to care across provinces (Bashevkin, 2023; Foster et al., 2017). Studies of people's experiences of abortion care in Canada have tended to concentrate on the geographic, cost, and access barriers in Canada, especially for people living in rural or remote areas (Cano & Foster, 2016; Foster et al., 2017). However, over the last decade, a number of legislative and healthcare changes has impacted abortion access and care. One of the most significant changes to access was the introduction of medication abortions in 2017, which established new pathways to care for patients seeking an abortion. Up until this point, procedural abortions (i.e. aspiration, dilation and evacuation, or historically dilation and curettage) were the primary method of abortion in Canada, delivered in a clinic or hospital and performed by a medical practitioner with specialized training (Costescu & Guilbert, 2018; Devane et al., 2019; Kapp & Lohr, 2020; Shaw & Norman, 2020). With the approval of mifepristone and misoprostol by Health Canada in 2015, medication abortions could be done at home with a two to three-day pill regimen prescribed by a primary care practitioner (Costescu et al., 2016; Kapp & Lohr, 2020). This shift in services has created additional avenues for access for patients with no contraindications (LaRoche et al., 2020; Renner et al., 2022; Zusman et al., 2023). In 2022, there were over 40,000 procedural and medication abortions reported in Ontario (Canadian Institute for Health Information, 2024). However, research following the recent political and healthcare changes have tended to focus on service providers' perspectives (Carson et al., 2023; Ennis et al., 2023, 2024; Renner et al., 2022, 2023; Zusman et al., 2023) with only a few Canadian studies providing insight on how these

changes may have impacted patients' obtaining abortion care and what challenges may still persist (Hukku et al., 2022; LaRoche et al., 2020; Monchalin, Pérez Piñán, et al., 2023) Using qualitative inquiry, this thesis sought to understand the experiences of people accessing and receiving abortion care in Ontario and their perceptions of their care encounters along their journeys. From this knowledge, suggestions are made for improving care from point of access to follow-up care from a person-centred, reproductive justice lens.

A note about language:

This thesis uses the terms “medication abortion” and “procedure abortion” to differentiate between the two types of abortion. These terms are the most clinically accurate and are in agreement with the language guides put forth by The American College of Obstetricians and Gynecologists and the Society of Family Planning Committee (The American College of Obstetricians and Gynecologists, 2023; Upadhyay, 2023). However, at times, participants may refer to procedural abortions as surgical abortions or medication abortions as medical abortions as these are terms in common parlance and still used by some abortion providers.

Importantly, I want to assert that people of all genders may have abortions and, to reflect this, have incorporated gender inclusive language throughout my thesis. In my review of the literature, however, I use “women” when either the source text or research study refers to only women.

## Chapter 2: Literature Review

### 2.1 History and Politics of Abortion Care in Canada

In Canada, abortion has been a contentious socio-political issue throughout history, inciting activists and abortion providers to fight for abortion rights. In 1869, abortions were first prohibited in Canada with its adoption of Britain's 1861 Offenses Against the Person Act (Johnstone, 2017). The ban on abortions, along with other reproductive care such as birth control, was maintained in Canadian law through the creation of its criminal code in 1892 (Johnstone, 2017; McLaren & McLaren, 1997). Many powerful people in politics, religious institutions, judicial systems and academia vocally supported the ban, espousing ideals of womanhood and womanly duty -- to give birth and raise children (McLaren & McLaren, 1997). They sought to control women's sexual and reproductive practices, restrict employment, encourage large family size, and prevent "race suicide" (McLaren & McLaren, 1997, p.15). Popularized by the American President Theodore Roosevelt, "race suicide" was the notion that women were responsible for the falling birth rates in North America because they "selfishly" did not produce enough children (McLaren & McLaren, 1997).

However, women desired control over their fertility and continued to seek out abortions despite its illegality (McLaren & McLaren, 1997). While health and safety conditions had improved in hospitals, abortions had to be illicitly sought outside of the hospital system, where conditions were unsanitary and precarious methods utilized (McLaren & McLaren, 1997). The dangerous nature of the procedure, as well as an increase in the number of women seeking abortions, resulted in a high rate of abortion deaths in Canada. In a 1933 Ontario study, 17.7% of reported maternal deaths were due to abortion; more than a third of these deaths were classified as "self-induced" (Phair & Sellers, 1934). Many abortion deaths also went unreported by doctors (McLaren & McLaren, 1997). The high abortion rates from the 1920s-1960s led some scholars to deem it an "abortion epidemic" (McLaren & McLaren, 1997, p. 50)

In the 1960s, Canadian socio-political values started shifting towards the government taking a more liberal position – one that would impose less of a moral stance on the legislation of sexuality and reproduction issues (McLaren & McLaren, 1997). In addition to the lobbying of family planning associations and feminist organizations, doctors and lawyers gathered together in 1967 to protest that abortions laws were too restrictive and that the state was interfering on matters they considered within medical practice and clinical judgment (McLaren & McLaren, 1997). In 1969, the criminal code was amended to permit abortions under very specific circumstances, mainly to protect the physicians providing those abortions (Johnstone, 2017). Under the new amendment, a pregnant woman had to be approved for an abortion by a "Therapeutic Abortion Committee" in an accredited hospital (Shaw & Norman, 2020). Abortion access was legally allowable when the pregnancy "endanger[ed] the life or health of the woman" (McLaren & McLaren, 1997, p. 136). However, at the time, only about 20% of hospitals were accredited to offer abortions, and committees enacted their powers differentially from hospital to hospital, creating unequal access (Shaw & Norman, 2020). Some approved almost all abortions regardless of the circumstance while others required in-person interviews with the women or the consent of the husband (Hundal & Hundal, 2024; Johnstone, 2017; Shaw & Norman, 2020).

Delays in services averaged about eight weeks, and cost barriers further perpetuated inequitable access (Shaw & Norman, 2020)

These issues in accessing abortion instigated feminist student groups at the University of British Columbia to travel to Ottawa to make a case for abortion rights to the reigning Liberal government in 1970 (Johnstone, 2017; Shaw & Norman, 2020; Wells, 2020). While travelling in their “Abortion Caravan” across Canada, a group of students held public demonstrations and gained followers across Canada (Johnstone, 2017). In Ottawa, they held a rally for abortion rights with over 600 protesters and requested a meeting with the Liberal government (Wells, 2020). When neither the Prime Minister Pierre Trudeau nor any other Liberal member showed up to hear their demands, they took their protest to 24 Sussex Drive, the home of the Prime Minister, and dropped a coffin on the veranda (Wells, 2020). Later that week, they chained themselves to the viewing galleries of the House of Commons before security removed them. Back in British Columbia, they continued their advocacy work, which eventually gained them an audience with the Prime Minister who dismissed their concerns stating that public opinion would never sway enough to allow for universal abortion access (Wells, 2020).

One of the spokespeople at the abortion march was Dr. Henry Morgentaler (Wells, 2020) who had opened a clinic in Montreal in 1968 that provided abortion services illegally (Johnstone, 2017; Shaw & Norman, 2020). He believed that denying abortion services to women went against his professional directive to “do no harm” (Johnstone, 2017, p. 57). In the following years, he was arrested several times, spent time in prison, and lost his first battle for abortion rights in the Supreme Court. Despite this opposition, he continued to make his services publicly known and opened more clinics in Quebec, Winnipeg, and Toronto (Johnstone, 2017; Shaw & Norman, 2020). Eventually these events culminated in the pivotal legal battle of *R. vs. Morgentaler* in 1988 where Ontario doctors who were charged for performing abortions appealed their case to the Supreme Court (Johnstone, 2017; Shaw & Norman, 2020). The Court decided that Canada’s abortion laws are unconstitutional because forcing the birth of a foetus infringed on a woman’s rights to security of the person according to section 7 of the Charter of Rights and Freedoms. With the decriminalization of abortion nationally, the provinces became responsible for the administration and regulation of abortion (Johnstone, 2017). Many provinces initially tried to restrict access to care; however, the Ontario provincial government upheld the court ruling and decided to treat abortion as a medical procedure (Johnstone, 2017; Shaw & Norman, 2020). In 1989, the Supreme Court also ruled in *Tremblay v. Daigle* (1989) where the boyfriend of Chantal Daigle tried to legally prevent her from having an abortion (Johnstone, 2017; McLaren & McLaren, 1997). The Court ruled in favour of Daigle, stating that a foetus’ potential father cannot overrule the woman’s decision to have an abortion (Johnstone, 2017; Shaw & Norman, 2020; *Tremblay v. Daigle*, 1989). It also set the precedent that a foetus does not have legal rights.

Throughout the 1990s, the issue of abortion was contested by anti-choice politicians and advocates. In 1991, a bill recriminalizing abortion was brought forward by the Conservative government (Bill C-43) and passed in the House but was defeated by a tie vote in the Senate (Johnstone, 2017; Shaw & Norman, 2020). Since then, more than forty-five private members’ bills have also been brought forward to restrict or recriminalize abortion but have failed each time (Johnstone, 2017). Tensions remained high in this period between abortion supporters and

adversaries. During 1994-1997, three obstetrician gynaecologists were shot for providing abortions, but all survived (Shaw & Norman, 2020). In 1992, the government of Ontario commissioned a task force that issued the *Report on Access to Abortion Services in Ontario* which outlined barriers to access (such as lack of physician and hospital availability) and recommended that all public hospitals should be required to provide abortions – a recommendation that was not implemented (Kaposy, 2010; Palley, 2006).

Over the last decade, abortion access and care has been impacted by legislative and healthcare changes due to the introduction of medication abortions. In 2015, Health Canada approved the use of mifepristone and misoprostol pills for medication abortions (also known as medical abortions) (Devane et al., 2019; LaRoche, Wylie, et al., 2022; Shaw & Norman, 2020). Up until this point, procedural abortions (i.e. aspiration or dilation and evacuation) were the primary method of abortion in Canada, delivered in a clinic or hospital and performed by a medical practitioner with specialized training (Costescu & Guilbert, 2018; Devane et al., 2019; Kapp & Lohr, 2020; Shaw & Norman, 2020). With the approval of mifepristone and misoprostol, medication abortions could be done at home with a two to three-day pill regimen prescribed by a primary care practitioner (Costescu & Guilbert, 2018; Kapp & Lohr, 2020). The availability of medication abortion created a shift in access, including where the procedure could occur and who could administer services. However, this flexibility in delivery was initially impeded by restrictions imposed by Health Canada (Devane et al., 2019; LaRoche, Wylie, et al., 2022). These federal restrictions included mandating ultrasounds, limiting prescription dispensing and fulfillment of prescriptions to physicians with mandated training, and limiting prescriptions for those pregnant within 49 days of the first day of their last menstrual period (Devane et al., 2019; LaRoche, Wylie, et al., 2022). Most restrictions were removed by November 2017 when pharmacists were allowed to dispense the medication, nurse practitioners were given authority to prescribe the medication, and the gestational age limit was changed from 49 to 63 days (LaRoche, Wylie, et al., 2022). In April 2019, the ultrasound restriction was retracted and left to the discretion of individual care providers. The restrictions were inconsistent with how most medications are approved in Canada and created massive confusion among healthcare professionals in terms of implementation and administration (Devane et al., 2019; LaRoche, Wylie, et al., 2022; LaRoche & Foster, 2020).

As the administration, funding, and regulation of health care is the responsibility of provincial governments, legislation and healthcare policies have differed and continue to differ from province to province (Johnstone, 2017). Legislators in some provinces, such as Manitoba and Saskatchewan, initially refused to provide healthcare funding (Shaw & Norman, 2020), but since 2019 all provinces provide universal coverage for the abortion procedure (Hunter, 2019; Kusch, 2019). Up until 2015, procedural abortion services were excluded in the inter-provincial billing agreements of the Canada Health Act (1985) that allows for the health services to be reciprocally billed in other provinces (Shaw & Norman, 2020). Currently, the number of clinics and hospitals that provide abortion services vary provincially (Sethna & Doull, 2013). These clinics and hospitals decide the type of abortion services offered and impose gestational limits, which can mean longer wait times and further travel distance for services especially for residents in rural, Northern, and coastal communities (Sethna & Doull, 2013).

Recent legislative changes in Ontario's regulation of physicians have also created differential access to abortion services across provinces for patients. The national Canadian Medical Association allows physicians to refuse service or referrals to other practitioners based on their personal beliefs (Johnstone, 2017). Many provincial regulatory colleges uphold this policy. However, in 2015, the Ontario College of Physicians and Surgeons created a human rights policy that included provisions for "effective referrals" (Dickens, 2021). This regulatory body mandated that if physicians object to providing services or medications, they must make an "effective referral" to a "non-objecting, available, and accessible physician, other health-care professional or agency" (Dickens, 2021, p. 557). This policy was upheld by the Court of Appeal of Ontario in *Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario* (2019). The Court decided that mandating physicians to make effective referral for patients seeking medical services, including abortion, did not infringe on a physician's religious freedom. The Court found evidence that patients suffer harm when refused referrals or services are delayed, especially in time-sensitive procedures such as abortion (Dickens, 2021). As in the above case, Ontario courts, governments and healthcare services have approached the provision of abortion services as medically necessary and has incorporated them as such into healthcare policy and legislation (Johnstone, 2017). However, despite abortion being decriminalized and supported through legislation in Ontario, barriers to abortion access may still exist through the practice and administration of abortion services.

## **2.2 Barriers to Abortion Access in Canada and Ontario**

Primary care physicians are often the first access point for abortion and can act as gatekeepers for abortion healthcare services (Shaw & Norman, 2020; Wiebe & Sandhu, 2008). Canadian scholars suggest that some primary care physicians may be purposefully delaying or refusing abortion services (Foster et al., 2017; Kaposy, 2010; Shaw & Norman, 2020; Wiebe & Sandhu, 2008). Some patients are also apprehensive about being stigmatized or judged by health care providers when requesting an abortion, especially in the case of needing multiple abortions (LaRoche & Foster, 2018; Shaw & Norman, 2020). In a Canadian study of 39 women seeking an abortion, 20% said they avoided going to their family physician to receive services because they felt uncomfortable, and 15.4% of women stated they went to their family physician but had a negative or distressing experience (Wiebe & Sandhu, 2008). Findings from a phenomenological study of fourteen Canadian women seeking abortions revealed that they sensed judgement from their healthcare providers, felt ill-informed of their healthcare options, and perceived their healthcare providers to be unsupportive of the woman's decision to have an abortion (McIntyre et al., 2001).

People accessing abortion may also feel judged and stigmatized by anti-choice protesting groups. In a 2017 study of twelve facilities in seven provinces, facilities self-reported 571 instances of picketing (97%), harassment (2%), trespassing (1%), and threats of harm (0.2%) (LaRoche, Martzke, et al., 2022). In a qualitative study of 30 Canadian women, many participants reported feeling frustrated, stigmatized, and upset when having to encounter protestors while accessing an abortion between the years of 2012-2016 (Foster et al., 2020). Since these studies were conducted, some provinces, such as Ontario, have enacted safe access zone laws prohibiting protest activity around certain abortion facilities or providers' homes (Foster et al., 2020; LaRoche, Martzke, et al., 2022). However, it is the choice and responsibility of abortion facilities

(non-freestanding-clinics such as hospitals, pharmacies or physicians) to apply for protection (Ministry of the Attorney General, 2021; Safe Access to Abortion Services Act, 2017). Some abortion facilities, such as hospitals in London and Kitchener, were initially reticent to apply for protection and only did so after community and media pressure (Lupton, 2018; Weidner, 2018). However, it is unclear if any of these facilities were granted protection. According to the Abortion Rights Coalition of Canada, there has been no movement on approving new applications from a facility or clinics since *The Safe Access to Abortion Services Act, 2017* was first passed (ARCC, 2024b). The status of these applications should be further examined and approved.

Research in Canada on abortion access has also highlighted travel distance and associated costs as a significant barrier to abortion services, especially for rural communities (Foster et al., 2017; Norman et al., 2013, 2016; Sethna & Doull, 2007, 2013). In 2013, there were only eight free-standing abortion clinics in Ontario offering procedural or aspiration abortions all in urban areas (mostly in Toronto and Ottawa); 33 hospitals (17% of all hospitals in Ontario) offered procedural or aspiration abortion services with only one in Northern Ontario (Sethna & Doull, 2013). Gestation limits at clinics and hospitals for procedural or aspiration abortions can be anywhere between 12-24 weeks, potentially resulting in farther travel for those further along in their pregnancy (ARCC, 2024a). In a pilot study of the travel distances to the Morgentaler Clinic in Toronto, 73.5% of people accessing an abortion had to travel over an hour (Sethna & Doull, 2007). Women making less than \$30,000 were more likely to travel between 200 kilometres to over 1000 kilometers to access abortion in comparison to women from higher income groups (Sethna & Doull, 2007). In addition to the cost of the travel itself, other associated costs could include childcare, food, accommodation, parking, and loss of income due to time off work for the abortion recipient themselves and any accompanying support people (Foster et al., 2017; LaRoche et al., 2020; Sethna & Doull, 2007; Sethna & Doull, 2013; Shaw & Norman, 2020). Additional challenges in accessing procedural abortions at clinics and hospitals may also be wait times or difficulties getting in touch with services due to their voice messaging system (Foster et al., 2017; LaRoche et al., 2020; Sethna & Doull, 2013; Shaw, 2009; Wiebe & Sandhu, 2008).

While the recent introduction of medication abortions services has increased access to abortion, especially in rural areas, barriers to medication abortions still exist (Ennis et al., 2021). Medication abortion can only be accessed in Ontario for up to 9 or 10 weeks pregnant, depending on the abortion provider (ARCC, 2024a; Costescu et al., 2016). It also may require more health care visits than procedural abortions, especially ones that deliver streamlined services at a clinic (Costescu et al., 2016; LaRoche et al., 2020). A qualitative study of abortion care in the city of Ottawa reported that individuals accessing medication abortions had 4-10 encounters with health care professionals, including physician appointments, ultrasounds, blood work, prescription fulfillment at the pharmacy and follow-up appointments (LaRoche et al., 2020). Those who received a medication abortion also felt that they lacked information regarding the process for receiving an abortion. Participants who had inflexible schedules or limited transportation options found accessing these health care services particularly difficult. During the Covid-19 pandemic, there was an increased uptake of low-touch medication abortions accessed virtually through telemedicine, which lessens some of the travel burden on clients (Ennis et al., 2021; Smith et al., 2024). However, it is unclear how much of abortion care services will still be accessible virtually after the pandemic.

Moreover, not all pharmacies stock and dispense medication abortion. In a study of 24 pharmacies in Ontario in 2017, Munro et al. (2021) reported that only 33% of pharmacies had stocked mifepristone. In a 2022 mystery-caller study in Hamilton, Ontario, only 6% of 208 pharmacies contacted had mifepristone and misoprostol (medication abortion) in stock (Guarna, 2023). Furthermore, 64% of pharmacies contacted stated that they never stock the medication while 30% of pharmacies reported that they were “out of stock.” Of those who did not stock the medication (94%), only 51% of pharmacies offered to order the medication with the ability to dispense it between 1 business day to a few weeks. Notably, this study took place in a large urban area and accessing pharmaceutical services may be more difficult in rural areas in Ontario where there are fewer pharmacies than in urban areas.

One step that often prolongs the process to getting a medication abortion is obtaining an ultrasound. While ultrasounds are no longer legally required to administer a medication abortion (LaRoche, Wylie, et al., 2022), they are often requested at the providers’ discretion before and after the procedure. In Canada, between 90.3%-100% of providers request a dating ultrasound whereas in other countries ultrasounds are not routinely used to determine gestational age (Costescu et al., 2016; Ennis et al., 2022; Guilbert et al., 2016.). In a qualitative study by Carson et al. (2023) of barriers and enablers for nurse practitioners providing medication abortions in Canada, there was variance among nurse practitioners as to how much they required ultrasounds from their patients. While some routinely requested one, others viewed them as potentially intrusive for patients when not clinically necessary (i.e. ectopic pregnancy). Clinical practice guidelines state that gestational age can be determined using other means, and research has indicated that an ultrasound does not improve safety of procedure in comparison to other methods of dating the pregnancy (Costescu et al., 2016). Furthermore, Canadian providers have indicated experiencing barriers to accessing ultrasounds for patients such as limited availability in some areas, long wait times, or individual technicians refusing to provide service (Carson et al., 2023; Devane et al., 2019; Ennis et al., 2022; Norman et al., 2013). In a survey of 383 Canadian providers, 13.6% of rural providers and 15.3% of urban providers stated that they experienced barriers in accessing ultrasounds (Ennis et al., 2022). Based on the research, there appears to be improvements that can still be made to streamline the process of medication abortion.

Lack of information may also be a barrier for people in accessing care. Abortion care services are not always publicly advertised in Canada (Carson et al., 2023; Ennis et al., 2023; van Berkel, 2004). In Ontario, there is no information about abortion on their provincial website (Action Canada for Sexual Health and Rights & Women’s Legal Action and Education Fund (LEAF), 2024) despite the medication and procedure being covered by the Ontario Health Insurance Plan (OHIP) (Ministry of Health, 2024). In the Northwest Territories, British Columbia, Nova Scotia, Prince Edward Island, Quebec, Saskatchewan, and Alberta, provincial and territorial health agencies have included information about abortion and where to access it on their websites (Alberta Health Services, n.d.; Gouvernement du Québec, 2023; Health and Social Services Authority, n.d.; Health PEI, 2023; Healthwise Staff, 2023; Nova Scotia Health, n.d.; The British Columbia Public Services, 2022). While there are websites that list or connect individuals with Ontario-based abortion providers (ARCC, 2024a; Planned Parenthood Toronto, 2024; SHORE Centre, n.d.), not all of these abortion providers list their services on their own websites. As an

example, Grand River Hospital in Kitchener-Waterloo does not provide information about accessing abortions on their website despite being listed on other websites as providing abortions (ARCC, 2024a; Grand River Hospital, n.d.). In a recent study by Carson et al. (2023) that examined barriers for nurse practitioners to provide medication abortion, nurse practitioners spoke about being reluctant to advertise medication abortion services due to feeling stigma, being isolated from other pro-choice providers, and wanting to stay anonymous. For some nurse practitioners, this sentiment was held more strongly than others, depending on the stance on abortion of where they lived and worked. In some cases, information may be deliberately hidden. A news article in the CMAJ journal reported that a Catholic hospital had blocked staff access to several abortion websites (Glauser, 2020)

Access and quality of abortion care may be further compromised for diverse groups such as Black Peoples, Indigenous Peoples, and People(s) of Colour (BIPOC), immigrants and refugees, or incarcerated individuals. In Canada, there is a paucity of data on how the systematic oppression and discrimination of certain groups may impact access (Carson et al., 2022; Paynter & Heggie, 2023). However, there have recently been a few studies that suggest some potential barriers. In a qualitative study by Monchalín, Pérez Piñán, et al. (2023) on Indigenous Peoples within Canada who had accessed a procedural abortion, participants noted several barriers to compassionate abortion care including logistics (travel time and cost), poor treatment by service providers, stigma, and lack of follow-up care. Importantly, participants spoke about how colonialism and, by association, organized religion negatively impacted attitudes towards abortion; they expressed that Indigenous knowledges and practices, such as plant medicines, should be more incorporated into abortion care. Other diverse groups may also be negatively impacted by a lack of culturally safe care from abortion care providers. In a study of abortion care providers using the 2019 Canadian Abortion Provider Survey (CAPS), 91.2% of 356 clinicians reported they had not received training for specifically providing care for diverse populations and only about half reported (47%) that they are responsive to patients' needs most or all of the time; however, respondents did give qualitative examples of how they have shifted their care to be more culturally or religiously responsive and trauma-informed or gender-affirming (Ennis et al., 2024). While this study suggested that some providers have adjusted their language or communication style, a qualitative study by Hukku et al. (2022) revealed that individuals have also reported feeling discriminated against when seeking out services or difficulty understanding medical terminology when not explained in their primary language. Furthermore, while the cost of the instrumentation procedure or medication is covered in Ontario, certain populations who do not have access to the Ontario Health Insurance Plan (OHIP) (i.e. undocumented immigrants and some refugee and visitor groups) may have to pay out of pocket for the abortion (Cohen & Caxaj, 2018; Downie & Nassar, 2007; Shaw & Norman, 2020). On Planned Parenthood Toronto's website, they list the fees for abortion services for uninsured persons to be between \$340-\$2300 depending on type of procedure and gestational age (Planned Parenthood Toronto, 2024). These are just some of the potential barriers that may impact diverse groups of people; there is still much further research to be done on how discrimination based on age, gender, ability, religion, Indigeneity, race, culture, and mental health may impact accessing and receiving services.

### **2.3 Experiences of People Seeking Abortion Care in the Health Care System**

In 2022, at least 40,313 people had an abortion in Ontario (Canadian Institute for Health Information, 2024). Through an analysis of Statistics Canada data from 1974 to 2005, it was estimated that 31% of Canadian women had at least one abortion during their reproductive years (Norman, 2012). Yet, little research has been conducted on people's experiences of abortion, especially as it pertains to their journey through the Ontario health care system.

A few published studies on peoples' experiences of abortion have focused on access to abortion care in other provinces in Canada such as New Brunswick (Foster et al., 2017) and the Yukon Territory (Cano & Foster, 2016). These studies have concentrated on women's experiences of geographic, cost, and access barriers to abortion services where there are very few abortion providers, especially in rural and remote areas. Obtaining a procedure in these systems often requires multiple appointments and long wait-times in a fragmented service delivery system (Cano & Foster, 2016; Foster et al., 2020). Given that health care is provincially regulated, administered, and funded, it is unclear how much and where these barriers might persist in Ontario.

Very few qualitative studies have looked at experiences of people seeking abortion access in Ontario. The studies that have included Ontario participants have had a broad scope, examining experiences across Canada (Hukku et al., 2022; LaRoche & Foster, 2018, 2020; Monchalin, Pérez Piñán, et al., 2023). Canadian studies have also tended to centre around experiences of one type of abortion only, either procedural abortion (LaRoche & Foster, 2018; McIntyre et al., 2001; Monchalin, Pérez Piñán, et al., 2023) or medication abortion (LaRoche et al., 2020; LaRoche & Foster, 2020). One notable recent study considered the impact of the COVID-19 pandemic on women's procedural and medication abortion experiences across Canada (Hukku et al., 2022). Some participants faced barriers to receiving timely care such as being discriminated against at abortion facilities or having to navigate multiple steps to obtain an abortion. In addition to suggesting a more streamlined model of abortion care is needed in Canada, the study proposed de-medicalized models of abortion to participants, such as telemedicine or pharmacist prescribed models, which the participants were receptive to as potential future models of delivery. While telemedicine was available during the pandemic, there is little in the Canadian research literature as to peoples' experiences accessing abortion care since pandemic measures have subsided, including the extent to which telemedicine models of delivery are still available and accessible.

### Chapter 3: Study Objectives

In order to understand the experiences of people accessing an abortion in Ontario, it is important to capture the journeys from the perspective of people receiving care. There is a dearth of research that has taken a holistic and temporal approach in examining a person's abortion care journey from point of access to follow-up care. Through the use of healthcare journey mapping and case narratives, this study aimed to depict people's trajectory through Ontario's abortion care system, describing challenges and facilitators that were encountered along the way. In analyzing these maps and case narratives, this study made recommendations for improved access to abortion care in Ontario.

The primary research questions this study addressed were:

1. **What are the experiences of people accessing and receiving an abortion in Ontario?**
2. **When reflecting on their abortion care journeys, how do people perceive their care encounters?**
3. **How can the provision of abortion care be improved in the Ontario health care system?**

## Chapter 4: Methods

### 4.1 Research Design

I used a qualitative research design utilizing in-depth narrative interviews to create space for abortion care patients to share their stories and perspectives about accessing abortion care services. For data collection, I utilized a semi-structured interview to guide the conversation while also leaving space for the participants to share what they viewed as relevant to their overall story. A combination of a narrative-thematic approach and healthcare journey mapping was used for data collection, analysis, and knowledge dissemination. I used a reproductive justice lens and feminist approach to guide my research process. A feminist narrative approach has been taken in previous studies (Fraser & MacDougall, 2017; Woodiwiss et al., 2017) and narrative approaches have been utilized by reproductive justice advocates (Price, 2020).

### 4.2 Theoretical and Methodological Orientation

#### *4.2.1 Theoretical Orientation: A Feminist, Reproductive Justice Approach*

Feminist approaches make visible the embodied lived experience of women, transgender, and non-binary people as these experiences are often silenced, suppressed or dismissed in male-dominated discourses, including social sciences research (Fraser & MacDougall, 2017; Hekman, 2007; Klostermann et al., 2020; Smith, 1974). Abortion access is a feminist concern: it is the pregnant person's right to choose whether to continue the pregnancy or abort the foetus (Sherwin, 1991). The foetus resides in their body and will meaningfully impact their lives if the pregnancy comes to term. However, the patriarchy, embedded in systems of power, strives to assert control over women, transgender, and non-binary reproductive and pregnant bodies and make it difficult for pregnant people to access quality abortion care (Sherwin, 1991). Highlighting the ways in which the healthcare system may be oppressive and may prevent abortion access or preclude person-centered abortion care is important for feminist research. A feminist approach to research also has a political agenda: to raise the consciousness of its audience members and instigate action for change (Giacomini, 2012; Landman, 2006).

Feminist approaches also concern themselves with the relationship of power between the interviewer and participant, often most notable during the interview process (Landman, 2006; Thwaites, 2017). One way for feminist researchers to combat power imbalances is to be reciprocal: to share knowledge and experiences with participants to build rapport and to consider what participants may gain in return for their thoughts and stories (Landman, 2006). It is also important for researchers to engage in critical reflexivity to understand how their social identity may impact their relationship with the participant and may have influenced the construction of the research problem, results, and findings (Landman, 2006).

In response to feminist approaches to abortion, women of colour activist groups (such as SisterSong) created the reproductive justice movement to fight for reproductive rights beyond just a person's right to abortion (Luna and Luker, 2013; Price, 2011, 2020; Ross et al., 2001). In general, reproductive justice advocates are concerned with the right to not have children as equally as they are with the right to parent and the right to have children (Luna and Luker, 2013).

Their critique is that when feminist advocates primarily focus on the right to abortion, especially in a legal context, systemic barriers to having children or being able to parent children are not addressed, especially for people of colour or those with lower-incomes (Luna and Luker, 2013; Price, 2011, 2020). They also critique the language of “choice” in pro-choice movements (Price, 2011, 2020; Shaw, 2013). The “choice” to have an abortion is limited to people with resources and status to make such a decision (usually white, middle-class women) whereas low-income and/or people of colour do not have access to the same resources nor privilege to make such a “choice” (Price, 2011, 2020; Shaw, 2013).

#### *4.2.2 Narrative Interpretive Approach*

A narrative approach places value on the story-telling experience for the participant, interviewer, and audience. Stories (or narratives as will be used synonymously throughout this study) can have many different functions for the teller and listener, especially in the sharing of challenging experiences (i.e. accessing abortion) (Riessman, 2008). They can make sense of an experience, incite others to action, create empathy or connection with others, and link personal experiences to “the flow of power in the wider world” (Riessman, 2008, p. 8). As the purpose of this study is to explore the experiences from the point of view of the people accessing and receiving an abortion in the health care system, it is fitting to use a narrative approach.

A narrative approach focuses on the events and experience over the “plot” of a person’s narrative; the researcher views participants both as actors with agency and as recipients of an experience, including unwanted or undesirable experiences (Riessman, 2008). In alignment with an idealist ontology and interpretive epistemology, a researcher does not seek out what “really happened” over the course of events. Rather, the focus is on how the participants perceived their experiences and created order, coherence, and meaning out of them through their telling (Giacomini, 2012; Riessman, 2008). By using methodology such as interviews to facilitate the creation of stories, the researcher does not simply unearth these narratives but co-creates them with participants (Fraser & MacDougall, 2017; Riessman, 2008). Analyzing narratives is an interpretive process; it becomes important for the researcher to be reflexive and critically consider what informs their interpretation of events (Riessman, 2008).

The challenges of a narrative approach can be in delineating the boundaries of where the narrative begins and ends (Fraser & MacDougall, 2017; Riessman, 2008). For the purposes of this study, abortion care was considered broadly from the point of access to post-abortion follow-up care. However, flexibility was given to participants for them to delineate where their abortion care journey begins and ends and which events and care encounters they deemed most important to their overall journey.

#### *4.2.3 Healthcare Journey Mapping*

Healthcare journey mapping, also known as patient journey mapping, focuses on the person’s experiences, needs, and preferences as they traverse multiple health care sites (Kelly et al., 2015). Through participant narratives, a researcher visually maps out the person’s experience, often in conjunction with the participant, to identify the health care encounters along a person’s care journey as well as the challenges and facilitators to access quality, person-centred care

(Kelly et al., 2017). While a range of graphic tools can be used, the maps are often depicted as a flow chart mapping key encounters across time (Freeman, 2020; McCarthy et al., 2016; McLean and Flynn, 2012). The purpose of these maps is to illustrate the complexity and diversity of health care journeys for patients, to compare and analyze patients' journeys, and to point out potential gaps and areas of improvement in the health care system (Kelly et al., 2015). Adapting the concept of "care encounter" from the abortion research work of La Roche et al. (2020), I defined "care encounter" as each time a person interacts with the health care system or other reproductive health/non-profit organizations to access information, obtain the procedure and receive follow-up care. For this study, the abortion care journey maps focused on the "care encounters" that were most meaningful and important to participants. While centered on care encounters within the health care system, they also included abortion-related encounters that occurred outside of the health-care system prior to receiving care and in follow-up care (i.e. therapists, sexual and reproductive health organizations, Crisis Pregnancy Centres).

### **4.3 Study Sample, Recruitment and Data Collection**

#### *4.3.1 Study Sample and Eligibility*

Participation in this study was open to women, non-binary and transgender persons who had received an abortion in the past 3 years while residing in Ontario. Participants had to be adult over the age of 18 years, although could have had the abortion prior to turning 18 years old.

#### *4.3.2 Recruitment*

Participants were recruited through the sharing of the study poster (see Appendix A) on the social media accounts of sexual and reproductive health non-profit organizations (i.e. Planned Parenthood Ottawa, SHORE Centre), abortion doula services (i.e. Ottawa Abortion Doula Collective) and other related non-profit advocacy organizations (Laurier Students' Public Interest Research Group). As a partner organization, SHORE (Sexual Health Options, Resource and Education) Centre was particularly intrinsic to recruitment, sharing the study a poster several times over the course of a few months on their Instagram, Facebook and Twitter, and sharing a physical copy of the poster in their abortion clinic. The recruitment poster contained information about what was involved of participants, eligibility criteria, remuneration details (\$20 President's Choice Grocery Gift Card), and ethics clearance. A statement was also included encouraging the participation of people of diverse racial and gender identities, specifically women, non-binary and transgender people.

I began recruitment in September 2023 by advertising first through my community partner, the SHORE Centre. After only receiving a few interested participants, I reached out to more sexual and reproductive health and abortion-related non-profit organizations over the course of a few months, slowly amassing and subsequently interviewing more participants. I did one last push for recruitment through SHORE Centre in November 2023, which resulted in a high number of interested participants and met the goal for study participants.

Upon receiving an expression of interest in participating in this study, I sent out the letter of information (LOI) and consent form via email outlining the purpose of the study, sample

interview questions, method of data collection, confidentiality measures, data storage, voluntary participation and withdrawal, benefits and risks of the study, remuneration details, and ethics clearance number. I also offered some potential dates for interviews, allowing participants to choose whether they wanted to be interviewed over the phone, virtually using either Microsoft Teams or Zoom, or in person, if possible.

#### *4.3.3 Data Collection*

Thirteen interviews occurred via videoconferencing, with a few participants opting for the video to be turned off, and three interviews occurred over phone but were recorded using video conferencing. Participants either emailed the consent form prior to the interview or their verbal consent was obtained prior to the start of the interview. In every case, the letter of information (LOI) were reviewed with participants and any questions about the study were answered. I also offered participants the opportunity to select their own pseudonym, which some participants opted for while others preferred that I decide.

In total, 16 participants who had received at least one abortion between 2020-2023 were interviewed for this study. In terms of gender, 12 participants identified as woman, 3 participants as non-binary and 1 participant as woman/agender. Participants were from diverse racial groups. 9 participants identified as white, and 7 participants identified their race as one of the following: Filipino-Canadian, Chinese-Canadian, Latina, Indo-Caribbean, First Nations, Eastern European, Chinese-Vietnamese. Participants were a range of ages at the time of interview from 18 to 39 years old, with a mean age of 28. A few participants were mothers (n=3), but most participants did not have a child (n=13). Participants reported a range of educational backgrounds: some or all of high school (n=2), college diploma (n=5), and University degree (n=9). Occupations at the time of interview varied across participants with some describing themselves as working in one or more of the following employment areas: self-employment, financial services, hospitality/customer service, administration, social work/social services, student or as unemployed/homemaker/full-time mother. Participants primarily lived in urban areas at the time of their abortion (n=12) but a few had lived in rural areas (n=2), a small town (n=1), or suburban area (n=1). Some participants also recounted having more than one abortion: 12 participants had one abortion; 3 participants had two abortions; and 1 participant had four abortions. Participants had mixed types of abortions: 10 participants had medication abortions; 4 participants had procedural abortions; 1 participant had a medication and procedural abortion for 2 separate pregnancies; and 1 participant had a medication and procedural abortion for the same pregnancy.

I opened each interview by telling participants a bit about myself, why I was personally invested in conducting this research, and a brief summary of my own reproductive health journey. In alignment with a feminist approach to interviewing (Landman, 2006; Oakley, 1981), I hoped that this disclosure would build rapport, allow for reciprocity between the interviewer and interviewee, and help to dismantle some of the inherent power dynamic between researcher versus researched. I was also intentional about stating that this project was a part of my master's research in the School of Public Health Studies and that the original seed of interest in this study was in my connection with the SHORE Centre in Kitchener-Waterloo.

In keeping with narrative inquiry, I told participants I was interested in hearing their “journey” of accessing abortion care from point-of-access to follow up care. I also suggested to participants to think about sharing their experience as a story: to describe the places they went, the people they spoke to (professionals or support persons), and their overall process of receiving the abortion. I stated that, if they were comfortable, I was interested in hearing how they felt through the process and if there were any feelings that still linger as I wanted to understand how they perceived their interactions with healthcare professionals and the encounters that took place (see *Interview Guide*, Appendix E). I told participants that I would be sketching out a “healthcare journey map” while they were speaking which I would later share with them for their feedback.

I started off all interviews with asking them to “tell me a little bit about yourself before you accessed an abortion,” which prompted most participants to then also begin describing their abortion journeys.

I found that all participants were receptive to this storied approach of interviewing, describing in details the steps they took and the events that occurred. As the participants’ stories unfolded, I would probe to ask for clarification, elicit more details on interactions or events, or paraphrase participants’ feelings or thoughts on what had occurred. However, if participants were in the flow of telling their story, I would engage in what Riessman (2008) calls “following participants down *their* trails” (p. 24), allowing them to describe in detail the events that had occurred.

However, there was some methodological tension as I was also interested in healthcare journey mapping (Davies et al., 2023; Kelly et al., 2017). If participants did veer into more ideological conversations or other personal stories, I would give them space to speak but then re-direct them back to their experiences in the abortion care system. I also interjected in the interviews more than perhaps a pure narrative approach, which might simply ask “what happened next?” (Anderson & Kirkpatrick, 2015; Jovchelovitch & Bauer, 2000; Riessman, 1993). I would probe to see if certain abortion care encounters had occurred (i.e. pharmacy visits, blood tests, ultrasounds), to further understand any barriers or facilitators, and to ask about personal resources (i.e. transportation time, service fees, time off work) that may have been expended to access services.

During the interview, typically near the end, I would also ask about a person’s social location or identity (however they defined it), suggesting that it could include race, gender, class, age, ability, and/or mental health. I would inquire about how they perceived it affected their access to services or quality of support they received. I wanted to include a question regarding social identity to open up space for people to speak to experiences of systemic racism or other inequities, if they desired, in keeping with a reproductive justice lens (El-Mowafi et al., 2021; Idriss-Wheeler et al., 2021; Luna & Luker, 2013).

Lastly, I also asked a few questions at the end of the interview with the purpose of understanding how participants evaluated or made meaning of their experiences as a whole. The purpose of these questions was to allow for reflection given the time that has elapsed from their experiences to now and operate as a sort of “coda” to their stories. These questions included: “If someone else were to go through a similar abortion health care journey as you, what would you want to share with them?” and “if you’ve consented, someone may one day read your story – whether

it's your neighbour, friend, a strange, a policy maker, a politician – is there anything you would like them to know about your journey?" These questions also gave participants the opportunity to be more political in their responses and make suggestions for improvements in the system, which aligns with feminist (Landman, 2006; Riessman, 1993, 2008) and reproductive justice lenses (Coen-Sanchez et al., 2022; El-Mowafi et al., 2021). At the end of the interview, I asked demographic questions about their occupation, education level, race, gender, age, and number of abortions and year of abortions. For the complete interview guide, see Appendix E.

After the interview, participants were sent a \$20 President's Choice Grocery gift card as remuneration for partaking in the interviews. Gift cards were sent to participants within 24 hours of the interview. Funding for the gift cards was provided through the "Small Grant Funding" from Abortion Rights Coalition of Canada .

#### *4.3.4 Ethics and Consideration*

This study was reviewed and received ethics clearance through a University of Waterloo Research Ethics Board (ORE#44518) before commencing recruitment and data collection.

Of particular note, there were times in some of the interviews that I could sense through tone of voice or visual cues that the participant was emotional (i.e. crying, tearing up) or upset discussing a sensitive event. I was intentional about asking the participant if they would like to stop, pause, or continue on with the interview. In all cases, participants chose to pause or continue on with the interview; none decided to stop the interview. I also made known to participants that I could share a list of post-abortion support resources, if they desired. Due to the relational nature of the interview, I also would take the time to validate that participants' experiences were challenging or upsetting, when appropriate, instead of viewing my role as simply "information gathering." Occasionally, I would offer information about my own life in an act of solidarity and relationality with participants or to make participants feel less lonely in what can be an otherwise stigmatizing, shaming, or silencing experience. However, I was careful to then direct the interview back to the participants' perceptions and experiences of seeking and obtaining abortion care.

While the letter of information explicitly stated that there may not be any personal benefits to participating in the study, many participants spoke at the end of interview that they found the experience beneficial and hoped that their story would be helpful to others.

## **4.4 Data Analysis**

For data analysis, I used a combination of narrative-thematic analysis (Riessman, 2008) and healthcare journey mapping (Freeman, 2020; Kelly et al., 2015; Kelly et al., 2017), which I termed as abortion care journey mapping in my results. I also used the steps outlined in Braun and Clark's thematic analysis (2006) to guide my process of conducting narrative-thematic analysis but adapted it to be more concentrated on the story as the analytical unit rather than analyzing simply across cases (Riessman, 2008).

### *4.4.1 Abortion Care Journey Mapping*

Preliminary analysis began during the data collection phase. While participants spoke during interviews, I sketched out a preliminary abortion care journey map, taking notes of the key interactions with professionals and support people, places, events, timeline and dates, facilitators, barriers, emotions, and resources utilized (Kelly et al., 2017). I also would take notes of any elements that needed further clarification or anything that stood out to me about the participants or their interactions with care providers.

After the interview, I made a draft of their abortion care journey map in Canva from my notes and memory, occasionally consulting with the interview audio if needed. After conducting two interviews, I identified four key milestones or stages of care based off of Freeman's (2020) thesis research with midwifery clients navigating early pregnancy loss within Ontario's healthcare system. These milestones were labelled on the y-axis of the maps and were as follows: 1) accessing care (yellow), 2) diagnostics and assessment (blue) 3) abortion procedure (red), and 4) post-abortion care (green). On the initial drafts sent to participants, Milestone 2 was originally labelled on maps as "confirmation of pregnancy" but changed to "diagnostics and assessment" to be more clinically descriptive. For the final versions of some of the abortion care journey maps, I also added a label for "discovering pregnancy" for events that occurred before accessing care or receiving a formal diagnostic or assessment of pregnancy.

I mapped out the abortion care journeys by event using square text boxes in a flow chart (Davies et al., 2022) with particular attention to the care encounters (LaRoche et al., 2020) within abortion care (i.e. healthcare system, non-profit reproductive organizations, therapists, or pseudo-care organizations). The events were organized temporally: the x-axis of the maps represented the elapsing of time. They were colour-coded according to the stages of care. While most times events occurred sequentially from one milestone to the next, sometimes events happened out of order due to barriers or complications. Some encounters elaborated on how participants experienced them, including emotional, informational, physical or contextual factors, depending on how much importance or meaning participants ascribed to these events during the interview. For example, in the draft of an abortion care journey map sent to a participant, a meaningful event at the clinic reads, "male doctor comes out to discuss birth control while patient recovering – feels judged and rushed" whereas a post-abortion event at the lab simply reads "gets bloodwork at walk-in clinic near house 2 weeks later" as this encounter had no noteworthy interactions when described in the interview. In diamond boxes, I labelled places (i.e. ultrasound clinic, hospital, walk-in, doctor's office, home, work) that I connected to events.

I also used the abortion care journey maps to emphasize barriers and facilitators to care and resources utilized by participants, drawing from the style of Kelly et al. (2017). I represented these with icons and a brief description: phone represented a phone call or virtual call; hourglass represented wait times; vehicles represented transportation needed; clocks represented time off work; dollar symbol with hand represented expenses out of pocket or income loss; clipboard represented missing information; a person represented supportive healthcare professional or partner or friend.

Participants were sent these versions of their journey map within 24-48 hours after their interview and given the option to offer feedback. While some participants thanked me for the

map, only one participant gave feedback, responding with minor corrections to the timeline and a more detailed breakdown of events by gestation date.

After all interviews were completed, I compared the abortion care journey maps, noting similarities and differences between each stage of care as well as the level of complexity as a whole. For five participants, I made a finalized version of the abortion care journey map along with their written-up narrative. I carefully edited the initial maps, comparing them to the interview transcript and adding more details to events. I chose these five participants to be able to compare their maps based on the different routes that they accessed care (walk-in clinic, midwifery care, hospital care, procedural procedure at an abortion clinic and a medication procedure at an abortion clinic and home). The remaining eleven participants all accessed care primarily through an abortion clinic. My other aim in choosing these individuals was to capture the diversity in the degree of complexity of their journeys: three complex journeys and two relatively straightforward journeys.

I asked these five participants if they would like to read and review their stories and maps before I included them in the final version of this thesis, giving them the opportunity to provide feedback as the stories often relayed sensitive events. All five participants opted to read the stories beforehand but none requested any changes to the stories be made.

#### *4.4.2 Narrative-Thematic Analysis*

Concurrent to creating the abortion care journey maps, I also engaged in narrative-thematic analysis. Narrative analysis focuses on the sequences of actions or responses of participants in a specific place, time period, and context (Riessman, 2008). Polkinghorne (1988, as cited in McCance, et al., 2001) emphasizes placing actions, responses, and events in sequential order to determine their significance in the overall plot and outcome of the story. This analytical approach is in alignment with health care journey mapping where care encounters are visually depicted in temporal order (Kelly et al., 2017).

In comparison to other forms of narrative analysis, narrative thematic analysis focuses on the content of the stories that people tell rather than how they tell story or to whom (Riessman, 2008). It is similar to thematic analysis (Braun and Clarke, 2006) in that themes are generated and general concepts can be elicited. However, instead of generating themes across categories of fragmented data, themes are drawn from examining sequences of events where case narratives are kept largely intact and details are preserved (Riessman, 2008). Narrative thematic analysis also pays attention to how the personal narrative of the participant is shaped by their societal and structural context, identifying power relations, systemic barriers, and inequalities based on one's social location (Riessman, 2008).

#### *Memos*

After transcribing each interview, I familiarized myself with the data (Braun and Clarke, 2006) by taking memos or record quotes in a journal as I was transcribing. I noted events or interactions that stood out to me as particularly meaningful for that participants' overall experience, especially if they indicated a facilitator or barrier to care or provoked an emotional response for the participant. For example, I wrote in one participant's notes "felt needlessly

questioned around birth control.” I also wrote potential interpretations in this section to consider for my discussion section, including feminist critiques (i.e. interaction seemed to be influenced by “gendered power dynamics”) or gaps in care that could be improved (i.e. interaction seemed to be indicative of “importance of having a support person”). While I mainly concentrated on the content of the narratives and how the participants made meaning of their experiences, I also noted any outstanding questions I had about the person’s narrative (i.e. “I wonder why this person had an abortion? Finances?”). As well, a few times I pointed out where I seemed to have an influence on the participants’ narrative during the interview due to my influence as researcher (i.e. “when I asked if they gave feedback, the person initially responded, ‘well I guess I still could.’”).

### *Re-reading each interview and initial coding*

After I had transcribed and written memos about all interviews, I re-read transcripts and engaged in generating initial coding (Braun and Clarke, 2006). I used the commenting feature in Word to summarize and interpret the meaning of large chunks of transcript using inductive codes. I coded based on how participants perceived and felt about their interactions and events along their journey, often relying on the use of gerunds to indicate actions or responses. Codes were general at this stage and often tried to incorporate words used by participants. For example, one participant’s interview consisted of codes such as: “feeling supported by partner,” “difficulty finding where to go,” “not feeling questioned by professionals about decision,” “feeling well prepared with information given,” and “feeling pain from medication abortion.” While my focus was on the meaning-making of the individual’s experience, I did at times jot down stark divergences or comparisons to other participant accounts. For example, in the above transcript, I noted that for the above participant, her “feeling weird about how practitioner prepared her for the pain” contrasted the experience of another participant where they would have liked to be more prepared.

My supervisor also read two-thirds of the interviews and coded the first half. At supervision meetings, we discussed our interpretations of individuals’ accounts of their experiences based on our codes.

### *Searching for themes for individual stories*

As I wanted to retain the narrative as the analytic case for my narrative-thematic analysis, my next step was to conceptualize each transcript as a “story” and search for themes within each participant’s story (Braun and Clarke, 2006; Riessman, 2008). For each interview, I wrote out 6-10 themes conveying my interpretation of the most important perceptions and emotional reactions to interactions and events. For each story, I sought to answer for myself: “how easy or complicated was it to access an abortion?” “how did the person perceive their interactions with professionals or support persons?” and “how did the person feel throughout the experience?” For example, for Willow’s story, I wrote out the following themes: “knowing your body but not feeling in control of your care,” “needing to advocate for trauma-informed care,” “wanting a baby but not being able to provide at this time,” “experiencing judgement for seeking out an individualized abortion,” “receiving supportive individualized care from midwives,” “experiencing complications and pain from procedure and ineffective pain management,” “experiencing healing through goodbye ritual,” and “experiencing connection through peer

support.” I then attempted to write a title or two (core narrative(s)) to capture the crux of the conflict and emotional resonance for each story. For example, for Diwa’s story, I wrote: “feeling proud and empowered about choice: overcoming medical fears and voice of Catholic childhood.”

### *Writing out case stories*

After I wrote out the themes for each story, I began the process of writing out individualized stories using pseudonyms. As noted above with the abortion care journey maps, I selected which stories I was going to write out based on the different routes that they accessed care. However, as narrative analysis is also concerned with how a person’s story is shaped by their socio-political context and social structures (Riessman, 1993, 2008), I reviewed the five stories I selected to ensure that they conveyed stories of individuals with diverse social locations and intersections in terms of race, gender, parentage, partnered/non-partnered, and rural/urban. As well, I made sure that the stories selected would demonstrate a range of emotional resonance and decision-making rationales about having an abortion. In this way, while these case stories were individual accounts, I believe that all the participants in this study would be able to relate to the elements of at least one or more story.

I wrote the stories by referencing the abortion care journey maps for the sequencing of events and then consulted the transcripts to enrich the stories with details, emotional resonance, and interpretation of events. While writing the stories, I kept in mind Labov’s structural approach that states that stories have six elements: an abstract (summary of the context and character), orientation (setting and context of the narrative, including time, place, situation, characters), complicating action (events: what did the narrator do or what happened to the narrator), evaluation (significance and meaning of events by the narrator), resolution (what happens at the end of the narrative), and coda (present day reflections on events) (Riessman, 1993; Riessman, 2008; Josselson & Hammack, 2021). The orientation introduced the participant by their social location, context, and rationale for decision to have an abortion. While I did not directly ask about this latter part, participants often began their interviews this way, so I felt it important to add at the beginning of the story. I then summarized the complication actions and used quotes from the transcript to demonstrate participants’ perception or interpretation of events (evaluation). The resolution was generally indicated by participants’ post-abortion care and sometimes I included a present-day reflection on what had happened if the participant also remarked on their perceptions or interpretations currently of abortion access and care (coda).

### *Comparing themes across cases*

Simultaneous to writing up individual stories, I also engaged in a process of comparing themes across cases (Braun and Clarke, 2006). The broad narrative-thematic findings are, in a sense, a composite of all participants’ stories organized loosely based on Labov’s structural approach and the milestones in the abortion care journey maps. After deciding on the broad themes, I inputted these into NVivo and grouped the initial codes into sub-themes. Sub-themes were not determined solely by the prevalence of an occurrence, as there was great range and diversity between participant accounts’ but were also included if it was important and meaningful to a participants’ overall experience of their journey. Afterwards, I cross-referenced sub-themes I generated with the themes within each individual’s story to ensure that the most meaningful components of each participants’ story were included. In this way, while I did “cut across cases” so to speak, in

generating these themes across cases, I made sure that the core narrative(s) of each participant's story were incorporated.

#### **4.5 Reflexivity and Positionality**

As abortion access has been highly politicized and contested throughout Canada and North America, it is essential to make clear my stance when addressing the topic of abortion access and care experiences. My views of abortion align with the feminist, pro-choice movement in that I believe that abortion is solely the pregnant person's decision and that it should not be the decision of the courts, governments, partner or anyone else. The pregnant person should be the decision-maker as the foetus is housed within *their* body, and it is *their* life that will be profoundly impacted if they give birth and/or raise a child.

My goal in doing this research was political. In alignment with feminist narrative research (Riessman, 2008), my hope is that the stories I have captured and re-told move audiences toward empathy, connection, and action. By pointing out areas for improvement, I hope to instigate systemic change in abortion care.

Up until my engagement in this thesis, my perspective on abortion has been shaped by my own reproductive, birth, and parenthood journey, and the stories of my friends, family, and community members who have chosen to have children or terminate a pregnancy. I have also been influenced by the stories shared by staff at SHORE of their challenges in helping others access abortion. As a social worker who has worked with vulnerable clients, I also have seen how a variety of circumstances and contexts can make it difficult for people to obtain birth control, raise a child, or access an abortion. In alignment with feminist methodology, I believe that by engaging in interviews relationally, I connected with participant not just as a researcher but also as human, even though the particularities of their experiences may have differed from mine. While participants are clearly told in the informed consent documents that this study may not provide any benefit for them, as a social worker, I do hope that some participants found the experience of re-telling their story to someone who could validate them to be helpful, if not healing.

That being said, I was surprised by some of the data I collected from my interviews, particularly how painful, both emotionally and physically, an abortion could be. I expected that perhaps there would be some challenges to accessing an abortion or perceptions of receiving sub-par care. However, I did not entirely comprehend, before doing these interviews, how complicated the decision to follow through with an abortion can be for someone based on their personal context and desires. In particular, I was stretched to meditate on the emotional experiences of participants who might have pursued parenthood had their circumstances been different.

While I may have had some commonalities with participants, I know that, as a white, middle-class, cis-gender mother working as a student-researcher in an academic institution, I have privilege and power in hearing and analyzing the experiences of others about accessing and receiving abortion, especially if they were a young, racialized and/or non-binary person. I actively tried to combat this by building informed consent throughout the interview process but participants may have shared more than they otherwise would have due to these power dynamics. As a result, I was intentional about building in a process to have participants see and

give feedback on their stories before publication of this thesis and by not revealing parts of a participants' story that was irrelevant to the overall meaning of their experience in the abortion care system.

In addition, I am cognizant that my own background, biases, and privilege may have contributed to me missing opportunities to further explore participant challenges from an anti-oppressive perspective. During interviews, I asked participants directly about their social identity (i.e. race, gender, class, age, ability, mental health) in relation to their accessing services but was unable to make substantive conclusions about discrimination or racism in the abortion care system. I am aware that my privilege has enabled me to traverse the health care system and adjacent services with greater ease than participants who negatively experienced these systems, and therefore I may not have picked up on undertones of oppression or micro-aggressions. My lack of attentiveness may have inhibited deeper exploration of these areas. It is my goal to take action to reduce barriers that exist in the abortion care system for non-binary and transgender people, racialized people, Indigenous Peoples, and individuals in the prison system.

## Chapter 5: Findings – Participants’ Stories of Accessing and Receiving Abortion Care

### 5.1 Camille

Camille (pseudonym) is a white mother of two children who operates multiple self-employed businesses with her husband in rural Ontario. In the summer of 2021 at the age of 37 years old, she had a procedural abortion at a hospital in a small city in Southwestern Ontario about a 30-minute drive from her home. This is her story:

After the birth of her second child, Camille obtained a copper intrauterine device (IUD) as she did not want another child. When she found out she was pregnant, she was very upset by the discovery as she loved being pregnant. For Camille, the decision to have another child was an immediate firm “no” despite her husband wanting to take some time to think about the decision:

“I’m like, ‘no, we’re not thinking about it.’ Because I had [complications] at the end of my last pregnancy, there was no way I was redoing this again. There were a lot of boundaries for me that were like, ‘no, that’s my body and this is what I’m choosing.’ [...] And later, it also made sense [to him]. I mean, financially and everything, we are the motor behind two self-employed businesses. I mean it’s precarious enough. For me, I [would] have to carry another child and you know.... I knew what I would be engaging in because I also breastfed, I co-slept. I mean I still co-sleep. Attachment parenting takes a lot of you. So I was like, ‘nope!’”

She felt so in shock after finding out that she was pregnant that she went to the pharmacy to pick up emergency contraception. But when she picked up the package to read the instructions on the back, she knew it was too late to take the pills: “oh fuck, this is not going to work.” Accepting that she was actually pregnant, she felt awful. She had no idea how to go about obtaining abortion services. She looked online but all the services she saw were either far away or not relevant to her as they only provided medication abortions. A medication abortion would not be an option for her with an intrauterine device (IUD) in place. She recalled her friend mentioning that she had previously accessed an abortion through a gynecologist. She had to wait until Monday morning to call hers since it was the weekend.

When she called her gynecologist’s office first thing that Monday morning, the receptionist told her abruptly, “if you don’t want to keep the baby, you’ll have to see your family doctor.” Camille was taken aback by the receptionist’s response. Why wouldn’t she see her gynecologist for an abortion when she was the person who she went to for all of her reproductive and sexual care? Camille had been consulting with this professional for years; she knew her medical history: “all of a sudden, it’s like a ‘no.’” With little room to push back, she called her primary care physician’s office and had to explain again to this receptionist that she needed an abortion. She was told, “well, your family doctor is on maternity leave, so you’ll have to see the doctor who is covering her.” After all this coordinating, Camille’s reaction was, “sure, whatever. I don’t care.”

Camille and her husband attended that first appointment together with the physician. Camille asked her, “how is it possible that I have an IUD and I got pregnant?” The physician examined her: “oh, I see. The IUD is stuck to the side.” Lying there on the table, Camille cried, feeling emotional over being pregnant. The physician asked them what their plans were moving forward.

Camille and her husband told her they had decided they were going to have an abortion. Her husband added, “well, yeah, I’ll be next on the table,” explaining that he would have a vasectomy to prevent future pregnancies.

The physician explained that she would have to go for an ultrasound. However, the wait was up to three weeks at that time, about a year into the COVID-19 pandemic. Camille could not comprehend having to wait that long, thinking to herself: “I’m not fucking waiting for this. What are you talking about?” She had already been experiencing nausea and other unpleasant pregnancy symptoms and did not want the pregnancy to progress even further. Taking matters into her own hands, she reached out to her friends in the medical field and asked, “what do I do?” Her friend who was a nurse responded, “you go to the ER. Go to the ER.”

That very night, her husband drove Camille 30 minutes to the hospital in the nearest city. She checked into the ER and then started to wait. Midway, her husband had to leave, needing to pick up the kids from the sitter and put them to bed. In total, she waited for 6 hours: “I was there waiting and waiting and waiting and waiting and waiting and waiting.” On her own initiative, she decided to check in with the nurse at the registration desk, asking, “when am I supposed to see someone?” To which the nurse replied, “Oh, I thought you left! I discharged you.” Camille was baffled as to how this had happened: she had stayed in the exact same spot in the emergency room the entire time. They told her, “come back tomorrow morning at 8. We’ll get you in for the first available ultrasound appointment.” Camille got in her car and drove home.

The next morning, she returned to the hospital for an ultrasound, which felt very hard for her. As the ultrasound was being completed, Camille did not want to look at the screen but when she did glimpse at it, she could see something there. With previous pregnancies, this experience was worrisome but always a bit exciting. Now, she could only think “holy fuck, I really do have something. This is not okay.” She felt it was very unfair that she had gotten pregnant and was having to choose an abortion. The nurse could see that she was upset and walked her back to the Emergency Room after Camille’s ultrasound was completed, holding her hand. Camille explained the impact of that compassionate gesture on her:

“I’m not asking each nurse to do this, but that really was amazing. I will always remember her. I have no idea [what] her name is. But that really, really, really helped me a lot. It’s those angels that, you know... you’re in the bottom and then you’re not expecting it because you just have to go through the emotion on your own and stand on your own and then that person comes and gives you support, and it’s like, ‘thanks, thanks for seeing me.’”

She was then sent for a urine test and spoke to a doctor who told her she had to book a “family planning” appointment next to discuss having an abortion. The doctor then told her, “they are only available every other week.” Camille responded, “what do you mean I have to wait one whole week?” The doctor shrugged: “yeah, that’s the only availability we have.” Camille felt very discouraged at having to wait longer as her emotions had started really ramping up:

“Personally - I’m going to be very honest - I never felt suicidal. But [pause]. I was in such distress at this point. Plus the emotions. Plus the hormones that were kicking in. And I was **so lonely**. I felt very lonely. I felt very isolated. I felt so terrible even though I knew I did not want

to keep this child. Or this seed in me that would grow into a child. I just felt so awful. Like why did I have to make this choice? I just couldn't comprehend it and I hated it."

She went back home. And then she waited again. When she did not hear anything for a day and a half about the upcoming appointment, she decided to call her gynecologist, the only person she could think to call: "Listen, I know you're not supposed to help me with this. I get it. But this is what happened. Why haven't I heard anything?" Her gynecologist looked into it for her and came back and told her, "Oh, I'm so sorry. They sent your file somewhere else." Again, Camille was flabbergasted at the system. She thought, "if I hadn't called, would have I just waited and waited and waited for an appointment that would have never arrived? What's going on?" She never found out what had happened to the referral.

She then proceeded to call multiple places and was finally able to book herself a "family planning" appointment for a week later. She found this time very difficult and lonely. Even her partner, who was typically a very sensitive man, could not fully grasp the depths of her despair: "nobody else but a woman could understand that I was going through honestly [...]. Like he just has no clue." They fought over him not showing her enough support. Her mother-in-law, on the other hand, was deferential to her choice: "it doesn't matter if you want to keep the baby, we'll help you out. If you don't want to keep the baby, we'll help you out." She confided in her parents who were compassionate, but she felt their separation since they lived in Europe: "I just wanted my mom to cuddle me."

Her husband drove her to the family planning appointment at the hospital for 10 AM. When she entered the room, she immediately noticed the posters on the wall that read, "how big is the baby?" according to each week of gestation. Camille found these posters upsetting: "Oh my gosh, I don't wanna fucking know. [...] I don't need this kind of information. I just want to get rid of this pregnancy because it's my choice and my right. Why would I have to see these and know the size of whatever, you know?"

She then spoke to the doctor at the family planning appointment who brought up the topic of contraception. Even though she had been told it was possible she would go immediately into the procedural abortion, Camille was unsure if this doctor was going to grant her an abortion: "it was like, 'okay, I'm going to choose yes or no or whatever.'" The doctor offered to have her uterine tubes removed while they were doing the procedure, "you know, they can do that too when they do the surgery. Then there's no more worries." Camille responded, "no!" thinking to herself, "I'm the one who took birth control, had a vaginal birth, experienced medical issues after the birth, then had an IUD put in: what more do you want me to go through? It's like butchery after all I've been through." The doctor implied she needed a contraception plan before moving forward. She found the interaction condescending: "I'm 36 years old, and I'm going through this abortion! I will never go through this every again in my life!" She explained that her husband was going to have a vasectomy, thinking to herself, "he has to take responsibility too." The doctor remarked to her, "oh, he's not here." She then felt she had to call her husband and have him re-explain over speakerphone to the doctor that he was planning on having a vasectomy.

She was booked in for the procedure for 1:30 PM and was given pills to start the abortion process. Up until this point, she had been fasting all day as per recommendations from the

hospital and was very exhausted, already feeling the day was very strenuous. Her husband brought her to a family friend's house in the city where they waited until her appointment, and then he drove her back to the hospital.

She had the procedure at the hospital, and she found each staff member she interacted with considerate and kind, not giving her any side looks or making her feel judged. As she lay on the table, they joked around with her until the anaesthesia put her to sleep. When she woke up, she felt they were gentle with her and explained there might be some mess and what to expect over the next few days. After that, there were no further check-ups from the hospital. A few days later, she had follow-up blood tests where she ended up knowing the person who did the blood draw. When her friend asked her, "are you okay?" she confided in her and was able to cry in her arms.

She stepped away from her family businesses to recover. This time off was in addition to all the time she had already taken for all the appointments. It resulted in a loss of income for them, and her husband had to juggle the tasks across the multiple family businesses. Taking care of her children was also challenging for Camille during that summer, but fortunately for them, Camille's parents had already been planning to visit their place from Europe and stayed for a month to help out with child care. Camille described the emotional toll of parenting during this time:

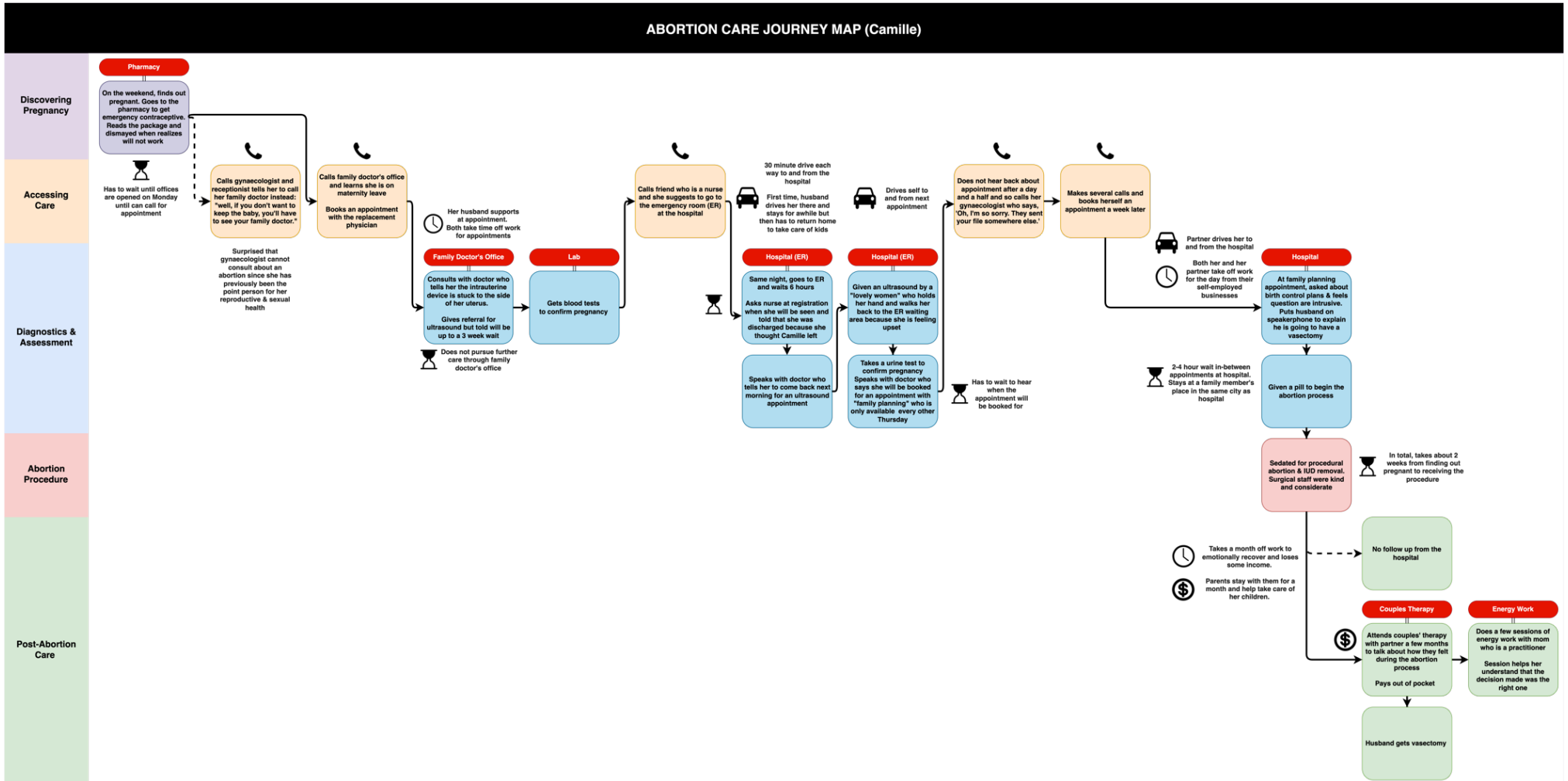
"Pffft, there was no way of me being able to parent when I had all this to deal with. When I was crying by myself and feeling [despair], my kids were in front of the TV, and I was like crying in a ball in my bedroom. They didn't know I had an abortion. [...] Mummy was crying, and they didn't know why I was crying, right? So I was like, 'oh I'm just feeling sad. Something is sad in me.' And that's it, you know."

As a couple, they also did not feel there was any room to talk about the abortion and sought out couple's therapy a few months later, which they paid for out of pocket. These sessions were helpful for Camille and her husband; they were able to connect and understand each other's emotions during the abortion, but felt regretful they had not in tune as much to each other's needs during the time: "instead of being against each other, there should have been a moment where we were unconditionally supporting each other, but it didn't happen. So, there was also some grief about that." Her husband also got a vasectomy, which Camille attributed to him having some insight into her journey: "I think what made him choose this is because... one, he saw what I was going through and decided, 'I think she's been through enough. So I think it's just my turn.'"

She had some lingering feelings of unsettledness about having had the abortion. She felt a sense of stigma driving past signs in cattle fields that read "life is a precious gift." So she engaged in "energy work" with her mom who was a practitioner of this spiritual alternative medicine. Camille had two sessions where she talked to her inner self: "what is it telling me? Is it allowing me to have done what I've done?" She felt those really brought her closure because she then knew the core of herself had no doubts that her decision was the right one.

When looking back on her experiences, she wished people knew how hard it was to get an abortion, that it was “so bumpy,” even for someone like her, a white, well-educated woman who could self-advocate for herself. She hopes that in sharing her story it will break the stigma around needing an abortion and dismantle any myths around who might want one.

**Figure 1** Abortion care journey map of Camille



## 5.2 Beatriz

Beatriz (pseudonym) is a 30-year-old, Latina woman who is a program manager at a non-profit organization in an Ontario city. In the spring of 2021, she received a medication abortion through a walk-in clinic but then needed to have a procedural abortion at the hospital due to complications (retained product of conception). This is the story of her experience:

It was a spring day, one year into the Covid-19 pandemic, when Beatriz realized she had been feeling weird lately and decided to go to the walk-in clinic to get her symptoms checked out. She had no primary care physician at this time but had been seeing a physician through the walk-in clinic for three years and felt the clinic had a good range of services. She told the doctor that she had had unprotected sex a month before but had taken emergency contraception. They both agreed that they did not think she was pregnant but should test for it anyways in addition to some other medical tests.

She did not expect the call the next day that she was pregnant: “The pregnancy was a complete accident. Something that I was not prepared for at all. And the way that I found out about the pregnancy was also a bit of a shock.” The physician from the walk-in clinic asked her what she wanted to do. She knew that it was not the right time for her to have a child. He offered to do a medication abortion there at the clinic, a procedure that, at that time, he told her the clinic had been doing about 3-5 times per week. “You have lots of time to decide,” he said. “No, I’m sure of my decision,” she said but gave herself 24 hours to think through her options. She was a year into a job that she loved and had recently graduated from a postgraduate program. She came to the conclusion, “I’m definitely not ready yet.” Her partner was also a factor in her decision making:

“Even though they were supportive to whatever. I knew that they weren't ready as well. So, it's like if I'm going to take on this huge task.... And my partner, even though very lovingly would say yes to having the baby, and told me that if we wanted to have it, we would have it, he was not ready at all.”

Her first step in her journey was to confirm the pregnancy via ultrasound. The same day after receiving the positive result, she went to get an ultrasound at the walk-in clinic where the technician assumed the pregnancy was wanted: “it was like, ‘congratulations.’ A lot of happiness. Like, ‘ohh good for you.’ Like, ‘blah, blah, blah.’” The technician also handed her an ultrasound photo.

Her next step was to get more information regarding the abortion process and look into options of where she could access an abortion. While she had been an advocate for abortion, the experience of needing one herself made everything feel completely new to her. When searching online, she inadvertently ended up calling several anti-abortion organizations who questioned her decision to have an abortion and left her feeling a sense of shame. She also called some freestanding abortion clinics but was told the waiting time was between 2-4 weeks because of the influx of unexpected pregnancies during the pandemic. To Beatriz, the wait was intolerable:

“It's not something that [pause] I think anybody should take lightly. Um... so I was like, if I'm

gonna do this, I'm gonna do it now, because I'm ready for it now. I'm not gonna let the process extend and things grow. So I said, 'no, I can't. I'm not going to wait like two or three, four weeks to get an appointment at one of these clinics.'”

Next, she had an appointment with the physician at the walk-in clinic where he explained the procedure and gave her an injection to stop the growth of the fetus, likely intramuscular methotrexate. In reflection, she wished she had been given more standardized information about the different types of abortion medications as she was later unhelpfully told by an obstetrician gynecologist that she would have given her a different type of medication abortion.

At home, she took the medication pills the physician had prescribed. Her partner was able to take two days off work to support her. However, she decided to hide it from their roommate because, although they were close, it was a very raw process for her. She reflected on her experience at home in the interview:

“And it was very difficult. [...] It was very painful... and emotional, obviously [...]. I wasn't ready to tell other people that I was going through that. The whole thing was and is still very emotional for me [pause]. [...] I was very sure of my decision. Very sure of what I had to do [voice breaks] [pause], but that doesn't eliminate that it was very, very hard.”

The physician from the walk-in clinic frequently checked in with her at home, before and after she took the pill, providing direction when the pills did not seem to be working. She ended up taking three rounds of the medication pills at home upon her doctor's advice. After releasing “what the doctor described,” she thought the pregnancy had been terminated and went back to work. But a few days into returning to her job she felt “severe, severe pain,” despite having a high pain tolerance. She knew something was wrong. She called her doctor back who advised her to go to the emergency room.

At some point between the medication abortion not working and getting the procedural abortion completed at the hospital, she had another ultrasound with the same technician at the walk-in clinic. This experience had a particularly negative impact on Beatriz when it was clear to her that the technician had a different stance on abortion than her. Upon seeing the retained products of conception in the uterus, the technician used insensitive language stated, “ohh no, it's dead now. Like it's dead now. It's stopped.” Beatriz did not bother to give the technician any explanations but inside her head she was thinking, “this should have been **out** by now.”

She drove there alone – her partner was still at work and would not be allowed in the hospital. She waited awhile in the emergency room at the hospital to see a specialist, about 6-7 hours, what she qualified as a typical wait. The first doctor she spoke to was a female gynecologist who kindly explained that the ultrasound indicated that there was retained product of conception (RPOC) – still some embryonic tissue in her uterus – and that she would need to undergo a procedural abortion since she was experiencing so much pain. However, her experience with the surgeon was vastly different in terms of his bedside manner. He was just coming into his shift and came into the room reading her file. He did not take the time to connect with her: he did not look at her, did not introduce himself, and barely spoke to her. Important to Beatriz, he did not

tell her how long the procedure was going to take nor explain that she was going to be completely sedated:

“I’ve never gone to the hospital. I’ve never had surgery. I’ve never had anesthesia. Sadly, because it was the pandemic, my partner couldn’t go in with me [...]. I never knew how long the procedure would take. And I didn’t know I was going to be put under completely. I did not know that. I didn’t know. I did not know that. [...] Like she just told me that, ‘they would go in and into the uterus.’ I was still dilated from the other procedures, so they had to act quickly because I was still dilated. [...] The procedure was: they go in and they scrape off whatever is left of it. So that’s pretty much what I knew. But I didn’t know how long the procedure would be and that I would be put under completely like that. Like I knew that there would be anesthesia but not fully. [...] The procedure which was - I found out later should be just a few minutes - was when I woke up, let’s say like 40 minutes after that.”

She went into the recovery room and never saw a doctor afterwards, only the nurses who told her she could expect a lot of bleeding over the next 24 hours or so. Her partner picked her up and drove her home. Beatriz described being grateful that she recovered quickly, not bleeding as much as they described nor in pain after: “I felt a lot better, a lot more normal.”

She received follow-up care, meeting with the physician at the walk-in clinic and receiving another ultrasound from the same technician. However, the technician stated that she still had product in her uterus, which created a lot of fears and anxiety for her that “what had happened would affect my fertility or my reproductive system permanently.” She described that she thought it would be a straightforward process getting an abortion but the complications made her experience tumultuous, which profoundly impact on her mental health:

“Now the mental health part was very, very tough. And I have to say that I did not get any resources in any institution about the follow up on getting a therapist, getting somebody that can help you after that. Because it does affect you emotionally. And especially with me, I had a lot of complications. It affected me a lot. I, I know that I cried. I cried every day for about a month and a half after work. I would go to work. I would do my job and then the moment that I would leave work, I would cry because that I was just so anxious too. Because I didn’t know—I just felt the whole thing was just so complicated and tough for me.”

She attempted to get mental health services on her own as she had counselling services through an employee assistance plan. She thought, “let me reach out.” The intake counsellor asked her if she had preferences regarding gender and what she was hoping to discuss. However, when she voiced that she had an abortion and was hoping to speak to somebody who was pro-choice, they told her, “we can’t guarantee that,” because they could not know if their counselors were pro-life or pro-choice.

She decided, “let’s give this a try I guess” but then had a counseling experience where she felt very judged. Her first session was with a male counsellor over the phone. She told him, “I went through this very complicated process. I’m sad this happened to me. I don’t know why this happened to me.” The counselor’s response to her was, “you know why this happened to you.”

She was like, “what?” and hung up the phone. She reported this person, but then postponed seeking out therapy services again.

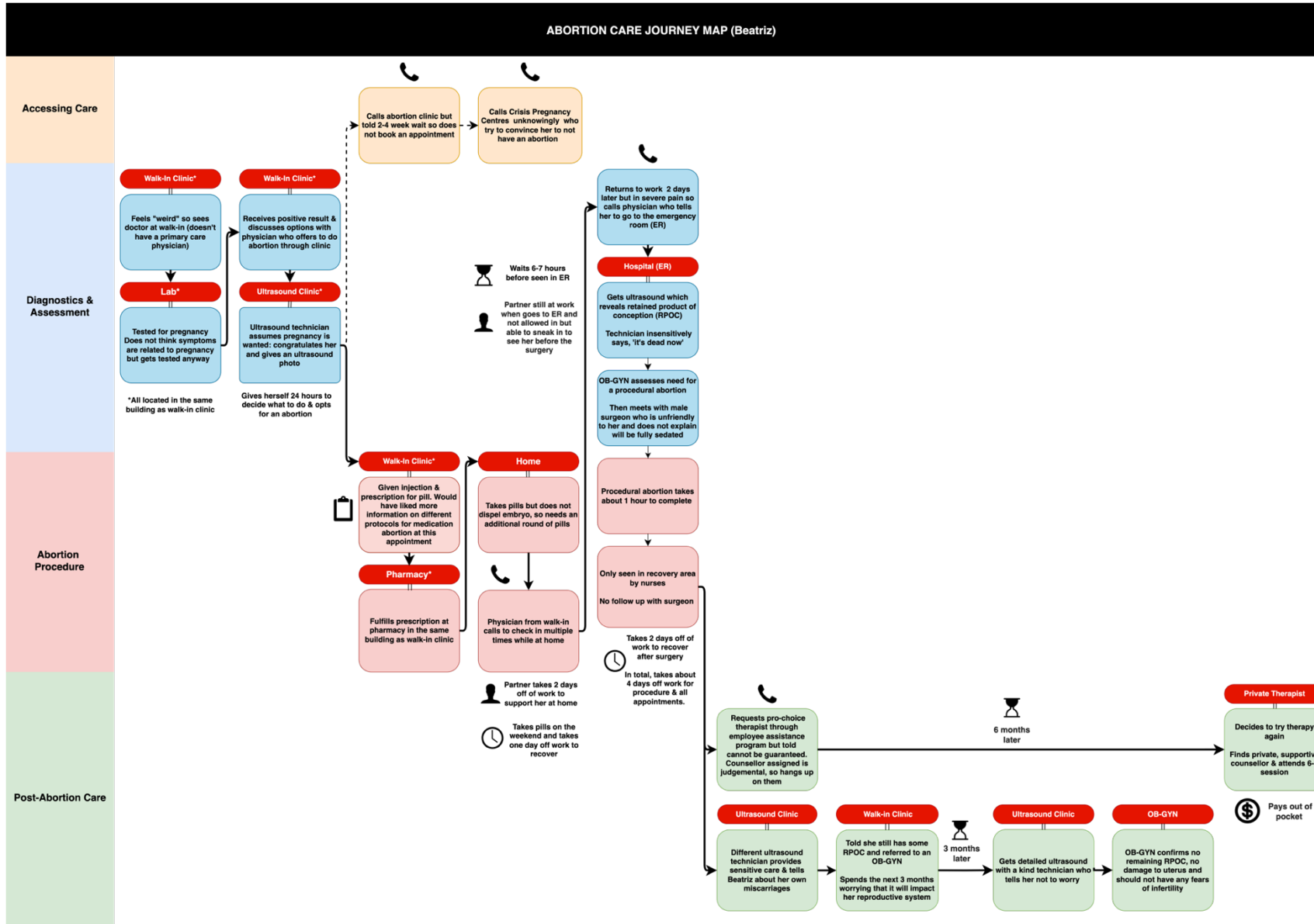
It was not until an appointment with an OB-GYN three months later that her fears were assuaged. She was able to get “an answer that everything was fine, everything looked fine, and [she] shouldn’t have any fears of infertility or damage to my uterus.” The assessment was in response to another more detailed ultrasound she had with a different technician who, while they could not say exactly what was in the ultrasound, reassured her: “don’t worry about it. There shouldn’t be anything wrong.” She also took the time to personally connect with her stating, “I had three miscarriages before I had my first child.”

Six months after her encounter with the therapist employee assistance program, she finally felt ready to try therapy again. However, this time she sought out a private therapist who she was able to screen based on their online profile. She felt this new therapist was a much better fit, taking the time to listen to her story. She described how these sessions helped her combat dark thoughts, questioning their validity:

“So sometimes I do fear like, ‘what if I can’t have a baby?’ [voice falters] and that was my only shot. You have to question those thoughts. Those strategies I was able to utilize to make myself feel better and get through those tough moments.”

She paid out of pocket for 6-7 sessions with this therapist. Now, 2 years later, Beatriz is hopeful about being able to have a baby in her future and does not want to dwell on any fears of infertility: “I’m not in a place to have the baby right now. I just turned 30. I do see a baby in my future, but it’s not a thought I should have now.”

Figure 2 Abortion care journey map of Beatriz



### 5.3 Willow

Willow (pseudonym) is a 29-year-old white person who identifies as a woman and agender, living in rural Ontario. It was important to Willow to receive a medication abortion without a transvaginal ultrasound that was as no to low-touch as possible. A procedural abortion was out of the question for her. This is her story of accessing a medication abortion in the summer of 2023:

Willow had always been cautious not to get pregnant, getting a copper intrauterine device (IUD) inserted as soon as she turned 18 years old and then later a Mirena IUD: “so it was never really a concern for me. The risk of getting pregnant.” In 2020, she wanted to try to conceive so had her IUD removed. As she was getting ready for this new transition in her life, the need to exit an abusive relationship diverted her trajectory into parenthood: “I just **really** wanted a baby, and that’s why I took the IUD out. I was getting ready for that in my life. But then, I got divorced and circumstances changed.”

When she started having sex with her current boyfriend, she told him, “I’m not interested in having an abortion, so we better not get pregnant.” She was “paranoid about it,” intensely keeping tracking of her basal temperature, ovulation dates, and menstruation dates. However, despite her best efforts, things were about to take a turn for her: “But um... things happen. Yep, the condom broke. And it was the day before I ovulated.”

Two weeks after she ovulated, she started noticing that “it seemed like something was abnormal” in her body. She had previously experienced emotional and physical changes during menstruation, but what she was experiencing now was amplified: “I went completely nuts. I quit my job, just ghosted. I was just super depressed, could not get out of bed. I just felt awful, really awful, really tired [...]. However, it just wasn’t in line with anything I had experienced recently.”

Approaching near the time her period should have occurred, she started to think, “I’m probably pregnant. I swear I am.” Around three days late, she took a pregnancy test and saw a “very, very faint” positive. She ordered more pregnancy tests, and when they arrived two or three days later, it was quite clear that she was pregnant. She had just come back from visiting for three weeks with her boyfriend who lived out of province. Right away, she knew that she was going to get an abortion: “I couldn’t live with him in the circumstances he’s in right now. Not because of anything bad. It’s just we live very different lifestyles right now, and there’s not a great way to marry that.” Her current residence was in the middle of the woods, and her lifestyle did not allow for a child: “I love living here, but it’s very hard. I have mold issues. It’s not a healthy environment to be pregnant in. Let alone have a child in. [...]. I don’t have electricity here. I don’t have running water here. And people have made it quite clear to me that my child would be taken away if I had a child here. So I just knew immediately what I was going to do.” She started looking at her options for an abortion.

She knew that she was not willing to have a transvaginal ultrasound or a procedural abortion, but she did not know how difficult this would make finding a low- to no-touch medication abortions: “It was really, really hard, and it took **way** [emphasized] longer than I thought it would because I just couldn’t find a provider that would prescribe me the pills without doing a transvaginal ultrasound.” She would explain to healthcare providers that she knew all the dates of ovulation,

date of conception, and the date of her last period, but they remained unconvinced and were not willing to budge on forgoing the ultrasound, despite her having evidence-based protocols that they could proceed without one. At the same time, she was experiencing early pregnancy symptoms that were extremely difficult, feeling nauseous and dysregulated: “It was hell. It was really bad.”

She spent weeks trying to find a provider. She called her primary care physician and was connected with a male resident who was patronizing about her request for a medication abortion: “we cannot do that here. There is nothing that we can do that would make us comfortable with prescribing that. We’ll refer you to this one specific clinic, but they’re going to require a transvaginal ultrasound. We won’t do it here.” She tried to explain, “I live in a rural area. I don’t have a car. Even if I wanted to come in for an examination, that’s not really possible. But also, I have a history of trauma. I’m not okay with getting a transvaginal ultrasound. I won’t do it!”

She called clinic after clinic, trying to obtain trauma-informed care but was unsuccessful. The professionals she spoke to asked her questions like, “oh is this your first one?” with disdain in their voice. For Willow, she found the manner in which she was asked about her pregnancy problematic, “It felt like, with the ones who were asking that, there was this implication that if you’ve had an abortion before, you’re irresponsible and less deserving of care.” She felt shocked by how “really unempathetic people were,” perceiving them as contemptuous, as if they looked down on people who get abortions. For Willow, there was also the added complexity of wishing she did not have to get an abortion: “And it was really horrible because it was already something I didn’t really want to do and just knew I had to.”

Realizing quickly how inaccessible it was, she looked into herbal abortions, reading protocols on their effectiveness and case studies. But the black cohosh pills she took made her sick. She tried a few other herbal methods, but nothing was working. She called more clinics only to have one nurse tell her, “It would be irresponsible for me to prescribe medical abortion without doing a physical examination.” And she retorted, “it’s irresponsible to let me self-manage an abortion with unregulated herbal supplements in the middle of the wild!” It took perseverance to keep calling clinics: “it was so difficult because I would have these horrible exchanges and then try and calm down and call the next one on the list.”

There were clinics that said on their website that they would prescribe a medication abortion through telehealth, but then when she called their office, they’d say, “oh, we don’t do that anymore. It was just something we were offering during COVID. There’s not a demand for it, so we don’t do it anymore.” She said, “Well I am the demand right now!” She cited studies and protocols about how telehealth prescription of medication abortions is recommended, but health care providers would not prescribe it despite technically being able to. Willow remarked, “there’s really no reason not to do it if you have the right information about the patient and can assess the risks properly. And they could. I was telling them the date of conception, date of ovulation. It was all there. But they wouldn’t budge.” Just clinic after clinic after clinic.

She cried harder than she had ever cried. A friend of hers had also connected her to a national non-profit abortion access line (Action Canada) who was working with her to find a provider. The professional helping her was kind and supportive but also was having difficulty finding her a

provider that could meet Willow's needs. When she relayed this to Willow, Willow just sobbed, "I just can't do it. I can't. There's no way I can do it." The professional talked to her for about two hours while she vented and cried: "They were very, very supportive. They were very attentive with me. They were sure to follow up with resources and everything. I don't think I could have done it without them, if I'm honest. They made sure that I had what I needed, and they were very empathetic."

She was willing to pay for an abortion if she had to. She called over sixteen clinics in three different provinces, but still could not find anywhere to do it. At this point, she felt as if she was just holding on for dear life: "I was already just so depressed and fucked up about it and couldn't really process the emotions because it just felt like the clock was ticking. I just had to find a way to do it. There was no time to slow down and feeling my feelings about it. I became pretty self-destructive, like smoking cigarettes and everything, anything to make it more difficult for this fetus to hang on."

In the end, the person from Action Canada did find a provider - a midwifery clinic. Willow had to wait for a little over a week for the virtual appointment with the midwife. She found the wait very anxiety-inducing: "I was gonna be 7 weeks and some [pregnant] when I had the appointment, so I was really scared that they were not going to be willing to prescribe it." She was nearing the end of the window in which medication abortion could be prescribed and there was no guarantee they would prescribe it to her. She felt that she had exhausted all her options: "this really is the end of the road except maybe the black market and having them mailed from Mexico or something, which is scary in and of itself." At the same time, the pregnancy symptoms continued to be hard on her and these, in conjunction with the emotional enormity of the situation, impeded on her other responsibilities:

"I was just in so much pain. I was so tired. And I live in the middle of the woods. I have a lot to do. And around that time, it was still pretty chilly. I needed to be chopping wood and I couldn't do anything. I was exhausted. I had ghosted my job, so I had no income. I didn't really have a plan going forward. I just knew I couldn't do it. So all I did all day was just worry about this and call other places. Yeah, it was a long week."

To make sure she had all her bases covered, she called some pharmacies to ensure they would dispense the pills to her and arranged with some friends to have them pick them up. However, this step ended up not being needed.

Her appointment with the midwifery clinic was completely different to anything else she had experienced with any provider at that point. Everyone from the receptionist to the midwives was so kind: "I wasn't just another number." The midwife listened to everything Willow had to say about the dates and her symptoms, but she was not concerned: "you know, maybe we would need to do blood tests, but it sounds like you know exactly when you got pregnant and how your pregnancy has been progressing." For Willow, this appointment was so different from the other providers who had a "complete unwillingness to engage in any type of individualized care at all." Contrastingly, she felt that the midwife provided compassionate, trauma-informed care, as Willow explained: "There was no question about why I would not be comfortable with a transvaginal ultrasound. It was like 'okay, that's something you're not comfortable with. Let's

try and figure something else out.’ [...] She was very willing to customize the care to what I needed.”

The clinic sent the pills to Willow for free in the mail. There were some delays because she lived in a rural area, but she received them at 8 weeks, 5 days. A relief, but not the end of her journey.

Willow took the first set of pills, the mifepristone, at home and did not feel any side effects. Next, she was to take the misoprostol pills. She was apprehensive about taking these as a few friends had told her horror stories about incomplete abortions and infections, and she was spooked that the pills were not going to be effective. At the recommended time, she took the misoprostol and within 15 minutes she started feeling side effects, a lot faster than she had been told the medication would kick-in. She thought to herself, “oh my god. This shit works fast.” Her vision became blurry, her hands felt numb, her body sweating like crazy, and she felt pain and nausea. Reflecting on her symptoms at the time, she said,

“I thought I’d be able to deal with it. I’ve had some really fucked up periods that have literally made me throw up and pass out from the pain. So I’m like, ‘it couldn’t be worse than that.’ But something just felt really wrong.”

About an hour and 15 minutes into the abortion process, she ended up calling an ambulance. At the same time, she also called her boyfriend to start driving to the hospital, knowing that it was going to be awhile before he could arrive. She had not wanted to go the hospital because she was concerned about the risk of contracting COVID-19 but felt that this was the best course of action for her given her symptoms. When the paramedics arrived, they went to assist her into the ambulance but were not wearing masks. She had to repeat herself again and again for them to put them on. When she entered the emergency room at the hospital, she had to have the same conversation with the nurses there who asked her, “why?” to which she had to explain, “I have a weakened immune system. I would just really prefer if you put masks on.” Most of them did, but then when they went to take her temperature orally, she had to fight with the nurses to put on masks again.

The pain got significantly worse and came in intense waves for extended periods of time, and she really had to coach herself through it, “You’re going to be okay.” The nurses seemed to only check on her vitals when she was feeling okay, as if they thought she was overreacting. In the midst of it, a doctor came to see her and was terse, demanding, “where did you get the pills?” and she told him, “a midwife prescribed them.” The doctor replied, “well, where? Who?” When Willow responded that she did not remember the name, the doctor stated inaccurately, “well midwives aren’t usually allowed to prescribe these.” Willow described her perceptions of this encounter: “It was very rude. She was just really rude. And I was in an incredible amount of pain, so it just felt really inappropriate in that context.”

The nurses asked her for a second urine sample. While in the bathroom, she all of a sudden felt a gush of blood and, when she went to wipe, saw the whole fetus there in her hand: “For me, it was just this really emotional moment, because I just felt like I knew everything about him in that moment [...]. Immediately I was like, ‘oh there you are.’” She was grateful that it happened to her in this way as she felt a special connection to the fetus in this moment. Then, as the nurses

were knocking on her door asking, “are you okay?” she furtively hid the fetal tissue and took it home, figuring that they would not otherwise let her keep it.

The fetal tissue having been dispelled, the pain subsided. It was only then that she was told by the nurses that the doctor had approved giving her pain relief medication, which she took at the persuasion of the nurses but did not feel she needed. Her boyfriend met her at the hospital, and Willow went back with him to his family’s home where she was taken care of by his mom. Willow connected with her ongoing therapist and had one session to debrief the abortion. She found it helpful, but chose not to pursue further care with him at that time.

She had a follow up appointment with her midwife who told her, “it sounds like you maybe are allergic to misoprostol. Most of those symptoms are relatively normal, but the numbness in the hands is a bit concerning.” She did not have to get follow-up blood work due to having released everything. She asked Willow how she was doing. Willow replied “I’m fine. The cramping’s really not bad, but emotionally I’m still kind of all over the place.” The midwife gave her some resources with a post-abortion counselling organization. Willow pursued follow-up care with this organization and found the peer-to-peer counselling healing:

“It was very, very helpful in ways I wouldn’t have expected [...]. I’m the kind of person who avoids feeling and thinking about things if I can [...]. So, to have that space carved out in my week for that was just a really intentional way to come back to it and process what I needed to process. The peer counsellor that they matched me with was just a really excellent, excellent match and left a lot of space for silence while still providing really concrete, compassionate support [...]. She never really shared her experience with me, but there was just like this innate connection and understanding between the two of us that felt very empowering and just what I needed then.”

She also attended a support group that was for people who had experienced perinatal loss, including those who had experienced abortion. She found the other women in the group relatable, even though the way their losses occurred had been different, because she also felt similar complex feelings. She felt that, for the first time in her life, she was able to really connect and be seen and supported by other women. She also felt it impactful to unpack her experience of accessing abortion, especially since she found it “honestly really traumatic.” In reflecting on her experiences of abortion, she spoke about how the group consequently brought healing to her loss:

“I know a lot of people who have had abortions, but most of them don’t feel the way that I do about it. It’s not something I hear talked about a lot. And I always thought that if I ever needed an abortion, I wouldn’t feel anything about it. I thought that it would be an easy choice for me, and it would be an easy experience for me. And maybe it would have been back then when I was thinking about these things. But now I’m just in a point of my life where it was just very, very difficult for a lot of reasons, and that was really reflected in that group. There was just a lot of understanding and a lot of support. I felt a hundred percent seen by those people in a way that I never really had before, so I healed a lot.”

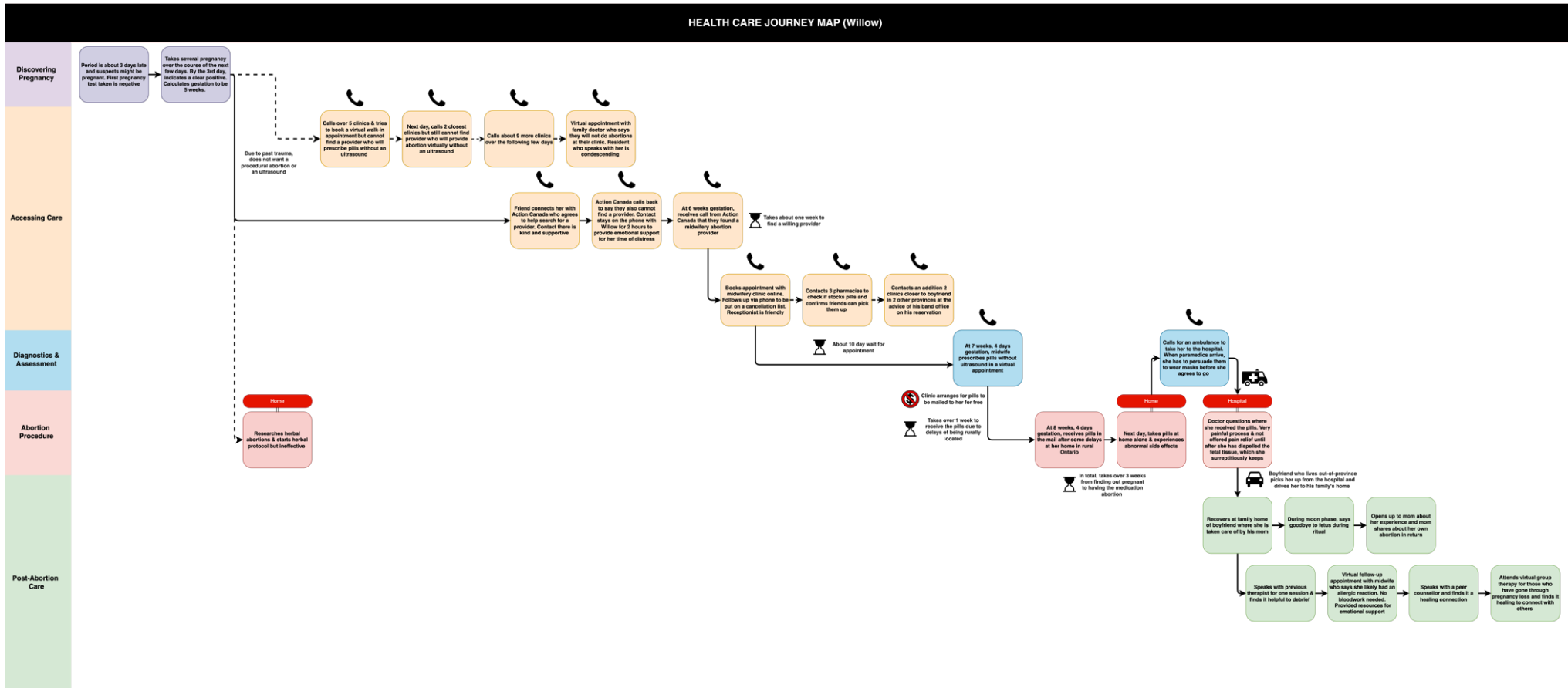
She also was able to open up to her mother, with whom she had a complicated relationship, about her experience. In telling her mother, she learned that she also had had an abortion: “it was a good opportunity for us both to feel through some of that and connect and heal those wounds a bit.”

Around the new moon, she spoke to a friend who had also had some feelings of grief around her abortion. Her friend recommended that Willow, “maybe take some time now to connect with the spirit of that child and say what you need to say.” So Willow, who typically did something for moon phases, did a ritual and connected and said goodbye. She described how she has been a part of all the moon rituals she has done since and been the impetus to take care of herself: “since then he’s been involved in everything I’ve done. It was a strangely healing experience, honestly, as difficult it was. I was really struggling after my divorce with taking care of myself, which is pretty understandable after leaving an abusive relationship [...]. The whole experience of connecting to my child and caring for myself and him in that way was just really impactful for me. I feel that I *was* able to come away with a renewed sense of vitality [...]. I’ve been able to mother myself in a way that I wasn’t able to before.”

When reflecting on her journey, Willow wants others to know that it is **possible** to find someone who will prescribe a medication abortion without the need for a transvaginal ultrasound even though it may be a hard road to get there. From policy makers, practitioners, and politicians, she advocates for more compassionate, evidence-based care:

“All I could think as it was happening, and reflecting back on it, is just like there's just no reason it should have been that hard. There is so many factors [why it was so hard]. Like so many people who can prescribe it who won't. And so many people who are just not operating based on evidence-based care guidelines. The medical system tends to be 20 years behind, but it's just really shocking. It never had to be as hard as it was, and I really wish I had had the space to... emotionally process what was going on instead of having to be... in that level of fear.”

**Figure 3** Abortion care journey map of Willow



## 5.4 Lucy

Lucy (pseudonym) is a 22-year-old, Muslim, Chinese-Canadian woman who accessed a procedural abortion through an urban abortion clinic in 2023. While finding care took her only a few quick phone calls, her experience at the clinic was unpleasant, which she compared to a “busy haircut appointment” for a “conveyor belt” of patients. This is her story:

Lucy had just graduated her Bachelor’s degree and was working a part-time contract position when she found out she was pregnant. She was in a toxic situation with one of her male neighbours where she felt pressured to have sex with him. He also told her he was not capable of getting her pregnant. One day, they got in an argument, and she stopped talking to him for two weeks.

It was during these two weeks that she was feeling fatigued, light-headed, and noticed that her breasts were swollen. She thought, “this is weird because I haven’t got my period in a little while.” To assure herself that everything was okay, she bought two pregnancy tests: one displayed a negative, the other positive. She sat on the toilet looking at the positive result and saw her cat sitting in the hallway, who she had adopted 2 days prior, and said to her, “this can’t be real.” The cat just stared back at her. She texted her friend who said, “yeah, probably fake.” She was really scared and brushed it off. She said nothing to the man who coercively impregnated her.

Despite being in denial, she called up a University-affiliated sexual health organization who recommended an abortion clinic to her. She called up the clinic and booked the appointment for the following week, annoyed that she could not get the abortion done then and there. She estimated that she was about 3 weeks pregnant at the time. Meanwhile, she was taking pregnancy tests every day to confirm that she actually was pregnant. As a Muslim, it aligned with her personal beliefs to terminate the pregnancy as soon as possible, before ensoulment, “where the soul is breathed into the fetus.” The wait was onerous on her and the silence that surrounded her entrenched her fear:

“I was really scared at this point. I was like alone, alone. Like I lived alone [in] my apartment at this time. My parents are in [another city many hours away], so I felt like super alone. I didn’t have anybody. My friend, she just recently moved away. So, I was **super** alone [...]. I hadn’t talked to a single other human being for a whole week.”

Having no one to support her at home also influenced her preferred method of abortion. She had watched YouTube animations about the different methods and while they seemed to suggest to her that medication abortion was the less intrusive option, she felt that she could not risk doing the medical procedure on her own:

“I chose the surgical one because I was scared to die alone. Because, I don’t know, if I took the pill one... I heard there might be complications. Like if I take it and I go home: what happens if you start bleeding at home and it doesn’t stop? Or the blood clots? Like I don’t have anybody beside me at that time, right?”

In retrospect, she wished she was taught in high school and in University more about the different abortion options and the risks and complications that can occur from both avenues.

The day of her procedure, she took an Uber to the clinic. She had to enter it through specific instructions given to her by the staff as it was hidden and not publically visible. She then waited for somebody to consult with her about the pregnancy. Instead, she was given a clipboard with a form requesting her consent for the procedure. She described still being in denial about her pregnancy at this time:

“Basically, there’s no takebacks. I can’t sue them; it just felt like one of those liability papers. That was a little bit scary to me because I didn’t even know what I’m supposed to do [about the pregnancy]. Because if I were to keep it, my life would be ruined. I wouldn’t be able to do anything that I’m currently doing now because I don’t want to be tied down to that guy. Because he has consistently coerced me for way too long. But it was definitely a difficult choice. I just thought I would go in there and they would be like, ‘okay, you’re not pregnant. Go home.’ You know, I thought that’s what would happen.”

From there, she was told to change into a gown and was sent into the ultrasound. During the ultrasound, the technician could not locate the pregnancy and she was told that they could do a procedural abortion but that “it might fail because we can’t actually locate it.” She was given a urine test and a finger prick test to confirm the pregnancy but was not told the results. While speaking to this nurse, she started to cry. In response, the nurse appeared to be irritated as if she could not understand why she would be crying. She questioned her about still going through the procedure: “are you sure you want to do this?” and Lucy felt as if she was saying, “why’d you come here if you didn’t want to do it?” For Lucy, she was feeling a turmoil of emotions including guilt about her decision to have an abortion and fear that the man who impregnated her would come back into her life. She wished that that someone would have helped her through those emotions and walked her through the steps of the abortion:

“I wish there was just really somebody to help me through, before the procedure. I feel like at that point I was the most vulnerable, and that was a time where I felt so lonely. I literally cried to my nurse, which I’ve never done in my entire life. Like, I never cried in front of a person before. I just wish that they just had somebody to talk you through that process. Afterwards, there’s definitely a feeling of relief after the process. But before, there’s the feeling of... fear and... terror. I guess if that’s the right word? Um, it’s a terrible feeling right before.”

In retrospect, she felt that the abortion was the right decision, but in the moment as she was sitting in the waiting room, she wrestled with feeling on the fence about her decision. She was given anesthesia and then the procedural abortion which she described the poking and prodding as being akin to a “dentist appointment in my vagina.” She went on to explain, “They just scraped around. I was really uncomfortable for like 5 minutes or 10 minutes. Most miserable feeling in my life honestly.”

She was then put in a recovery room where she laid down and stared at a unicorn decoration on the ceiling. She finally felt a sense of relief and also peacefulness, which she attributed to the pain medication she was given: “It’s such a comfortable feeling. I can’t describe it. It just feels

like there's gold in my blood [...]. I don't know if it's the morphine or what it is, but it felt so peaceful. And it's definitely the drug. Because I remember sitting down, reclining on one of those chairs, I saw this girl across from me. She also got out of the surgery, and she's also sitting in a recliner. And we're both just there unmoving. And I just wondered like, 'how is she feeling you know?'" She was given a sample-sized cup of ginger ale and a cracker. Then after about 20 minutes she was told to leave. She felt rushed out the door, almost threateningly, by a nurse who seemed burnt-out and "very done with her job:"

"The clinic felt like they had one job: their job is just to remove it. And once they remove it, their job is done. They won't do anything like talk to you afterwards or sit you down like, 'okay, how did you rate the experience? 5 stars?' Nothing like that. She's just like, 'okay, it's time to go. It's time to go. If you don't wake up, I'm going to have to give you something to wake up.' And then like, it's very like, 'get out of here. Like next person needs to come.' But there's like a bunch of seats. I don't know why she was being so like, 'go-go-go now.' Because maybe they didn't want anybody falling asleep there? But the whole entire procedure was like probably 30 minutes?"

She called an Uber to go home, in total costing her about \$60 for the whole trip. She then fell asleep for 5 hours. Although she took the day off work for the procedure, she went back to work as soon as she could. She was working a part-time contract and felt that she did not have a valid excuse to take any more time off: "I think that if I had asked they would have given me time off, but it just wouldn't have been a very good look on me because I hadn't been working for a very long time." She continued to bleed for 4 or 5 days, not as heavy as period blood, but still heavy in the beginning. What stood out to her was the bright red colour of the blood, which terrified her as it was different than the colour of her period blood. As part of her follow-up, she did blood work a few weeks later and had to pay for an Uber to take her there and back, about another \$60.

She also started to feel some regret, and so she called the clinic to try to access some therapeutic support. At the same time, she asked the clinic if she had tested positive for pregnancy in the first place and the clinic confirmed that she was pregnant and that the termination was successful. The clinic also referred her to a texting hotline. However, when Lucy went to text the hotline, it was afterhours and she did not get an immediate response and did not try again.

Instead, she went to seek out a hotline on her own, but as she spoke with the person on the phone, she came to realize it was an anti-choice, Christian hotline, which tried to recruit her to going to some of their programs about Jesus and "life after abortion":

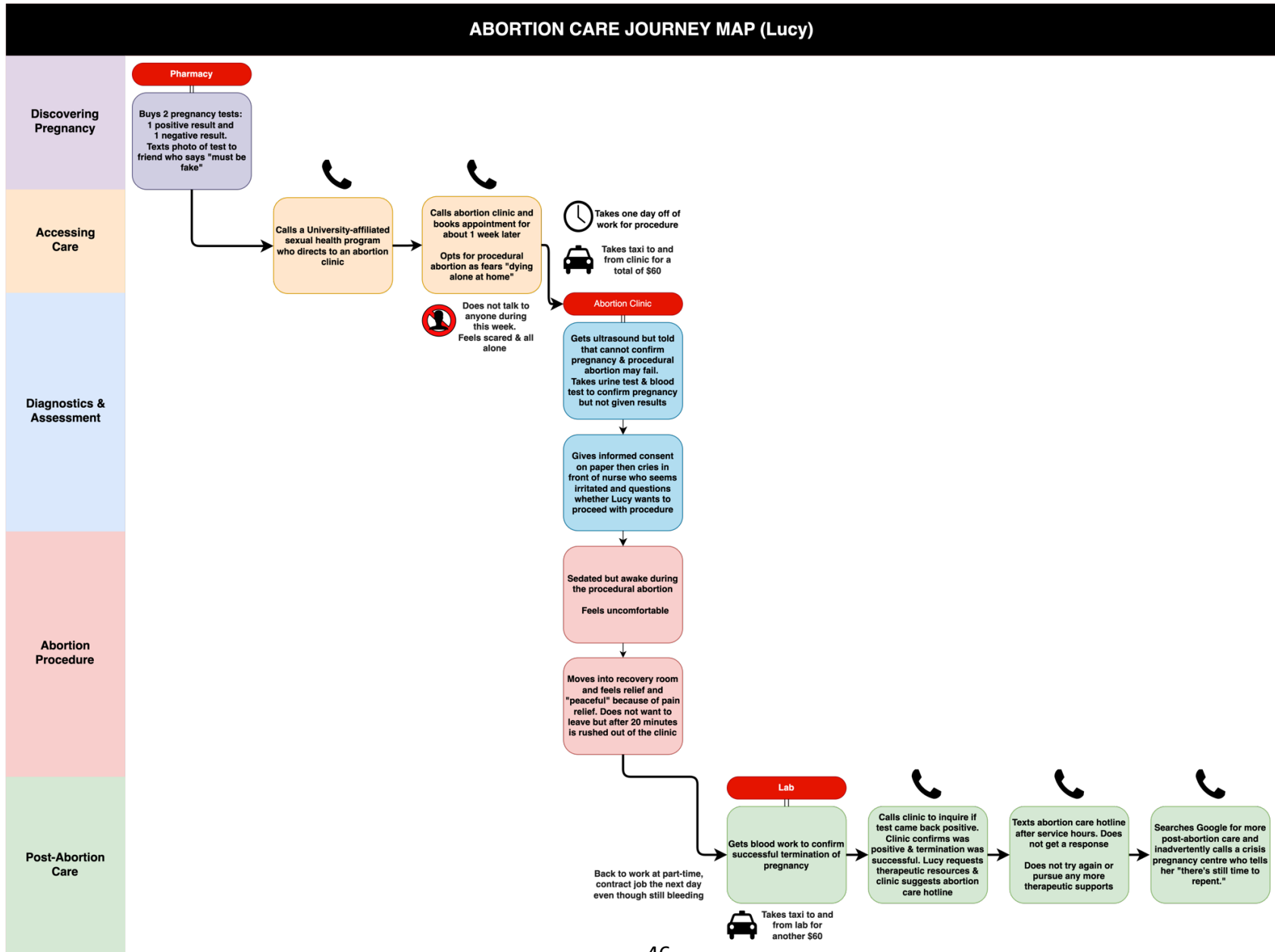
"And I found a really crappy one. I felt annoyed. [...] I was just telling them I felt bad about it. And the lady was like... she was nice and she was listening, but near the end I could really tell she was a Christian, like a hardcore Christian. [...] When I was talking about like, you know, [...] randomly about free will and choices and stuff like that and what not. And she's like 'oh... you know, there's always ways that you can repent,' and etcetera, etcetera.' I was like, 'okay, but like this doesn't really help that much, but thanks, I guess.' I feel like I just wasted my time with her, and that was just really counterproductive. I didn't really feel like explaining to her like, 'you know, like in Islam, like abortion is actually allowed.' I mean, she was Christian, and like in a hard core, anti-abortion kind of way, but she wouldn't show it until the very end, after I said everything."

After that experience, Lucy did not seek out any more therapeutic supports and stated that “I eventually got over it... on my own.” She said that nurturing her newly adopted cat helped her through her emotions: “human baby? I’m gonna go with this cat.” Lucy also went on to explain that having the abortion opened up the space in her life for her to take care of her teenage sister who was depressed and suicidal:

“I wouldn’t have been able to take care of my sister if I had a kid [...]. So far [my sister’s] been much better. And I wouldn’t be able to do all that. I wouldn’t be able to help my sister on her healing journey [...] During the year with the biggest stakes, I wouldn’t be able to help her with that stuff. I wouldn’t be able to prep her lunch, pick her up from school, drop her off. So.”

In retrospect, Lucy clarified during the interview that even though she had doubts and regrets initially, “in hindsight, I don’t regret my choice.” She explained that had she proceeded with the pregnancy, it would have “cut her life short in a way that would have made me be an inadequate caretaker and inadequate mother.” She felt that she would not have the financial resources to raise a child nor have the opportunity to pursue further education for herself.

Figure 4 Abortion care journey map of Lucy



## 5.5 Diwa

Diwa (pseudonym) is a Filipino-Canadian, cis-gendered woman and a first-generation immigrant. At the time of her abortion, she was 28 years old, working in administration and living together with her long-term partner. She accessed a medication abortion through an urban clinic and found the experience relatively easy to access but still had to resist feelings of internalized stigma and shame. This is her story:

When finding out that she was pregnant in the fall of 2022, she was living with her long-term partner who she had been with for almost 7 years. She had always been on the same page with him regarding their reproductive health and decision to not have children in the future. When she told him she was pregnant, it was a straightforward decision they made together to have an abortion:

“Our stance is that we don’t want to have children in the future. The part of the decision about having an abortion was quite easy in terms of like, ‘should I get an abortion? Should I not get an abortion?’ It was like, ‘I don’t want to have kids. I don’t have any desire to have kids.’ Even then, I think that desire to not have kids is a hard thing for some people to understand. It’s not the norm. A lot of people don’t really understand why you wouldn’t have kids. It’s not something I talk to my parents about.”

In particular, Diwa felt that she could not talk to her parents about her need for an abortion because of their Catholic beliefs. She and her parents arrived in Canada over 20 years ago from the Philippines, and her upbringing was cemented in Catholic religious principles. She went to both Catholic primary and secondary school but stepped away from her religious upbringing: “I don’t practice Catholicism anymore. I have a lot of disagreements with Catholicism [...] and I think that has informed what this experience for me has been.”

Her current convictions to not be a parent pushed her to pursue reproductive care that felt right for her. She lived in a major urban city at the time and found that it was easy to access an abortion; there was a clinic local to her neighbourhood. She called the clinic and took the first available appointment for a week or two later, despite needing to take sick days at her full-time job to go: “there was just a part of me too where I just wanted to get it done and not have it lingering. Because one, I wasn’t feeling well, and also, I was like, ‘I sort of just wanted to get this done and then sort of just try to move on.’” She did not tell her employer that she was getting an abortion, recognizing that she was privileged to do so: “Obviously, not everyone has that flexibility and that security to take a sick day off and not worry about it [...] we have job protection for people taking pregnancy leave and parental leave, but what protection is there for people when they have to get an abortion?”

The day of her appointment, she walked to the clinic, saying to herself, “oh I’m just gonna take a walk before I get this stressful procedure done. Could be nice!” She got signed in and the counselor went through the process with her, asking her about her decision to have a medication procedure: “why do you want the medical procedure? Why do you want the pill?” Diwa replied, “oh, it’s just less invasive, I guess.” The counsellor stated, “it’s going to really, really hurt.” Diwa did not feel that she was being judged or deterred her from her choice, but that the

counsellor was setting realistic expectations of the potential pain of the procedure: “Her just being upfront like that, I felt like I was a little bit more prepared in terms of what to expect. Before that, I didn’t even know it was going to be that painful, to be honest.”

She was sent back to the waiting room, with its plastic chairs and fluorescent lighting, where she observed the four people in the room with her. She felt connected to the other people in the room, “Oh, these are all other people who are getting an abortion like me. [...] They’re all going through their own journeys, but we’re all here for the same reason.” As the youngest-looking one there, she was also feeling a bit self-conscious: “do these people think I was careless or irresponsible?” She explained that the thought process stemmed from some remnants of the religious dogma she was indoctrinated with during her childhood:

“Part of that thought process was from the fact that I grew up in a religious background that shames people who are having sex before marriage, who are getting pregnant before marriage and stuff like that. So I know that’s coming from my upbringing. There is a lot of shame around it. You can’t help but go to that thought sometimes, but I know internally that it really isn’t [shameful]. At the same time, there really is no way to talk about pregnancy and abortion.”

With her partner not being allowed in the clinic, she had no one to talk to, which gave herself time to ponder her abortion decision. It was this moment where it really sunk in for Diwa that, “okay I’m really getting this done. I’m really making this decision now. This is basically it.” She felt firm her in decision: “I had no desire to leave the room.”

The staff then took her to another room where she had an ultrasound and confirmed that she was early on her pregnancy. They told her, “it’s hard to tell if you’re pregnant.” So they had her take another pregnancy test.

Diwa went back to the waiting room where she observed a couple who came in wanting to get an ultrasound. They were not interested in getting an abortion, but there was no sign at the clinic that said, “this is specifically for an abortion.” They were confused when the receptionist at the front desk had to tell them, “oh no, this isn’t for pregnancy ultrasounds. You have to go to another clinic in the building for a pregnancy ultrasound.” From Diwa’s perspective, the receptionist could not just say, “this is for abortions only” because it would break patient confidentiality: the couple could see everyone sitting in the waiting room and then would know they were here for an abortion. Diwa thought to herself, “oh wow, this is a complete misunderstanding based on the fact that the name of the clinic itself doesn’t say anything!”

After that, she was taken into another room again, and the nurse instructed her how to take the pills for the medication abortion. She took the first round of pills there and then was told to take the second round 24 hours later.

Her partner picked her up and drove her home. As a freelancer, her partner was in the middle of working but said, “I will take 2 days off with you so we can do this together.” She took the second round of pills and found it a really painful experience: “I can’t even describe it. It was like being punched in the gut. I was bleeding out really intensely.” During this time, she really appreciated having a partner who was supportive and involved, picking up pads for her from the

pharmacy while she was stuck in bed feeling sick: “I couldn’t imagine being able to go through this without him. I think it would have been so hard to go through all the pain by yourself.” For Diwa, the side effects were really intense for a day, but then after that she felt fine.

Diwa did not have to do much in terms of aftercare. She had to get blood drawn to ensure that the procedure had effectively terminated the pregnancy. The lab was in the same building as the abortion clinic who had already sent the referral for her: she just walked in, they took her blood, and she walked out. She could not remember how long it took her to receive the results back from the blood test but recalled being told it was negative.

She was already seeing a therapist who she paid out-of-pocket for, so she chose to talk to her about her abortion experience for one session but did not feel that any more therapy regarding her abortion was needed. She also mentioned it to a friend casually, “oh yeah, I had an abortion 2 weeks ago” but found it hard to know the tone to bring up an abortion experience in conversation. Other than those trusted people, Diwa and her partner kept the experience to themselves. She felt that she would not be able to tell her parents because “they’re too Catholic to understand.” While she could have told her in-laws, she opted not to:

“Initially, we felt we didn’t know how to talk about it. It would have been weird to visit them and be like, ‘well we had an abortion!’ It’s a different tone than being like, ‘oh we’re pregnant!’ Although I do think they would be understanding about.”

Looking back at her experience, she felt it was powerful for her to go through this encounter with the clinic on her own, even though her partner would have liked to been there to support her:

“Not to dismiss my partner’s support, but I think the idea that I went there by myself, I talked to the doctors, the nurses, the counselor by myself, I didn’t turn around or get scared, I wasn’t influenced by Catholic voices in my head, I feel really proud that I went through it by myself.”

In past medical encounters with doctors, she felt uncomfortable and guarded, especially with male doctors who did not necessarily believe her account of her symptoms and level of pain, leaving her second-guessing her own experiences. However, at this clinic, she felt proud that she could comfortably express herself and her needs without her partner to support her:

“I didn’t have to rely on someone else to take care of me in that process. I have a lot of pride in that. [...] I did it by myself. I feel like I have expressed myself really well when I talking to all the doctors and the nurses and all that. I know that if my partner can’t be there for whatever reason, and if I were to ever get an abortion again, I know that I can handle it by myself.”

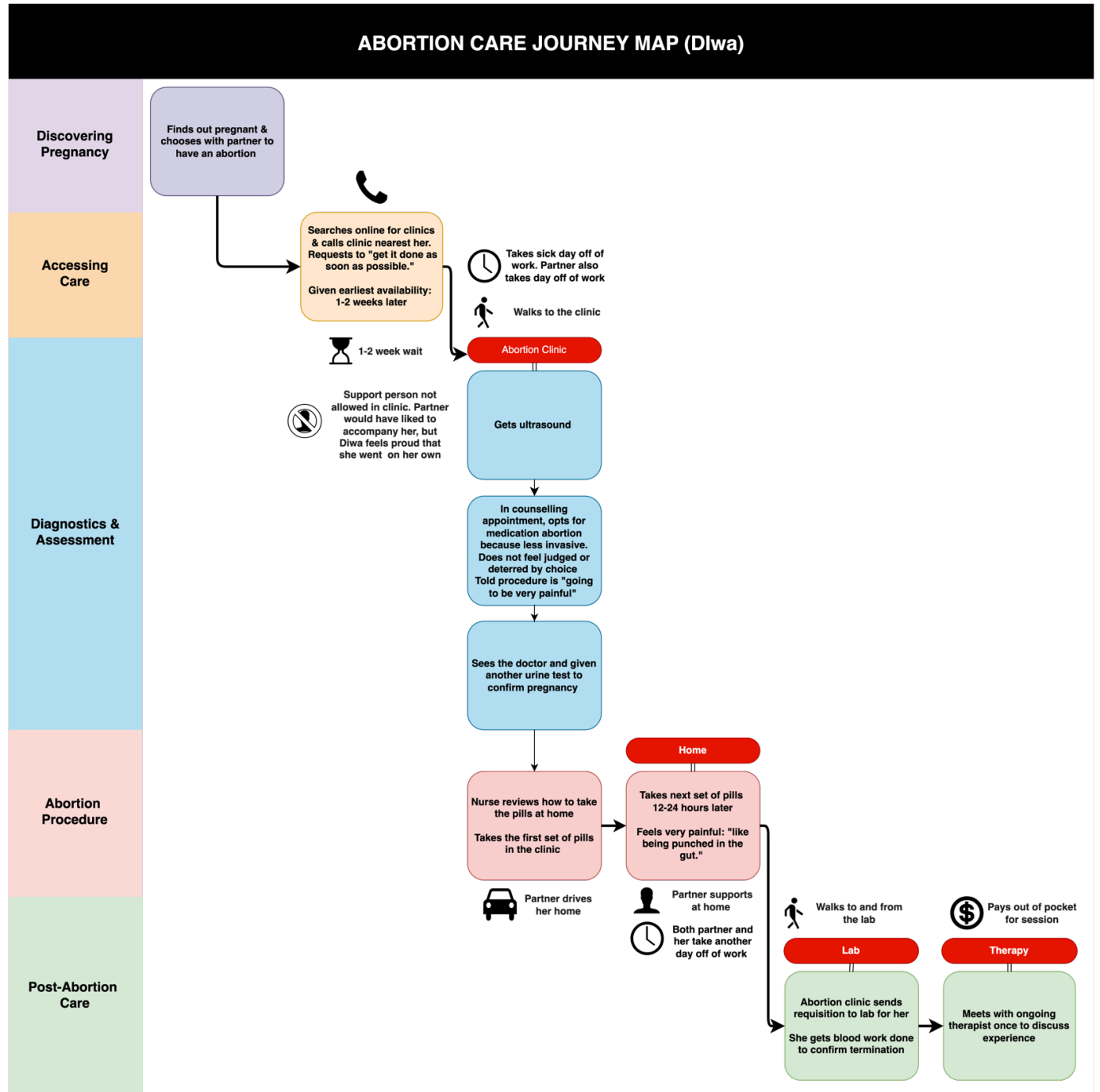
Contributing to her positive experience at the clinic was the level of care from the staff who were caring, non-judgemental, and unhurried as well as “seeing that the clinic was mostly women, and women of different ethnicities too, I felt a lot more comfortable just talking there.”

In retrospect, she also felt that it was especially easy for her to access abortion living in a big city. She has since moved to a smaller city and when arriving there, she looked up abortion providers and found that there are no abortion clinics. Accessing an abortion would require many

more steps. While Diwa is grateful for her positive experience overall, she advocates for the reduction of barriers to access in other Ontario cities. She chalks it up to the politicized nature of abortion care:

“It’s normal to have an abortion. I think the fact that it **feels** kind of strange and taboo is part of the problem. [...] Abortion is a personal choice that is also a healthcare choice at the end of day. For me, abortion is taking care of my body and myself and my future. [...] That’s why we need more of it. We need more clinics that offer low-barrier abortions, because I feel a lot of privilege being able to access it so easily the way I did. I love where I’m living now, but I know it’s going to be harder for me if I were ever to need to access it again. So that’s **not fair**. [...] That shouldn’t be the case. It shouldn’t be just the big cities that have abortion access. [...] It shouldn’t be politicized in the way it is; it is just a healthcare procedure.”

Figure 5 Abortion care journey map of Diwa



## **Chapter 6: Findings - Interweaving Participant Stories into Abortion Care Themes**

The previous section highlighted five individuals' different journeys through abortion care. The following section conveys the narrative themes from the stories of all sixteen participants, including the five participants above. While it is likely the eleven remaining participants would be able to relate to elements of the above stories, I took particular care to incorporate quotes from their accounts in the following section to be inclusive of their stories.

The four main themes are organized by story plot element. Most participants encountered difficulties and stress accessing care, which posed as the first complicating action in their journeys. The next complicating action stemmed from their interactions with abortion care professionals during diagnostics and assessment of the pregnancy. All participants received at least one abortion; the process of which I categorized as the plot climax of their story, as it was the turning point in their story from pregnant person to not pregnant. Lastly, the degree of "resolution" of participants' stories was impacted by the quality of post-abortion care they received for their ongoing physical or emotional needs. The specifics of these encounters and the impact of these events on participants varied, and thus I have interwoven participants' stories into sub-themes to demonstrate the range and similarities in these experiences.

### **6.1 Complicating Action: Difficulties and Stress with Accessing an Abortion**

#### *6.1.1 Difficulties Finding Credible Abortion Services, Especially Online*

The first complicating action in most participants' stories was not knowing where to go to access an abortion. Participants who did not know how to access an abortion either called a friend, conferred with reproductive care non-profit organizations (i.e. Planned Parenthood), were given referrals from physicians, or searched online. A few participants had pre-existing knowledge of abortion services, either from their professional or volunteer work in the area or from having had an abortion in the past.

Search engines were particularly problematic for many participants who tried to use them to find abortion services. Amelia, a 35-year old white woman living in a city in southwestern Ontario in, what she terms, "the hospital belt of Ontario," stated that finding where to go was the biggest barrier for her in accessing services. Despite being an advocate for abortion rights, she had no idea what the first step was to actually obtain one when needed. She searched online for clinics but missed finding the clinic that would have provided her with medication abortion in her city. She ended up booking a clinic in another city 45 minutes away, which meant increased parking fees, gas, mileage and transportation time for her and her partner. Other participants also described not being able to find a nearby clinic in their city when using search engines. Winnie, a 30-year-old white, non-binary person with a degree in social work, moved to a new city in Southwestern Ontario and described difficulty knowing where to go to get an abortion in their city:

"So I basically just Googled like, '[city name] abortion.' And I remember being... just confused over what... what... what place to go to? There was one that was through [the hospital], but it was only for a certain type: it was only the late stage ones. And then there was, also in the

Google search, pro-life places [that] popped up too. It's just not good access to resources. But then, the one I landed on, which I think was the second or third thing that popped up, was the [city name omitted] Women's Clinic. Which is the one I went to. But again, even then I had to do a lot of digging to make sure it was a credible place. I wish there was a registry of, 'these are actually like safe and accessible places to go to.' Maybe there is. It just didn't come up when I searched it. Anyway, I just looked at all the reviews, and it seemed normal and fine. And then, I just called there. And also, I will say that so many of them are called women's clinic, which is so annoying because not everyone--obviously—not everyone who needs an abortion identifies as women.”

For participants like Winnie, they were not only confronted with the challenge of knowing where to go but whether the places they found would be credible and safe for them to go to. Winnie had to do extra vetting online, reading reviews to determine the credibility of organizations appearing in their search results and even then, were dissatisfied that the abortion clinic did not acknowledge being open to all genders.

While Winnie was not able to find a list of credible places to access an abortion, a few participants did describe that they were able to find a clinic based on a list of abortion providers, either from a healthcare professional or online from non-profit reproductive healthcare organizations such as Planned Parenthood Toronto. Madison, a 22-year-old white woman with a bachelor's degree, described her experience of being given a list of abortion services from her primary care physician:

“She had a print-out sheet of all of the options. I think I have a picture of it [pulls out her phone and looks at the photo]. I think it was listing... [pause] yeah, it was pregnancy termination clinics. And it basically had a layout of all the different ones, all the different options. Trying to see here. It had the [city name omitted 1 hour away] women's clinic. It had [different clinic 1 hour away]. [...] Not only did it break down what they do, whether it's medical or surgical, but also the phone number, their email, and what they specialize specifically in doing, which again basically gave me the lay down. And I already knew, like I said, because of my experiences, I knew about the [local abortion clinic] and all of that, so I knew that was the way I was gonna go.”

Despite Madison already knowing where she was going to access a medication abortion, her primary care physician had a list of options readily available for her when Madison told her physician she wanted an abortion. She was familiar with her local clinic due to her advocacy work in reproductive justice in the period equity community. When I asked during the interview why Madison's primary care physician did not just offer to prescribe her the pills herself, Madison was unclear why that was not presented as an option but did articulate that she knew immediately that she wanted to access the abortion from the local clinic. When comparing participant accounts, it is apparent that lists of abortion providers do exist, but they are not always easily found online nor are they comprehensive of all avenues of care, often limited only to abortion clinics or hospitals.

### *6.1.2 Feeling Shamed by Crisis Pregnancy Crisis Centres*

For some participants, searching online meant that they were deceived by the list of service offerings on the websites of Crisis Pregnancy Centres [CPCs] or adjacent anti-abortion organizations, believing that they offered abortion services when they did not. During phone calls with people in these organizations, participants felt the organizations were trying to dissuade them from seeking out an abortion. Ash, a 22-year-old First Nations, non-binary person with some high school education explained their experience of unknowingly calling anti-choice organizations before finding a clinic that was accepting of their bodily autonomy:

Ash: "I googled abortion clinics, and the first three I called were like, 'you shouldn't do this. God wouldn't want you to do this.' I'm just like, 'And moving on to the next one.'"

Interviewer: "Did you just hang up or did you respond to them?"

Ash: "Yep, I did not deal with that. I'm not a big god person. [When I called an abortion clinic, they were like], 'oh yeah, we can do it, no issue.' I'm just like, 'That's it?!' No God-spiel? No, 'Jesus wouldn't want you to do this,' spiel. 'You'll just let me do this?' They're like, 'yeah.' 'Sweet!! Because that's all I've been hearing.' [The clinic was] like, 'oh yeah, we don't force people to do it. They do what they want. Your body, your choice.'"

For Ash, they felt that their abortion care access would have been improved if there was "less God talking and more accepting" as their encounters with anti-choice organizations made them feel shame about their choice to have an abortion, which was also being reinforced from family members at home. However, when they called the pro-choice abortion clinic, they felt immediately supported during the initial intake call to make whichever choice was right for them, including having an abortion. Ash was not the only participant to call up CPCs based on their website, other participants such as Beatriz, a 27-year-old Latina woman who works as a program manager and has a bachelor's degree, described these organizations trying to deter her from her decision as well:

"And another thing that I think was tough was when I was looking for other clinics and using search engines online, a lot of sponsored, uh... anti-abortion organizations popped up. And I called a few, and I did face people trying to convince me otherwise and tried to shame me, which was pretty tough I have to say [...]. So they pay for those spots, so young females, young women call them and [they] deter them from [having an abortion], right? So I did unfortunately fall and call some of those, but it was because they came up and the names that they have are very ambiguous. And you don't really think that they're not abortion clinics or abortion information centers [...]. So the one that I remember the most, I think it was the first one, I was very surprised. [...] The person, she asked me, 'OK, so how far along are you?' I told her, 'I'm four weeks, 3 days,' whatever. And she said, 'no!' Like, 'why haven't you thought about other options?' And... that kind of threw me off. You don't know what's going on until... you really don't what's going on. So I said, 'No. Like I thought about this. I don't wanna go forward with this pregnancy.' And she's like, 'well, you know, there's other options. You could adopt. You could wait. You shouldn't do this!' And I remember being like, 'no, I'm sure about my decision.'

And when I said that, the person did pause and wait for me to... I don't know. The person paused. And then that's when I realized, 'OK, this is not right.' Um... and I hung up the phone."

For Beatriz, she attributed her susceptibility to calling these places as duplicitous techniques of these anti-choice organizations to make her re-think her decision. She also presented the idea that the websites may not be run as part of real centres in the community but as fake websites purporting to be clinics. For patients searching for clinics online, these websites can thwart access to abortion care and, in some cases, may be harmful to those who feel shamed about or dissuaded from having an abortion.

### *6.1.3 Perceiving the Hiddenness of Abortion Providers as a Barrier to Accessing Care*

Another aspect that made abortion providers difficult for participants to find them was that they did not publically advertise their services to the public. A few participants remarked on abortion providers feeling hidden or that the services they offered were ambiguous from their names. Britney, a 26-year-old Eastern European woman with a college diploma, could not find the clinic located a 5-minute walk from her house when she searched online for abortion services in her city. Instead, she had to be told about the clinic from her primary care physician:

"and it's called [city name omitted] Women's Clinic. And to me, I'm like, 'how the eff would you know? How would you know? No wonder I couldn't find it.' I remember talking and saying, 'it just feels like it's some big secret.' That's how it felt, even online on normal Google. Like I could not find any [abortion providers] specific to [city name]. I'm like, 'what am I trying to find?' So that was that. And then when you get to the door at this place, it's in a building. Almost like a townhouse looking apartment building, right? But you had to ring the bell for the right door, but then it's not clearly labeled on this box to ring the bell. And if I... the first time, if someone didn't come out at the exact same time as I was trying to maneuver all this stuff... And again, I am logical and calm, I swear. Like I read everything, even in those moments. And I was like, 'how the fuck do I get in?' I was on the phone about to call the desk to ask and this girl came down [...] We both had our masks on and did that 'look each other in the eyes.' And I was like, 'is it upstairs?' and she's like, 'it's upstairs.'"

Britney questioned the rationale for this clinic to be so hidden as it made it difficult for her to find it both online and in its physical location. For her, it meant she ended up taking extra steps to seek out an abortion, going to her primary care physician and then later that same day to a walk-in clinic when, if she had found it first online, she could have instead just immediately gone to the clinic first. In her specific situation, trying to find timely care was essential for her as she believed that she was on the last day of the limit of gestational weeks for accessing a medication abortion, having only found out the day previous that she was pregnant. She later then also needed a second abortion and compared the difference in the ease of access between her first and second abortion now that she knew where to access services:

"The first time, in hindsight again, I went through all those hoops that I thought were just part of the process. Like calling my doctor. Getting a confirmed test from a doctor's office. Getting [to the clinic] at the very end of the day after back and forth on the phone with my doctor's office and the doctor and the nurse. When the second time, I just went to go do the test from the

drugstore, and I called the clinic immediately. So... I was, yeah, I was pissed. I was like, 'that is fucked!' Imagine somebody who doesn't have a family doctor, and they couldn't get in in a walk-in clinic that day. Like they have no idea what to do if I had no idea what to do. Do you know what I'm saying? [Interviewer: yeah] Like. Whoa, yeah."

Brittany took extra, unnecessary steps in trying to access the care that she needed because she could not initially find her local clinics, which angered her as she extrapolated the ramifications of this lack of access for other patients. However, it is worth noting that for one participant, the privacy measures of clinics did lend a sense of security. Ariel, a 25-year-old, white woman who accessed two procedural abortions at different times from one urban clinic, described her experience:

"And... a very private location, the access of finding the clinic came from an online search. And then calling them, they were very professional, very just clinical as well. Like, no frou-frou or anything. Just, 'here's what we do. Do you want us to use a specific name if we call you? Do you want us to call you? We do not have markings on the building. It is a [physical landmark]. Here it is for privacy reasons. If you need anyone to come down, meet you, escort you, if you need safety.' Like they were extremely thorough and wonderful. And so, I had a good experience accessing, getting an appointment very fast. And then the experience there was... secure. No phones allowed."

For Ariel, she was still able to access an abortion easily and felt a sense of privacy and safety during her visit because the clinic employed security measures.

#### *6.1.4 Perceiving Primary Care Physicians as Unapproachable for Abortion Care*

Most participants in this study did not access abortion care through their primary care physician. None of the participants were prescribed a medication abortion by their primary care physician and only one participant received the medication prescription through a physician at a walk-in clinic. Of those remaining that received a medication abortion, it was through an abortion clinic (n=10) or midwifery care (n=1).

While it did not occur to some participants to approach their primary care physicians for a medication abortion, most participants opted not to go their primary care physician because they were uncomfortable with seeing them specifically about abortion care.

Jane, a 30-year-old Indo-Caribbean homemaker, living in a Southwestern Ontario city, described her experience of facing multiple barriers to accessing abortion care from her primary care physician over the winter holidays:

"And I was really worried because, first of all, it's like the holidays, so a lot of doctor's office and stuff were closed. My personal family doctor is also very difficult to connect with: they have lots of days where they're just not open. And at that point, there was still a lot of care through the phone I'm not comfortable receiving a lot of care over the phone. And then also my family doctor, um... [...] he's kind of loose-lipped, and I don't really trust him [laughs]. Just because he's known our family for a long time, so sometimes they feel like he's very casual with things.

And I like to keep my parents out of my health care. And my parents are also very religious, and so there's a lot of things that go with that. So when I found out that I was pregnant, I was, kind of... pretty... I guess, devastated, because I knew this is not something that I wanted. But I was also like, 'oh my gosh, the timing. I feel like it's terrible. Like there's a lot of doctors' offices closed. My doctor's office is closed until the middle of January.'”

For Jane, going to her primary care physician presented both logistical as well as ethical challenges. The hours of operation of her primary care physician's clinic and their closures during holidays made them an untimely option for her. Jane also did not trust in the professional integrity of her physician, especially because he also provided care for her religious, anti-abortion parents.

Similarly, Amber, a 26-year-old white woman living in a small town in Southwestern Ontario, chose not to go to her lifelong primary care physician for her abortions because of his anti-abortion stance, which she had learned about many years prior when he told her about other clients trying to “demand” a procedural abortion from him and his refusal to provide a referral for one. Later, when Amber wanted to seek out an abortion for herself, she knew she did not want to go through her primary care physician: “I wasn't gonna be going to him for this.” She also described that, like Jane, he was also the doctor for her grandmother and extended family. Her aversion to going to her primary care physician also posed problems for her later when the ultrasound technician wanted to send the results to this physician, which was located in the same building. Amber had to advocate for the ultrasound clinic not to be sent the results to her doctor directly to which the technician just replied, “well, he has access to everything anyway.” It was difficult for her to keep her pregnancy and subsequent abortion decision private since data was shared between healthcare service providers.

For another participant, Diwa, a 29-year-old Filipino-Canadian woman with a bachelor's degree working in administration, the gender of her primary care physician played into her unwillingness to seek care from him:

“Yeah, and my family doctor is male so I think that too affects maybe my perception of what they would say. Um... and I don't really feel like testing it out [laughs], you know? Yeah, it just doesn't feel as safe or as open as if you just take yourself to a clinic, and you know that the people working there are working there for a reason. They're there to give you this procedure and let you know about what you're setting yourself up for.”

In comparison, Diwa felt comfortable and supported discussing her medical needs at the abortion clinic, which she attributed to it being run by mostly women and women of different ethnicities.

A few participants tried to consult with their primary care physician, but they either did not get back to them in a timely manner or they refused the procedure. Mallory, a 24-year-old, white person who identifies as non-binary was working in the retail industry when they got pregnant during the pandemic. Their first step was to call their primary care physician:

“I remember that was all I could get out was ‘I'm pregnant and I'm scared.’ And then I started like crying and [the receptionist] was like, ‘she'll call you.’ Like, ‘she'll call you back when she

has time,' kind of thing. And just like, 'click.' I'm like, 'well, brush off the tears, get in the car and go to [work].' Basically... I felt like I just had to keep pushing through and doing things."

Their doctor did not call them back until six weeks later, which Mallory notes, "is a long time to not return a phone call, especially when it changes how I'm receiving health care." If Mallory had waited the six week wait for their primary care physician to call them back, it would have made the difference between them being eligible to receive a medication abortion, their preference, and instead necessitated them receiving a procedural abortion. When Mallory later connected with their primary care physician again, she denied the abortion occurred:

"And now that's still my family doctor, but, because she didn't issue the abortion, because it went through [another clinic], as far as she's concerned, the abortion does not exist. Which is a really hard thing for someone to tell you over and over again: 'as far as I'm concerned, the abortion does not exist.' [Interviewer: what?!] It's like, 'Cool. Thanks.' [...] Because she wasn't the one that issued it, so... it's on [another clinic's] records, not on hers. And I'm like, 'I obtained my notes from [the other clinic], sent them to you.' And so... [Interviewer: wow] that's... I still don't really know what happened. I don't know if it's like her beliefs about abortion. I don't know if something did actually happen in that 6-weeks-time that she wasn't able to contact me. I really haven't... I've never gotten an explanation."

Mallory's experience demonstrates that primary care physicians can be a barrier to abortion care, delaying timely care under the veil of being too busy or not being responsible for the care.

In contrast, two participants unexpectedly ended up finding out they were pregnant through their primary care physicians and found them to be supportive and helpful. Beatriz described how the physician at the walk-in clinic called her multiple times at home throughout her abortion to follow up on a medication abortion that was not effectively dispelling the embryonic tissue. Madison described her positive interactions with her primary care physician, referred to earlier, when she was shocked to discover that she tested positive for pregnancy:

"She walks in and she goes, 'okay... so you're very pregnant. I have some resources here. We have some tissues.' And then we went into the conversation. But it was that moment of like, 'ahhh, damn it.' [...]. But also at the same time, I appreciate that she didn't sit and drag it on. I appreciate that she said it up front. Then she handed me some tissues, and she basically said, 'there's a lot of options available in this region and in this area.' [...] And to be honest, if I think I'm pregnant again, I'll probably do the same thing in using my doctor. Because I told my mom after, [and] she said, 'you didn't have that 'holy fuck' moment by yourself,' [...] which I appreciate really. It wasn't like I had the pregnancy test, and I was sitting [by myself] and I was like, 'holy fuck.' [...] Right away, when I had that moment, my doctor was there with the resources and the emotional support for me. So I mean that was super beneficial because there was no... I didn't have to go, 'what am I gonna do? How am I gonna do it?' Because she told me right away. And I mean also I didn't have to pay \$30 for a pregnancy test. I just peed in a cup, and it was covered. Um, which also I know that the cost is expensive."

Madison also explained how positive past experiences consulting with her female primary care physician regarding her sexual health made her feel secure in asserting her decision to have an

abortion. She received from her long-standing physician compassionate, emotional support, a willingness to discuss options, and a list of abortion clinics. Her experience shows what quality, person-centred abortion care from a primary care physician should be like for patients.

### *6.1.5 Experiencing Wait Times as Prohibitive or Stressful*

For some participants, wait times presented barriers to care, deterring participants from opting for certain avenues of care. Participants such as Camille and Beatriz chose to not wait the several weeks wait times of various abortion care services (i.e. three weeks for an ultrasound services for the former and abortion clinic appointment for the latter), which impacted the route they chose for their abortion care. Both these participants attributed the Covid-19 pandemic to elongating wait times. For these participants, they felt flabbergasted at the wait times and so instead used their self-advocacy skills to find other options.

For a few other participants, they felt that abiding by wait times was their best option despite the wait being anxiety-provoking. As described earlier, Amber was unwilling to see her primary care physician and had limited options when she sought out a later-term abortion during August 2021, a year into the Covid-19 pandemic. She chose to wait 3 weeks for an appointment at a clinic that took her 1 hour and 20 minutes to drive to:

“I didn't find out until I was much further along. And so that was very difficult. [...] And I was in [area of southwestern Ontario] region, so I live in a small town. And I had to drive to [a major urban city] in order to get my abortion. Just cause if I had to wait and get it here, like in my region, it would have had to take like a month or two because I'd have to get an ultrasound and then another ultrasound and something else and then at that point I'm too far along completely. And so then, I went to the women's clinic in [city name]. And I've heard about them because my very good friend [name omitted] had received an abortion from them in the past.”

Amber waited three weeks for an appointment at a clinic in the city because she believed it was her most timely option while, simultaneously, she also felt “panicked” about being able to terminate the pregnancy as she thought she was closer to the 3<sup>rd</sup> trimester when she found out she was pregnant (later she learned at the clinic that she was only 14 or 15 weeks of gestation and eligible still for a procedural abortion). Like Amber, participants who lived rurally or in a small town often had a longer time obtaining abortion services.

Some other participants may have only had to wait one week or less for their abortions, but even a short length of time waiting provoked heightened emotions in them. Jane discusses feeling anxious about waiting for the abortion and feeling guilty about not wanting the baby while some of her family members were going through infertility issues. Britney spoke about the emotional difficulties that arose waiting one week for abortion care for a second abortion:

“Uh... that was... an excruciating week... emotionally. Yeah, it's easy for me to slip into... especially with guilt, slip into that bad place [...], like ‘I'm an awful person. I have done this to another poor child.’ [...] I felt a lot with the first time. But this time was just like... Like, just yeah, just way worse.”

For Britney, the wait for an abortion made her stew in her feelings of internalized guilt for having “carelessly” gotten pregnant again and needing an abortion for a second time.

However, there were a few exceptions to the barriers that wait-times posed. A handful of participants, such as Winnie, did not feel upset about needing an abortion and therefore did not feel emotional in the week leading up to it. Furthermore, while most participants underwent some degree of a wait, whether one week or several, Britney’s account of her first abortion demonstrates that there may be opportunity and willingness from abortion care providers for last minute care. Britney thought she needed same-day care as she believed she was on the last day of the allowable limit to receive a medication abortion. In her journey, a number of healthcare providers were willing to see her last minute given her situation: her primary care physician took phone calls with her and would have seen her at an appointment in the evening if it had been needed; a nurse at a walk-in clinic consulted with her and tested her for pregnancy even though the clinic was technically closed for a lunch break; and the abortion clinic squeezed her in last minute for an appointment. She described her positive interactions with healthcare providers in this way:

“Every person I interacted with that day, dude, was... made me cry of happiness that they were so nice. So understanding. I felt so safe with every woman I was with that day. Oh, my goodness gracious. Yeah. Yeah. Wow, wow, wow, wow. Um... uh, man, okay [pew]. So yeah, [the nurse at the walk-in] and I just.... You know, she gave me her advice. She kind of went through a similar thing, classic.”

She then talked about “crying tears of joy” as she walked to the abortion clinic to receive the medication. Her experience demonstrates that some providers may have the capacity and willingness to prioritize some patients should the need present itself.

#### *6.1.6 Needing to Use Personal Resources*

Most participants noted using personal resources to attend appointments and obtain the abortion procedure. To get to and from appointments, participants often needed to take transportation, sometimes relying on cabs, public transit, or a support person to drive them. Some participants had to pay service fees at clinics or paid out of pocket for therapeutic services as part of their post-abortion care. While some participants spoke about having the financial resources to navigate around these potential barriers, others indicated that paying for reproductive healthcare caused undue financial stress for them. One participant, who was unemployed at the time, spoke about needing to steal a pregnancy test to determine if she was pregnant. Another participant, Britney, a 26-year old Eastern European woman, who was working multiple part-time jobs in the gig economy describes the financial impact of having to pay the \$50 service fee for each of her two abortion procedures:

“I was scraping by that whole year because I was only doing [a job in delivery] [...] And I was living alone. [The delivery job] paid my rent and my bills for like months of my life. And then I did other things to pay the rent. And, um... amongst working at [family friend’s store name omitted], which they graciously paid me for [...] And [my ex-boyfriend] offered to pay for [the abortion] [...]. And I was like, ‘no, no, no, actually, we’re not gonna talk after this either so...’

So yeah, I was like, 'I don't care. I'm gonna put this \$50 on my already racked up credit card and Bob is my uncle. I just need to make sure I can pay my last month of rent and I'm done.'"

For Britney, paying the service fee was a financial stress that she took on in order to not have to stay connected to her ex-boyfriend who had been otherwise unsupportive to her throughout this process. Parking and mileage charges were another accruing cost for participants as clinics were not always located locally. Jane spoke about it being financially challenging to pay the clinic's service fee of around \$80 plus a \$20 parking charge and mileage. Alice was a 16 year old Chinese-Vietnamese high school student, living in transitional housing at the time of her abortion; she resided in a city with multiple clinics and so opted for the clinic that did not charge service fees as these would have been prohibitive for her:

"Like I could pay for it. But it's just that I'm already on welfare. So I only get a few hundred from the government each month. At the time as well, I didn't have a part-time, permanent job. So I don't really have that steady extra income. I'm also saving because I'm going to start university this following September. So I was already thinking about that. Like I have schools to worry about. Um, I would like to move out of here in the summer, so I need that money for living costs. And so, I've always been trying to save where I can. So... why should I have to pay for this when there's other clinics that offer it completely free? And I do have OHIP, right?"

As in the case of Alice, who was able to find a clinic offering abortion services without service fees, not all participants were required to pay service fees. Amber spoke about being offered to have the service fee dropped for her first abortion when she was younger based on her financial circumstances:

"They were like, 'can you afford it?' And I was like, 'honestly, right now I can't.' And they're like, 'okay, no problem.' [Interviewer: oh amazing, okay]. Yeah, so they were really good about that."

What is unclear from Amber's accounts is how she was identified as needing the service fee dropped as none of the other participants were offered this option. Even though, as Amelia noted, it was offered as optional on the clinic's website she received services from:

"Yeah, it was called an admin fee. And on the website, it talked about [how] [pause] it was an admin fee. And they would give you the breakdown, and you could opt out of parts of the fee. That was not given to me as an option. And that was noticeable when I was there, and she just charged me the 70 dollars as a lump admin fee. And the critical thinking part, like the activist part of my brain was like, 'hey, what the hell! You're, you're missing a step.' And then the part of me that was just like, 'I just want to... like, I'm fine. I can afford it. I'll pay the 70 dollars.' So I didn't ask any questions. I think I did say like, 'can you tell me what this is for?' and she just said, 'admin fee.' And I was like, 'fine.' Not worth my... I'm not gonna fight with you today."

However, a sexual and reproductive healthcare non-profit organization and clinic did help one participant navigate and cover expenses. Ash, a full-time mother who had been job searching for the past two years, described that this organization, who had been providing them with options counselling, paid for their taxi cab to and from the ultrasound appointment and helped with the

logistics when they ran into problems:

“They covered my costs to go from my apartment to the medical clinic [Interviewer: oh amazing]. Because I told them I couldn't afford it [...]. They ordered me a cab. They covered it. And then somehow the cab had the wrong address [Interviewer: Oh no]. That started a whole kerfuffle. So I called the clinic. I'm like, 'hey, this is what's happening. They're trying to get me to [the ultrasound clinic's] old address that I don't want to go to.' [...] And they're like, 'oh, let's just fix that real quick.' And they called the taxi, and they sorted that out eventually.”

The same organization also consulted with their primary care physician on their behalf due to some potential medical complications and offered free therapy after the abortion, which Ash declined. For Ash, they were supported by an organization that helped them not only navigate the abortion in terms of informed decision-making but also made the abortion financially and logistically accessible.

Some participants were offered virtual appointments by clinics, which eased the burden of transportation and time to get to and from clinics. While some of these virtual appointments were offered during the onset and peak of the Covid-19 pandemic, others were able to attain access to a telemedicine appointment a few years later. For Amber and Willow, living outside of the city, the experience of telemedicine was beneficial in reducing the number of steps for receiving a medication abortion, with the abortion provider directly prescribing the medication virtually and then delivering it directly to their home.

## **6.2 Complicating Action: Interacting with Healthcare Professionals for Diagnostics and Assessment**

### *6.2.1 Counselling Appointments: Feeling Judged by the Questioning of Health Care Professionals*

Some participants felt particularly judged in their interactions with health care providers during patient education and counselling appointments prior to receiving their abortion. For a few participants, this judgement from healthcare professionals were perceived to have stemmed from their birth control choices. A few participants who received the procedural abortions felt they were being pushed to have a long-term acting contraceptive. Similarly, Jane spoke about how an older male physician came in after she had taken the first set of abortion pills to speak about her birth control options after a female counsellor had already asked about contraceptive planning:

Jane: “And he didn't even really introduce himself or say, ‘hi.’ He just came in and was like - he's this really old doctor too – and just kind of questioned me on that. And I was like, ‘no, my partner and I use condoms.’ And he was like, ‘okay, maybe you should use spermicide too.’ And I was like, ‘okay.’ And then he left [gives a small laugh].”

Interviewer: “Oh, that was it.” [Jane: “yeah, that was it”]. “Like, that was the end of conversation.”

Jane: “Yeah, that was the end of the conversation [laughs]. And I was like, ‘oh, that's kind of weird.’ [...] Because all of the people in the clinic that I'd seen were women. Like the one man came in had to put a stamp on this whole... like the end of the procedure. So that felt kind of weird. Um... because it also felt like he was like, ‘Do you use condoms? You should use spermicide. You shouldn't be in this situation.’ You know? I understand it's important to ask those questions, because, obviously, you don't want to be coming back to the clinic multiple times. But I feel it should have been more of a conversation. It felt really rushed. Whereas everyone else in the clinic really made you feel comfortable. And I felt like he just rushed in. Um, and I don't think I was even fully dressed, if I'm remembering correctly. I think I was wearing a dress with a sweater over top. And I had the dress on, but I didn't have the sweater on. And he just came in, and I was like, ‘oh.’ So I was kind of thrown. So I felt like if he had knocked and come in and sat down. He just stood. Um, and there was definitely chairs for us to sit and have a conversation. So I wish that it was a bit slower. [I wish that] he'd maybe asked some questions about [pause] about like... our contraception methods rather than just... make unfounded comments.”

For Jane, she also felt that her assumed age played into the conversation, thinking that the male doctor assumed she was “young and careless.” For another participant, Carter, a 34-year-old white woman working as a personal support worker, she felt that she was not only judged for her birth control choices of wanting to use the “rhythm method” as contraception moving forward, but that she was treated differently because of her contraceptive choices. She compared her experiences of receiving abortions on two different occasions based on the type of contraception she had opted for:

“I will say the one time that I opted to have my IUD put in during the abortion, it went a lot differently. I had a lot more... it was an almost pain free procedure. This is how I perceived the stigma with opting to not have the IUD. Because I've been at the same clinic and seen... a difference. And far and away, the most excruciating procedure I've had is when I just opted to be honest and say, ‘I'm just gonna use condoms going forward.’ And what I could have done is I could have said, ‘I'm gonna be taking birth control.’ You know? And I do think that I would have been treated differently and... But that's... just to give you an idea of how I perceived that, um, I interpreted that kind of stigma that I was receiving.”

For Carter, having been a person who had received multiple abortions, both with and without opting for an intrauterine device, she perceived a difference in her care and level of pain based on whether or not she opted for the clinic's suggested birth control method.

However, other participants spoke very highly of practitioners who were non-judgemental and continually affirmed that it was their choice whether or not to have the abortion. Ash said that they opted for options counselling with a non-profit reproductive health organization and received supportive, non-judgemental care:

“I felt like, ‘Your body, your choice. This is all based on what you want. We're not here to force you to do anything. And... if you want us to stop, we'll just stop.’ So, I felt like I was really in control of my body.”

While ensuring the clients are not coerced and are sure of their decision is important, these accounts demonstrate that the manner in which clients are presented their options and asked about their decision makes a difference to how they perceive their care.

### *6.2.2 Preferring to Receive Choices for Ultrasound Care*

The majority of participants were sent for an ultrasound as part of their care. A few participants either did not receive an ultrasound or could not recall receiving an ultrasound. The choice to forego an ultrasound was only offered to a few participants. For example, Madison was told that she did not need an ultrasound due to knowing her last menstrual period dates and conception dates:

“What ended up happening is that first conversation basically was more so in regards to, ‘okay, do you know when... let's figure how far along you are.’ And I basically was able to say, ‘I haven't had sex in like 7 months, other than this one day, so I can assure you this is the date,’ which was very, again, for me, very beneficial. I didn't have to go in; I didn't have to do ultrasound. I didn't have to do any of that.”

Where Madison was given the option to forego the ultrasound from her abortion provider at the outset, Willow had to spend considerable time, energy, and emotional fortitude self-advocating for herself to find care with an abortion provider that would forego the requirement. Willow's experience trying to find a provider without doing a transvaginal ultrasound presented many hurdles with “no willingness to budge” from providers who were rude to her during her request.

For some of the other participants who were required to have an ultrasound, they expressed wanting choices about how they experienced the ultrasound, such as to view the ultrasound imagery or to receive a picture. Alice wanted to see the fetus but felt that she had to brave speaking up to the “tired” clinician to request it:

Alice: “I saw it on the screen. And she gave me... she asked if I wanted to keep the picture, so I kept it.

Interviewer: “Yeah! Oh, you're smiling! Like does that feel special to be able to keep it? [Alice: yeah]. Awe.”

Alice: “I think I would have been really sad if I hadn't been able to. And I'm glad... because I was honestly scared in there, and I didn't want to speak a lot because... again, the vibe was she was tired [...]. And I wasn't in a particular chatty, positive mood. But I'm glad I did ask her about it and stuff because I don't think otherwise she would have showed me the screen. And I would have felt regretful about that.”

While Alice suggested that perhaps the practitioner was trying to be protective, she felt it was important to her to see the fetus and have a picture of the ultrasound image. Contrasting Alice's experience, Ash, a mother who had received fetal ultrasound previously, described the tact of the technician at a community care clinic in asking about their options:

“They're like, ‘do you want to hear the heartbeat?’ ‘Sure.’ And they’re like, ‘you can look if you want.’ I'm just like, ‘I'm okay. I don't wanna really see that.’ Cause I've already seen it, and I'm just like [shakes head]. They did give me a picture for it though. And I make jokes about it all the time. But that's how I cope: ‘Do you want to see my abortion?’ [interviewer laughs].”

For Ash, they were able to opt out of viewing the ultrasound while still being presented the options to hear the heartbeat or see the picture as they desired.

It is also worth noting that some patients may not want to view or know anything about the ultrasound at all. In the case of Britney, she does not remember much of her experience receiving the ultrasound but knew that she wanted as little information as possible:

“Oh my god, dude, I can't remember that. That part's a blur. I was just like, ‘don't tell me anything.’ ‘Don't.’ Yep. I was that person. I want to know, just the next steps, please. The end goal please. I don't want details. I'm not always like that, but especially for this, for me.”

Some participants also had strong opinions about whether or not they wanted to know if the embryo/fetus were twins from the ultrasound imaging.

### *6.2.3 Perceiving Ultrasound Care as Harmful*

Some participants described negative experiences of receiving their ultrasound care where technicians were insensitive or inexperienced. For example, Beatriz spoke about how the ultrasound technician in the community assumed she wanted to keep the pregnancy, congratulating her and giving her the ultrasound image at the end of the appointment. For Jane, she did not know she was going to have a transvaginal ultrasound until she got to the clinic and would have like this knowledge ahead of time to mentally prepare herself and/or research if an ultrasound was necessary. A trainee conducted the ultrasound and their inexperience resulted in a lot of discomfort Jane:

“I remember there was like somebody who was learning how to do the ultrasound, doing my ultrasound. And I'm also plus size, so it's more difficult sometimes to get readings. And they had never, I guess, worked with somebody who, I guess, had an apron belly. So, there a lot of prodding, which is really uncomfortable. And then finally the main technician came in and was like, ‘this isn't clear. Let me show you how to do it. And so then, that technician did it.’”

Jane found the process “pretty traumatic” because she was averse to having things inserted into her vagina, especially when she felt a lack of control in the situation. She also expressed she would have liked her partner, who was not allowed inside the clinic, to have been with her to support her. Similarly, Mallory, also found getting an ultrasound to be a negative experience. After experiencing pain from the medication abortion, they were sent for a post-abortion ultrasound where the receptionist at the ultrasound clinic did not understand that they were here for an abortion-specific ultrasound:

“I went down for my ultrasound. Um, and the... nurse, or whoever it was, that was checking me in, I guess didn't read the notes properly or the paperwork properly, and asked how far along I

was. And I'm like, 'what?' So then she repeated it louder in this room full of people. Um, and... yeah, so I'm like crying, trying to like explain to her what was happening. And then I went and sat down in the waiting room, still surrounded by all these people, and she came over and sat beside me and like whispered, she's like, 'I'm so sorry I shouldn't have said that.' I'm like, 'why are you whispering now?!'"

Mallory went on to explain that past trauma from having received an ultrasound in the past impacted her experience this time round:

"So I went in for my ultrasound. Everything was fine, like pregnancy wise. That's how I got my diagnosis with endometriosis. So an interesting story that way. But when I was done with everything, I just felt so horrible. It was like an intravaginal ultrasound, which maybe I should have been aware that was what was happening, but I didn't realize. I just thought they were gonna do like... you know, over my stomach kind of thing. When I see her point this wand— I don't know - it made me feel like she was a police officer. Like one of those Billy clubs. Just throwing it around. Um, and that was the second [ultrasound] I had ever had, and the first one was super traumatizing for me. Um, so when I tried to voice that to her... and I'm like, 'I just need a moment of like—' and she's like, 'I'm not gonna traumatize you, just lay down.' [Interviewer: What?] And I'm like, 'Okay, cool.' [...] So that was just... another thing with the medical people that I'm like, 'I feel like I'm doing what I'm supposed to be doing, and I just don't enjoy how people are interacting with me.'"

Mallory's experience demonstrates that ultrasound care could be more abortion-specific and trauma-informed.

However, a few participants received emotionally-attentive care during the ultrasound. Camille, a mother of two children, spoke about how the nurse was compassionate and non-judgemental in providing her care. This nurse went an extra step in holding her hand while accompanying her back to the ER afterwards as she perceived that Camille felt distraught. As Camille states:

"You know, I'm not asking each nurse to do this, but that really was amazing. I will always remember her. I have no idea her name is. But you know, like, it's just that really, really, really helped me a lot."

For patients such as Camille whose care professionals go the extra mile to attend to their emotional and physical well-being, it makes a world of a difference to how they perceive their encounters looking back.

#### *6.2.4 Feeling Rushed Along versus Unhurried*

Some participants talked about feeling rushed throughout the appointment whereas other felt healthcare practitioners were emotionally attentive and unhurried. For a few participants who received a procedural abortion, such as Lucy and Carter, they felt particularly rushed through the clinic. Lucy wished that the clinic staff had spent more time with her to emotionally process the events:

“I thought there would be somebody to talk to. Just to walk me through what’s going on, kinda thing. But there was nobody. It was very, very... it was like too straightforward. And they kind of see this almost as like--you know what it feels like? It almost feels like a haircut, you know? Like a busy haircut appointment. You go in, and they're like, ‘okay, go sit down.’ They cut your hair. And they're like, ‘okay 20 bucks to leave. Okay bye! Have a nice day!’ It's not even one of those nice haircuts where you can actually talk to them a bit, like, ‘oh, I want it like this. I want it like that.’ [...] It's like a conveyor belt. I feel like they just [are doing their] job. And their one job is just taking people daily. And they're like, ‘in,’ ‘out,’ ‘ok,’ ‘go.’ ‘In-out-ok-go’ [said faster second time]”

Lucy went on to explain that she felt particularly pressured to quickly get out of the recovery room at the clinic.

However, some participants felt that their experiences at clinic were comprehensive. Britney, who was squeezed into a same-day appointment for a medication abortion at a clinic, described the doctor as not “not in a rush,” taking the time to explain the medication procedure thoroughly to her, even though she was the last appointment of the day. As well, Ariel, who received her procedural abortions at the same clinic as Lucy, described her experiences very differently:

“The largely women staff was just very nice. It’s not like men rushing you through like, ‘oh okay, I’m here to do my job and get out.’ The female surgeon specifically when it was the second time – or third, I guess – was just like, ‘okay, are you sure you’re good? Like I can see you’re not feeling okay.’ So just that extra nurturing piece.”

Ariel’s experience also differed from Lucy in that she did not feel rushed through the after care. Ariel felt that the staff made sure she had support afterwards to help her get home, even walking her to the door: “I wasn't avoided. I wasn't discarded afterwards. Like they really did have just a thorough professional start to finish. Yeah, I’m very, very thankful for the experience I had.”

For her second abortion, Ariel also described how the clinic allowed her the time to decide whether or not she wanted to proceed the abortion after discovering she was having twins:

“And I don't know what compelled me to, but I did request to know if it was twins, and it was. So that was a whole other spin. And then I went back into the counseling room, because at that moment, finding that out without any ability to tell [partner name omitted]. And, not that it changed the decision, but it was a huge spin in the story. So, I went back into the counseling room just like... breakdown: a whole other round of feelings of guilt, because it was two instead of one. For whatever reason, it does change things [Interviewer: yeah, it triggers something in you, yeah]. Yeah, so a lot of that. Had really good counseling. Again, like I went right back into the room where the woman was that I spoke with, and it was wonderful. Gave me paperwork, said, ‘Your decision here is yours.’ And she actually called in the surgeon as well. Because I was questioning things and I was wanting to know, ‘okay, I was on vacation. We were drinking. I've been sick. I had this weird medical thing happen. Is there any way that they might be okay? Like could I possibly go through with the pregnancy?’ All of these things I was asking and I wanted to know. Um, and, yeah, it was a lot. But the surgeon was there. And again, no judgment. Just professional. Very kind. And answers like, ‘I cannot definitively say yes and no. I can't give you

a black and white answer. There's not enough research. We don't know for sure.' And just left me with answers. A lot of gray ones, but the answers that they had. And I was able to go out, tell [partner name omitted], and then re-book for a few days.”

Ariel found the counselling staff and surgeon incredibly supportive in giving her further information about her pregnancies and allowing her space to process her emotions, but ultimately gave her the choice in how to move forward. Her experience demonstrates the need for clinics to make space for vulnerable emotions that may arise during diagnostics and assessment.

Contrastingly, for a few participants, such as Winnie, seeking the medication abortion, they appreciated that their appointment at clinics was short as their primary goal was just to get the prescription and receive the necessary information for taking the pills at home. They did not need to unpack any emotions with healthcare practitioners.

### *6.2.5 Having Mixed Experiences of Pharmaceutical Care*

For those participants that received a medication abortion, most participants received the pills directly from the clinic, which were either shipped to the participant or handed directly to them. However, in a few situations, participants had to go into a pharmacy to get the prescription fulfilled. For Ash, they received clear instructions for how to take the medication from the pharmacist but felt judged when they went to pick them up: “they kinda just like gave me that eye thing they do, when they look you up and down.”

For Mallory, her experience with the pharmacist stood out to her because it was the first time she had received in-person care for the abortion. Her abortion occurred in November 2020, and all care from the abortion clinic occurred virtually because of the pandemic. An additional complicating factor was that her partner had become threatening and controlling during the course of the pregnancy. While Mallory had chosen to have an abortion for herself, she would have liked the opportunity to discuss this decision more with someone without her partner present:

“And when I did go to the pharmacy and pick up the pills and everything like that, again, my partner came with me [...] And not that it's the pharmacist's fault - like he was qualified to be a pharmacist - but it was a man. And I'm just wondering like if it was a woman, somebody would have picked up on a vibe about like what was actually happening in this relationship? Like would I have felt more comfortable confiding in them? [...] I know that like in different settings—but I just heard different times like where... like when women are giving birth, and like if their partner says something a certain way, then they're like, 'Hey, you go take a walk.' And then they talk to her for a second, and they're like, 'hey, like is everything good? Like are you safe? Like are you okay?' kind of thing. And I don't know. I felt like the pharmacist was giving me a prescription with my name on it. I'm the one taking it. But I felt like there's different times he was looking past me and talking to my partner [...] I don't know why I felt like that was happening. Like, but like maybe he thought that because both of us were there, and he was like helping me through it, that kind of thing. And again, I know that like being in the middle of a crowded Shoppers Drug Mart is different than being in a delivery room. I get that they're two different settings, but I just... I don't know. And I also wonder on my account, if it was not a man, if I would have felt

more comfortable asking something different or like initiating like a private moment away kind of thing. Maybe I wouldn't have, maybe it wouldn't have been different, but I don't know. [...]. I just kind of got the same kind of feeling like if I were to take my car to the shop and my partner would come with me, but sometimes they would be talking to him. And I'm like, 'but he doesn't even have a license.' I'm like, 'it's my car. Like, 'why, why are you speaking to him?' My partner would go along with it because they're talking to him. And like, 'cool, like you don't know anything.'”

While Mallory's situation was complicated by the pandemic, it is not beyond the scope of healthcare practitioners and allied health care professionals to be aware of and responsive to abortion patients in coercive or abusive relationships.

Contrastingly, Madison had a positive encounter with the pharmacists where not only did she not feel any judgement, but they went the extra step to source the abortion medication for her when they did not stock it:

“There were two pharmacists there: one man, one female. He was a little bit older. She was older as well, and... I didn't feel any judgment. When I went in, I would have asked for the medication, and they said, 'no, they didn't have it.' [...] They're like, 'let us see who does have it.' And then they said the one over by [area name omitted] definitely does. It looked like they were one of the only ones at the time who had it in Region. And I believe that when I went, I got the last package for that week of... the first pill I think? No, it would have been the second. Cause the first pill is more commonly used I know for like ulcers and stuff like that. So, that one's more commonly sourced where the second one is for abortion specifically. So that one I believe - I got the last packet of that.”

While Madison had a positive interaction with the pharmacists who helped her source the medication abortion, her experience does speak to a potential lack of availability of the medication from pharmacies in some areas.

### **6.3 Plot Climax: Undergoing the Abortion Procedure**

#### *6.3.1 Experiencing Abortion as Painful*

Most participants experienced the abortion procedure as physically painful. While some participants described the pain as manageable with pain medication or breathing techniques, several participants described the pain in extreme terms, comparing it to being “punched in the gut” (Diwa and Ash) or “something being ripped from you” (Ariel) or “5 hours of hell” (Winnie). Some participants described the pain as “the worst pain in their life.” Participants found the process painful despite having experienced other gynecological healthcare procedures (i.e. hysterectomy), painful reproductive conditions (i.e. endometriosis), heavy period cramps, or given birth previously.

A few participants felt a sense of injustice and anger at the level of pain they experienced. These feelings were often directed at health care professionals for not preparing them for how painful it was going to be and/or at the healthcare system for not having more options for pain relief.

Participants such as Winnie felt that they were ill-equipped for the pain by healthcare professionals:

“In terms of the side effects, she gave me like a little print out, handout, which was like, ‘all you'll need to take is Advil & Tylenol. You might experience some like heavy cramping.’ And so... just some basic stuff. And I will say it was the most excruciating pain I've ever been in in my entire life, and I did not **just** need Tylenol and Advil. I wanted it to be like highly, highly medicated. So that was... a terrible experience. But yeah, all it said was ‘it's just like a heavy period cramp.’”

Congruent with Winnie’s experiences, several participants noted the language of “heavy cramping” unhelpful for their expectations of pain as they perceived the process as much more painful. For Winnie in particular, they contemplated going to the emergency department due to the level of pain they felt but was dissuaded by their partner. They felt angry at the healthcare system for perceived gender differences where they saw men as more often believed about their level of pain and offered more pain options for procedures.

While procedural abortions often offered more pain management options to participants, some of the participants who received a procedural abortion spoke about pain or discomfort when describing the procedure. As described earlier, Carter, who had multiple procedural abortions, spoke of an encounter receiving one procedural abortion where it was rushed and much more painful than her past procedural procedures,

“There was not a lot on the pain management end. Um... it was a very painful procedure from what I remember. And I do know that it does not have to be [...] I feel like there's no reason for me to experience that much pain during the procedure. And again, it's quick, right? Like we're talking under 5 minutes. Yeah, that can be traumatizing, that can be really traumatizing to have a painful abortion like that. And um... yeah. I just don't think that it's necessary. So. [...] Extremely and unnecessarily painful, I would say.”

In this circumstance, Carter felt that pain medication was intentionally held back by the physician and that the clinic was ill-equipped with pain relief options. As mentioned earlier, Carter had opted out of the birth control options presented to her and had had multiple abortions, which she perceived as impacting the quality of her care. Beyond just the individual clinic factors, both Carter and Winnie felt that the lack of available pain relief options was a manifestation of the patriarchy in that abortion procedures happened to women, transgender and gender diverse people instead of men.

However, Ariel, who received two procedural abortions, felt supported through the pain by the medical staff at the clinic. In her opinion, there was nothing that the healthcare professionals could have done on their end to better prepare her for the level of pain she experienced:

“It felt literally like someone was ripping something from out of you, which is what happened. But the pain I would equate to that, which you can't really prepare for, even being a woman who menstruates. It's not like, ‘oh I'm gonna give you a needle for your injection. Now you're gonna

feel a little pinch and a little pressure.’ There's nothing that they could have said to adequately prepare the pain-level.”

Ariel also described the procedure being emotionally difficult and feeling supported by the medical staff, in particular a nurse at the clinic, who helped her put on her gown held her hand both “figuratively before the procedure and literally during the procedure.” She described the magnitude of how meaningful these gestures were for her:

“And it's funny because it's one of those weird things that, like, I don't know where she is in life now and I don't know what her goals or anything are. But if I could tell her that... somehow, I would just express how thankful I am in that she is or was in the best position she could have been in that moment and how much of a difference she made to me. I'm sure she's making it lots of times over. And there's these positions in the world that people don't think of being what they are [...]. These people exist in these places, and they make such an impact and difference that is incomparable to anything else. And yeah, her face will stick in my mind. I don't know if forever, perhaps, but [she] made an immense difference with my experience the first time. Of just being a human and there, and helping me get through it cause, yeah, it definitely meant a lot. “

For some participants, such as Ariel, practitioners who went the extra step to provide emotional support made a tremendous difference to how these patients perceived their experience.

### *6.3.2 Preferring the Attendance of Support Persons at Facilities*

There was variance in whether participants were allowed by facilities to have support persons present with them at appointments. The restrictions on support persons had differential impacts on participants. Some participants were allowed support people at doctor’s appointments or in clinics, whether it was just in the waiting room or even during the diagnostics. For other participants, they were prohibited from bringing support persons, either because it was an existing facility policy or a new measure due to the pandemic. Some participants such as Jane, who was nervous about the medical components of the diagnostics, felt that partner support inside the clinic would have been helpful for her:

“My partner and I went to the clinic. He wasn't able to come up. And that was like really—he had to stay in the lobby. And being somebody who's already nervous about it - and I get very nervous about medical procedures and taking blood and stuff - I was really anxious. And I really wanted to be able to have support. But I also understood that... like for it to be a safe place, I understood--in a small place, right? For confidentiality and just also space wise, yeah, he had to wait downstairs.”

While Jane acknowledged the clinic’s rationale for restricting support persons, as previously mentioned, the presence of her partner during the ultrasound could have made a meaningful difference to her as she described it as “pretty traumatizing.” Contrastingly, in another participant’s story, Diwa stated that, although their partner would have wanted to be at the clinic with them, Diwa was proud of herself for going through the anxiety-ridden process without her partner. Moreover, for a few participants, like Winnie, having a support person at the

appointment was not necessary as they were not emotionally impacted by the idea of needing an abortion.

However, Carter, who experienced care from a clinic where support people **were** allowed in the waiting room, felt that not bringing a support person with her resulted in differential treatment from the clinic. She described four different procedural abortion experiences with the latter one being a better experience when she had a friend as a support person with her:

Carter: “I did go back to that original clinic [...] but I brought a friend with me. It’s a totally different experience [gives a small laugh]. [...] The doctor was just so much kinder. He also gained a lot of weight. He was a lot kinder in that appointment to me. And... almost like a completely different doctor. It was incredible.”

Interviewer: “Huh! Oh, it was the same, the same doctor, but the way he interacted with you was completely different.”

Carter: “It was the same man, yep, the same man. Completely different because there was somebody else there. [Interviewer: Really?] And like that's something really important to consider when accessing medical care. Like sadly is if you have someone else with you [gives a small laugh] to witness how you're being treated, you are likely to receive different treatment.”

Carter went on to explain that she opted to bring a friend because her partner was not supportive during her abortion. She spoke about the necessity of having supportive persons allowed in clinics as it gave opportunity for partners to be more involved in the abortion process:

“There's so many structures interacting to make pregnancy and everything a woman's issue. And ugh, until the message is really like, ‘it's everybody's responsibility [...]. It takes 2 people to make the baby.’ [...] I’m kind of floored by the belief that some men have... around pregnancy being all on the woman. And I think if men were to be more involved in the abortion process, some of that responsibility... is transferred to them. Like I just go away and have an abortion and come back and what has he done? [...] I think it would have made my partner at least done more work, and at least see the reality of what is happening. Even to see what it looks like coming out of the operating room. Like last time I came out, I was completely soaked in blood [Interviewer: oh geez] [...]. Yeah, just like bled through the back of the gown that they provided. And I just think that these... it's so important. And the more that we keep it tucked away, we don't talk about it, we don't look at it, it's secretive, the more room there is for the services to be not great [laughs], you know. Or for pain management not to happen. Or for the, you know, just supports in general... to be poor.’

While some participants were trying to be understanding of the clinic’s parameters around partner support, Carter felt that supportive person should be allowed in clinics as it held the clinics to a higher standard of patient care and created opportunity for partners to become more involved in the process.

### *6.3.3 Supportive Person as Meaningful Difference to Journey*

Throughout their journey of receiving abortion care, many participants found having supportive person present made a meaningful difference to them. In particular, for those with attentive and caring partners, participants valued their partners' presence during their abortion care journey. Ariel described her partner as being a "rock" for her throughout her journey of having two procedural abortions:

"And so having my partner, who has been there from start to finish and was contributing partner for both of the pregnancies - he's wonderful - and so having that support, having somebody waiting for me outside, during both of the surgical procedures that I had. He was in my life for just a year before the first time that I had a pregnancy. And so, life has been good. Obviously, as we [went] through, it got heavy, and there was a lot of crap. But we're [now] living together and [it's] wonderful. And so, for his role playing in everything: amazing through and through."

During her abortions, Ariel's partner was not allowed in the clinic but she described feeling "super grateful" for him while she sat in the waiting room knowing that he was waiting outside of the clinic to meet her and drive her home. Similarly, for participants who had medication abortions, participants appreciated their partners taking care of them at home, such as Jane who described her partner bringing her heating pads every two hours and buying necessary supplies like menstrual pads at the store. Jane described feeling "lucky" for having her partner with her during that experience:

"My partner was there through everything. Tried to make me as comfortable as I could be. Yeah, and I literally did nothing that whole day except lie on the couch and have things brought to me. Just like physically and emotionally, was really there for me."

For participants, such as Jane, who felt their partners were supportive, they often also spoke about their partners being respectful of their decision to have an abortion and, in some cases, felt validated when their partners acknowledged that they could not fully understand the bodily or emotional impact of the abortion, due to them not being the one carrying the pregnancy.

While partners were often the primary support person, those who elected to have trusted friends as support persons felt their compassion during the experience. Madison explains that she was not only able to tell her parents about the abortion but was able to delay her at-home medication abortion until her parents left for vacation. She describes how she had several friends support her throughout:

"Because if I'm being honest, I... went through a lot more pain than I thought I was going to. [...] I had a friend who came over and I just had her stay around to check on me and such. But I mean I was basically like on the floor in the bathroom, near unconscious from the pain, which I've never experienced before. And I mean anything I tried to take medication-wise, I just threw right back up. But her sister, my friend who was [supporting me]... her sister's actually a nurse. So it was great, because I also had that on [standby]--like I had set myself up with all the resources I was going to need. I was able to call her and be like, 'Hey. So, I... am having an abortion right now [...]. I just threw up my whole box of fudge that I ate on the floor [...]. I just took [my medication]. It was about probably 45 seconds, then I threw it all back up. Should I take more meds?' And she was like, 'yes.' So I had that as well, which is nice, because for me, I

don't know... like, 'Are you able to? How fast does the medication digest, right?' So those are things that like I didn't know, but I was able to kind of fact check and like take care of myself through reaching out to people."

Similar to Madison, several participants were able to call upon trusted friends to support them through the experience. Participants who chose to rely on friends were able to discern who would be supportive to them throughout the process.

However, some participants felt that their partners were not supportive throughout the experience. A few participants went as far as regretting involving their partner in parts of the process, especially if they felt that their partners were self-involved about their own feelings of the abortion, such as Alice who explains:

"So I had already felt like, up until this point, he was pretty supportive. So I wouldn't say anything about that, per se. But I did still feel like I had more of the weight on my shoulders [...]. And then, I come out, and he's like playing games on his phone. Which is fine because you're in the waiting room, what are you going to do, right? [...] But then I would have expected that when I came out and you see me walking into the waiting room, you would have asked how I'm feeling? Or any kind of check in question or anything. Because I know personally had I brought any of my other friends, they absolutely would have done that. And I would have done that for any other person as well. Especially because like, he, out of all the people, he really did know how hard it was for me. Because he was the one that I would like tell about it to the most, because who else would I confide in about something so private? Except for a couple of close friends [...] because I know my friends would not judge me for it, but they did not like my partner. So, um, they would have... I did not want to give more reason for them to dislike him than they already had."

Similar to Alice, a few participants felt resentful for their partners not being more attentive to their needs throughout the process. Beatriz, as an example, felt resentful that her partner was not in attendance at more appointments due to his work schedule. Mallory regretted telling her partner about the pregnancy since, as described earlier, he had been controlling and threatening:

"I wished [that] like at 3 AM on November 12<sup>th</sup> that I could just like have grabbed my cat and like just left [...] That I didn't have to tell him [about the pregnancy] [...]. But in a way I wish that I had of - probably sounds horrible - but just like went through everything by myself [...]. But it's kind of like, I didn't really have a partner [I: no]. I had somebody controlling and like trying to pull puppet strings."

#### *6.3.4 Disruption of Abortion to Work and Familial Commitments*

Additionally, some participants were able to more easily attend to work and familial commitments during their abortion process and recovery than others. Some participants spoke about working jobs that were flexible and/or allowed for sick days that they could take before, during, and after the procedure. Amber even felt comfortable enough telling her work that she was getting an abortion:

“So I was open with what I was going through and... like I had that kind of rapport with my supervisor, so I was lucky in that sense. And so, it was made pretty easy. They just... were, like, ‘you can take the time that you need,’ and gave me the resources that I needed to do what I had to do.”

Amber said she ended up needing two weeks for her first abortion and then five days for her second one. Participants such as Madison, a recent University graduate living in her parent’s home, spoke about how she was able to delay her abortion for a few days to take the prescribed medication at a time convenient to her. In controlling the circumstances in which she had her abortion, she could have it privately in the comfort of her home with the support of a friend while her parents, although supportive of the abortion, went on vacation.

However, some participants described scenarios where the abortion procedure had a disruptive impact on their work or school commitments. Camille spoke about needing to cancel sessions with clients and her partner taking time off work to attend some appointments, therefore resulting in a loss of income for their self-employed businesses. Alice detailed needing to take time off school where strict attendance was taken, although allowable for medical appointments. She attempted to have the abortion on the weekend, but, after a last-minute cancellation by the clinic, she was forced to have to ask for time-off from school. In such situations, participants did not necessarily need to disclose the particulars of event, but they described it being clear to their relationships (i.e. teachers, clients) that they were undergoing a private medical event.

For a few participants with less flexible jobs, needing an abortion was particularly untimely for their lives. Britney described having to run a public work-related event during the process of undergoing the medication abortion, using the bathroom of her parents’ business to take the medication without letting them know she was having an abortion:

“And so I was like, ‘I’m just gonna use their bathroom.’ Like, but they can’t know. They can’t see the debris. I’m, again one of those people, I’m gonna... I stay calm. I just, you know, go poker face. And um... I know, it’s all gonna work out the way it’s supposed to go.”

Britney dispelled the embryonic tissue during a 10-minute public bathroom trip, after which she just focused on finishing up the event:

“I was like, ‘we gotta get out of here. We just need to go sit.’ I don’t know. And I was like, ‘okay, one more hour,’ I thought, ‘until I get home. Like one more hour. One more hour. Oh god.’ And... yeah, I already like by the end of that hour, we cleaned up everything, locked the office, everyone’s gone. I felt like almost 100% basically again by then already.”

Similar to Britney’s lack of privacy, Alice described undergoing the abortion in the medical room of the transitional housing complex, which allowed her some privacy with her boyfriend but also meant that she was interrupted by other housemates who had seen her go in there:

“And so... that night, he tried coming into the room! He came into the room! He knocked... girl, I’m telling you it was so bad. He knocked on the door, right? And it’s not like I’m gonna yell and

be like, ‘I’m having an abortion right now! Fuck off!’ I believe it’s my boyfriend’s job to tell his friend to fuck off because I’m not gonna tell him. You’re sitting in the room with me. Tell him to talk to you tomorrow! We live in the same building [...] And he smells, he stinks of weed, and it’s like giving me a headache because it’s so pungent, and the room is... it’s a small room. It’s smaller than this room right now. And like... Oh. My. God. Like I’m so over it at this point [laughs]. This is like the worst. Like top 10 lowest points of my life, right there.”

Eventually, with the help of staff, Alice was able to get him to leave the room. In a similar vein, Ash, who identifies as a “full-time mom,” spoke about not having childcare for most of the duration of the medication abortion and needing to parent their toddler:

“I was trying to get rest as well because I was super tired because... it's an exhausting process [emphasized]. Your body gets so tired. Add walking around and taking care of... a [toddler]. It's exhausting. [...] It's not easy because I have to change diapers, wipe her bum, and she just learned how to walk. So she's trying to run and crawl everywhere and just like... babble.”

For these participants, it was not only challenging to under the physical symptoms of the medication abortion but also to juggle the other familial and work responsibilities. These accounts demonstrate that there is not flexibility in all workplaces or living situations as to the timing and location of the abortion.

For another participant, the abortion had a significant negative impact on her career trajectory. Ariel described the impact of revealing her pregnancy to her employer:

“And I had to tell my direct supervisor, ‘Hey, I don't have COVID. I don't need to be off the floor, but I am sick because of this.’ And I did divulge I was pregnant. And I was met with that I would not be able to join the next class of progression in the workplace. They were going to hold me back, which is very illegal.”

For Ariel, this time in her life was challenging not only due to the pregnancy but also because of work-related trauma that she had recently experienced regarding an infant fatality; the combination of these two events made the process exceedingly emotional for her. Ariel attempted to go back to work shortly after the abortion but then ended up needing additional days off work to recover from her experiences.

## **6.4 Resolution: (In)Sufficient Post-Abortion Care for Physical and Emotional Well-Being**

### *6.4.1 Not Receiving Sufficient Follow-up Care from Abortion Providers*

In most cases, abortion providers did not connect with patients to follow-up after they received their procedure. The responsibility to pursue follow-up care was often placed on the patient if they needed it. Carter spoke about not receiving any follow-up care from the clinic:

“There was no talk of follow up. I wasn't asked to call back for a follow up in a week, which I also thought was really interesting. Um, there was a little package given to me that I could follow up with my family doctor if I wanted to. I opted not to. My GP is very Catholic. She won't. Yeah,

she doesn't offer IUDs and that kind of stuff. So. She's, yeah... it's just something I'd rather not speak to her about. And I don't think it's... super relevant if anything does come up. If there was any complication, I would have just gone to the ER probably. And skip the whole GP, um, general practitioner... rope end of things.”

For Carter, she was displeased with the suggestion to follow up with her primary care physician as she would have been reluctant to follow up with her physician. For another participant, a lack of coordination between healthcare providers caused confusion when pursuing later follow-up care for complications. Alice, an 18-year-old living in transitional housing, received conflicting advice from two different reproductive care organizations about whether she needed a follow-up procedural abortion. After reaching out to a different reproductive care clinic to get an intrauterine device insertion, she was referred for an ultrasound and then told to get a procedural ultrasound. However, while trying to book a procedural abortion with the first clinic where she initially had her abortion, she was told she did not need one. Alice describes the impact of being told two different medical opinions:

“The amount of calls I had to make and trying to sound professional on the phone. And really... I'm like, ‘oh so... I'd like to speak to so and so,’ and nah, nah, nah. You know the phone voice, right? When really, I wanted to be like, ‘you guys are really confusing me. I don't know what to do. Can someone actually tell me what's going on? Because I don't know anything. I don't know. Right?’”

Alice is told to consult with a third clinic but is unsuccessful when she calls them. In the end, she opted not to get a procedural abortion on the advice of a third practitioner at the initial abortion clinic.

Similarly, some participants expressed wanting more responsiveness of abortion providers to their mental health needs following their abortion. For some individuals like Beatriz, she would have liked to be referred to mental health supports, which were not offered by any healthcare practitioner throughout her journey. Similarly, Mallory discussed that they were provided with virtual follow-up care from the clinic but that they did not receive the full extent of mental health care that they desired:

“There were different appointments afterwards where they were doing follow-ups kind of thing. But again, it was all just on the telephone. And I think maybe I had 3 follow-up phone calls. And I think the first 2 were with the same person, but then the third one was somebody different, which, again, I don't remember the reason. But it kind of bothered me just because I'm like, ‘now I feel like I have to reiterate some things and I feel like you haven't been there through the whole like process,’ if that makes sense. And I remember each time saying about how depressed I was feeling, like how low I was feeling. And I don't think it was necessarily the procedure itself that was like bad or upsetting. It was just like the emotional stuff that all went with it. But I don't remember them... offering me [...] like post-abortion counseling. Like that was never brought up to me. Um... which I just think that would have been a nice option. [...] And if somebody is continuously telling you, ‘I feel depressed. I'm so sad. Like I don't wanna do things,’ that's an indicator that you shouldn't just be like, ‘okay, we'll talk to you next week.’ And then, you know, when the third phone call is over, it's just like, ‘this is over, whatever.’”

Mallory's account emphasizes the importance of having continuity of support during follow-up in order to reduce the burden of sharing one's story multiple times.

#### *6.4.2 Post-Abortion Therapy: Experiencing as Helpful but Sometimes Inadequate*

Many participants spoke about seeking post-abortion therapy. Some participants had upwards of 8 therapy sessions. Most of the time, these sessions were paid for out-of-pocket, but a few participants had access to benefits to cover the cost of sessions. On the other end, there were a few participants who found the experience less emotional, so only one session with an on-going therapist was sufficient.

A few participants pursued therapeutic care on their own after the abortion but did not always find these supports to be adequately compassionate. Beatriz found the initial therapist she reached out through her employee-assistance program to be judgemental but eventually found a supportive private therapist. Mallory felt some of her therapeutic supports were not focused enough on the abortion experience. Similarly, they also tried to access peer-support, loss group but felt uncomfortable as the only one to access an abortion:

“I found a support group that.... It was just very vague: pregnancy loss. And one of the things that was listed was abortion. So I thought, ‘good, this will be a good fit for me.’ It was not. I was happy because it was advertised as a queer space. I'm like, ‘okay, cool.’ Um... I was the only person that had an abortion. I was the only person with a male partner. And I was the only person that didn't get pregnant through IVF and lose a baby through miscarriage. So I had all of the... like I had these things that these people wanted, right? Like they wanted sperm. They wanted to have a pregnancy. And so, I just felt like I couldn't really open up and tell my story. I just kept going to the groups because I was worried if I didn't go somewhere and let myself be emotional that I would have nowhere for it to go. Um... which in hindsight again sounds silly because I knew it wasn't helping me since the initial session, but I needed to open up and I needed to talk, but I just... I don't know. I felt like that was my only option.”

For both Mallory and Beatriz, their negative experiences contributed to their delay in seeking out care again for a while. Over two and a half years later, Mallory did end up finding appropriate abortion-specific group peer support:

“[In this group], there's the expectation for... everybody to be okay with however [they] want to present themselves. I know for me, like week one, I didn't say anything. I was muted. Camera off. And then, I don't know, just the way that everybody interacted. Like it just... I don't know, made me feel like it was okay to like open up and like I could share my story and like I did have a safe space. It didn't feel like the group that I joined before where I'm like, ‘I'm just a wall flower and I'm not allowed to have a voice.’ I felt like I could... share my story.”

Mallory's experience shows the importance of creating a space where participants can engage according to their comfort levels and be respected for how they may have experienced their abortion differently. Willow also had a similar experience of healing in going to a post-support group; however, her experience differed from Mallory's in that she appreciated being part of a

group where people had experienced loss in different ways since she also was feeling a degree of loss about her experience.

#### *6.4.3 Informal Supports: Sharing their Story with Trusted Others Being Therapeutic*

While most participants who needed further emotional supports sought out support through formal support services or peer-to-peer options, some participants spoke about how sharing their abortion experience with family members and friends was beneficial. Two participants spoke about how they learned their mothers also had an abortion when they told them about their own experience. Amelia spoke about how she unexpectedly ended up telling her mother about her abortion when she experienced complications during a family function that required a visit to the hospital:

“I had not decided if I was going to tell her [...]. I kind of wanted her to know, but I didn’t want to be there for the telling and the experience of her experiencing it, like her finding out. But ultimately, she was actually... [pause] much chiller about it than I was expecting. I was expecting big emotions, and, uh... a little bit of sadness. And she was at first like, ‘oh [participant’s name]!’ And then I was like, ‘no, no, no. It’s a choice. We made a choice.’ And she was like, ‘oh, okay.’ And that was it. We didn’t talk about it, uh... much after that. And then she actually then disclosed to me. Months later, we were cleaning out her basement and it somehow came up. And she then told me she had an abortion, a surgical abortion when we were kids. Um, and so that was wild. And not something I expected to be a shared experience with my mom. So that was a whole other experience in and of itself, finding that we had that shared experience.”

Amelia went on to speak about how the differences in time and place and situation for her mother as a single parent made the experience much more of an emotional ordeal for her mother than it was her. Another participant spoke about having a complicated relationship with her mother:

“Incidentally, I also talked to my mom about it after it happened. Because I just felt like I... I don't know, I felt compelled to. Like... she's not been super emotionally supportive to me in my life. But it just felt like something I should talk to her about. And so... I called her up and told her, ‘I was in the hospital a couple of days ago. And, um, this is what happened and everything.’ And she was—yeah, that was also a very nice experience to have because she told me about her abortion that she had before she had my older sibling. And, yeah, there was a good moment of connection as well as [pause] a good look inside myself and my own tendencies to... avoid my feelings and stuff. Like my mom said she... left it for so long that she was quite visibly pregnant because she just couldn't... she couldn't wrap her head around the fact that she was pregnant. She just didn't want to believe it. And so she... was in denial about it for so long until she couldn't be. Um, and she felt very guilty about it [...]. So it was a good opportunity I think for us both to like... feel through some of that and connect and heal those wounds a bit.”

For this participant, it allowed for a time of emotional healing and connection with her mother as well as time for introspection on how she herself coped with the events surrounding the abortion.

However, many participants also spoke about choosing not to tell their parents as they did not feel it would be received well or that they would receive judgement for their choices due to their parents' religious backgrounds. One participant, Ash, spoke about how their mother was explicitly against the abortion and how it conflicted with their own personal values:

“my mom was there when I was going to take [the medication abortion], and she's like, ‘you shouldn't be doing this. Don't do it. You're gonna be taking a life.’ [Interviewer: oh, jeez]. And I'm trying to just not... react because her beliefs and my beliefs are different.’ ‘Your grandma will be disappointed in you if you do it.’ Just like... ‘and?!’ This is definitely not... no. My body, really. I don't want it to grow up in a traumatizing childhood. I grew up in the system, and it was traumatizing. So. I'm taking care of your safety.”

After they had the abortion, their mother said to her: ‘well that’s done.’ For Ash, they had to rely on their own internal convictions to help them make and validate their abortion choice instead of relying on the support of family and friends. Similarly, Mallory spoke to how they lost friends after they told them they were going to have an abortion. A few participants also spoke about how hearing about people’s negative experiences accessing abortion were particular unhelpful for them as they relayed “horror stories” or conveyed still feeling guilty about their choices.

However, some participants spoke about the therapeutic nature of telling friends about their experiences. Camille speaks about how telling people has been helpful for her:

“That's the only thing I can do right now to help, to tell my story to other people [...]. When it comes up, then I say, ‘yeah, I had an abortion.’ And it opens up other women to talk about theirs if they had one at all. Or if they don't, then to hear the story and to think that, ‘oh okay.’ Like to just erase the stigma of what maybe abortion could look like or who is getting an abortion. It’s not always teenagers who don't protect themselves or people who get abused for this and that. Like it's so, so important [for everybody]”

For many participants, the notion of who they could trust was important for who they could tell and, when finding that person or people they could trust, found healing in being able to share their story.

## Chapter 7: Discussion

The goal of this study was to understand the experiences of people accessing and receiving abortions in Ontario with a focus on how they perceived their care encounters and what challenges they faced along their journeys. It also aimed to make suggestions for how abortion care could be improved in the health care system. This study demonstrates that obtaining an abortion in Ontario can be a complex process. Most participants did not initially know where to access an abortion and some faced significant hurdles in trying to obtain the procedure. A few participants had relatively straightforward and even empowering journeys, yet still found elements of their abortion care journey challenging, such as feeling ill-equipped for the pain resulting from the procedure. While some participants felt health care professionals went out of their way to provide compassionate care and relay relevant information, others experienced professionals as disengaged, judgemental or even shaming. Individuals' experiences in accessing and receiving care were not only shaped by their personal context, resources, and proximity to services but were also impacted by the larger socio-political polarization and stigmatization of abortion that continues to persist in Ontario.

### 7.1 Key Findings

This study found that participants often needed to use personal resources to access care, which had differential impacts depending on their socio-location. Barriers to accessing care such as transportation time and proximity to services have been previously identified in the literature (Cano & Foster, 2016; Carson et al., 2023; Foster et al., 2017; Sethna & Doull, 2007, 2013). This study confirmed that transportation costs and time could present as a barrier for some individuals but also found that service fees, time off work, and need for childcare also presented as challenges for participants in some cases. Participants and their support persons (usually partners) who could easily take time off work, travel to and from appointments, and pay for service fees and/or therapeutic supports often reflected on their privilege that allowed them to do so whereas individuals who were younger, less financially secure, or less job secure discussed how these barriers made accessing an abortion more stressful for them. It is my interpretation that these participants often took less time to recover from their abortion and/or pursued post-abortion supports less. This study suggests that sexual and reproductive health organizations that help patients navigate or overcome these barriers are vitally important and should be funded to do so. Moreover, with only four of Ontario's freestanding clinics fully funded in the *Integrated Community Health Services Act* (Health Canada, 2024), the legislation needs to be expanded to include all freestanding clinics. Increased funding to cover operational costs would decrease the need for service fees from patients, which can be from \$50-\$400 depending on the clinic (Planned Parenthood Toronto, 2024).

In Canada, information regarding where to access abortion is often not advertised or easily accessible (Carson et al., 2023; Ennis et al., 2023; Monchalin, Jubinville, et al., 2023). In Ontario specifically, there is no evidence-based information about abortion or where to access it on the provincial healthcare website compared to other provincial and territorial websites that have listed this information (Action Canada for Sexual Health and Rights & Women's Legal Action and Education Fund (LEAF), 2024). In this study, many participants did not know initially where to find abortion services, despite it being an essential medical service. In particular, participants

reported that specialized abortion clinics were not always obviously demarcated as providing abortion services. In some cases, participants needed specific instructions on how to enter them. This concealment of abortion services may further entrench the idea in patients, who may already feel stigma, that abortion should not be something talked about or that it is something to feel ashamed of needing. Some research in Canada suggests that abortion providers are frequently hesitant to advertise abortion services due to staff and their own need for security and wanting to preserve their anonymity, which they also infer is important to patients (Carson et al., 2023; Ennis et al., 2023; van Berkel, 2004). While some patients may feel comforted by the measures abortion clinics take to make their services safe and secure (Foster et al., 2020), it comes at the cost of making abortion services visible for prospective patients. Increasing the number of providers that are covered by safe access zones and the radius of safe access zones may be one strategy to prevent harassment (ARCC, 2024b; Ennis et al., 2023; Foster et al., 2020). Another strategy to increase patients' level of security and cultural safety is to allow a support person to be present at appointments and during abortion procedures (Monchalin, Jubinville, et al., 2023)

Research in Canada has also previously suggested that stigmatization and judgement from health care providers influence patients' experiences of accessing and receiving care (LaRoche & Foster, 2018; Wiebe & Sandhu, 2008). This study highlights the important finding that the contentiousness nature of abortion continues to have an ongoing impact on people's ability to access care despite recent changes to make abortion care more available through the introduction of medication abortion and the mandate of effective referrals in Ontario (Dickens, 2021; LaRoche, Wylie, et al., 2022; Shaw & Norman, 2020). Many participants in this study did not feel comfortable approaching their primary care physicians for care due to fear of judgement and anticipated denial of care. A few of the participants who did reach out to their primary care physician were refused or delayed timely care. While preliminary research has shown that medication abortion has expanded access (Renner et al., 2022; Yalahow et al., 2020; Zusman et al., 2023), this study suggests that the moral opposition of some primary care providers still poses as a significant barrier.

Participants also experienced stigma and judgement from healthcare providers while receiving care throughout their journey. Abortion research in Canada has tended to focus on the impacts of staff who may be receiving moral opposition from those in leadership positions or coworkers (Carson et al., 2023; Ennis et al., 2023). This study uniquely highlights the judgement, shaming and silencing that patients perceived from clinicians themselves. Staff working in community settings, such as pharmacies, ultrasound clinics, or therapist offices, seemed at times to be particularly unprepared or insensitive towards clients who are seeking or have had abortions. However, participants also felt baffled by the staff at abortion clinics where they expected clinicians to be more compassionate and attuned to the patient's emotional needs since they had opted to work in that field. Counselling appointments do not need to be made mandatory as not all patients experience emotions around the event. However, more time needs to be carved into appointments to allow space for patients, if they choose, to debrief their feelings around the circumstances leading to this event and to ensure patients have an accurate understanding of the risks and benefits of the upcoming procedure to help allay any fears.

It should be noted that participants also had experiences with healthcare providers in a variety of settings where they felt immense gratitude for the compassionate care they received from practitioners in community settings, sexual and reproductive health organizations, and abortion clinics. In fact, this study is unique in conveying the positive interactions between healthcare providers and people receiving abortion care in Canada instead of just focusing on the barriers to care. While many participants described stories of feeling judged or stigmatized, adjacent to these recounted encounters were stories of empowerment, agency, and compassionate care. A few participants felt empowered from being able to access the care they needed; others would not go so far as to describe their experiences as “empowering” but felt grateful for the kindness of practitioners. More research could be conducted on abortion care providers that are administering non-judgemental, culturally-safe, patient-centred care and how that could be replicated and supported in more places through effective policy and leadership.

However, abortion care also needs to be attentive to the hierarchy of care that is perpetuated by some abortion providers with those deemed as “more deserving” of an abortion treated more compassionately and less questioned about their care choices than those deemed “less deserving.” Norris et al. (2011) suggests that some reasons for terminations are seen as more or less socially acceptable. They go on to describe how idealized womanhood values purport that sex should happen within long-term monogamous relationships with reliable methods of contraception for procreation, not pleasure. Internalized stigma can result when a person looking to terminate feels they made “one or several ‘bad choices’ about sex, contraception, or partner” (Norris et al., p. s51).

Several research studies on experiences of receiving an abortion have further substantiated the idea that patients may feel stigma while accessing abortion care (Hanschmidt et al., 2016; Ingraham & Hann, 2022; LaRoche & Foster, 2018; Monchalin, Pérez Piñán, et al., 2023; Sorhaindo & Lavelanet, 2022). In this study, participants were often made to feel “less deserving” of abortion care when they were judgementally questioned by healthcare practitioners about their contraceptive past behaviours and plans, number of abortions, and, in one particular case, rationale for not wanting to proceed with an ultrasound. My findings align with a research review by Baraitser et al. (2022) that described that while some people want to discuss contraception options, for others, this is particularly unwelcome and makes them feel judged. People receiving abortions need to be given informed choices regarding how they want to proceed with assessments and care that are person-centred and trauma-informed. Where possible, these choices could include, but not be limited to, opting out of having an ultrasound, choosing one abortion method over the other, viewing the ultrasound, receiving contraceptive advice, or choosing for support persons to be present at appointments and/or during procedures as congruent with research studies and reviews (Baraitser et al., 2022; Monchalin, Jubinville, et al., 2023) and the National Abortion Federation’s clinical guidelines (National Abortion Federation, 2024).

A feminist lens can aid in understanding why paternalistic care occurs from healthcare professionals. Participants often were explicit about the gender of practitioners, especially when highlighting interactions with cis-male professionals who they found dismissive or patronizing. Another particularly acute example of gendered inequities in care is in the lack of attention to pain management by practitioners. Research has indicated that women or gender diverse

individuals' pain can often be dismissed or underestimated by healthcare professionals in reproductive and pelvic care (Akintomide et al., 2015; Maguire et al., 2014; Oviedo et al., 2018; Shallcross et al., 2018; Williams et al., 2024). This study indicates that many participants felt ill-equipped for the pain resulting from the abortion and some felt that more realistic expectations could have been set by practitioners, which has also been stressed in other research of people's subjective experiences of pain in abortion (Aamlid et al., 2021; Georgsson & Carlsson, 2019; LaRoche & Foster, 2020). Particularly problematic for some participants was the comparison to heavy period cramps. Implicit in this comparison is the assumption that because people with uteruses may have experienced heavy menstruation cramping, they will be prepared for a medication abortion. In this study, heavy menstrual cramping, previous birthing experiences, and lifelong experiences of endometriosis did not prepare participants for the level of pain they experienced with medication abortion. While some participants were told that the procedure may be painful, discussion of pain management did not seem to happen in every encounter. A realist review by Baraitser et al. (2022) also concurs that there are no standardized options of pain relief presented to patients in practice. Furthermore, participants did not describe any discussions with practitioners about pain management strategies beyond pharmacological options; pain relief techniques or the coordination of support persons and resources appeared to be solely left to the initiative of the patient. Further research could also be conducted on analgesia options as there is currently no consensus about this option within the literature (Baraitser, 2022)

The lack of attention to pain management within research and practice can be seen as symptomatic of embedded patriarchy within the healthcare system: abortion care only impacts the embodied experience of women and gender diverse people and thus is not adequately studied or addressed. I highlight this not only to suggest improvements needed to be made at a clinic or health provider level but also to suggest that this is also a larger systemic and political issue. Under-resourcing of abortion care providers impacts their ability to provide adequate pain management.

In a similar vein, little attention has been placed on the emotional experience of individuals with few resources often earmarked for options counselling or post-abortion support. The need for emotional support is a difficult topic to discuss within the political climate of abortion because the suggestion that abortion may be an emotionally-challenging decision for some can be the impetus for anti-choice politicians to mandate counselling laws or create other abortion restrictions (LaRoche & Foster, 2017). However, in this study, it was clear that participants were confident that the decision they made was the right one for them, and that the need for emotional processing was much more complex than needing more time to contemplate their decision. In fact, for many participants, the wait to receive an abortion added to their stress and anxiety, heightening their overall need for emotional support. Based on my analysis of participants' stories, I would suggest that it is likely that the need for further counselling was not simply because terminating a pregnancy may have been emotional but also because of additional factors apart from needing an abortion, including negative interactions with the abortion care system, external stigma and/or other life circumstances that were occurring simultaneously as the abortion. As LaRoche & Foster (2017) eloquently point out, patients should not be pathologized for having emotional experiences and needing to debrief: "The experiences of our participants highlight that negative or complex emotions are distinct from mental illness and that a desire for support in the post-abortion period is not a reflection of an underlying pathology. This distinction

is important from both a policy and service delivery perspective, as well as from sociological and socio-cultural perspectives. (p.760)”

With that said, this study highlights that many participants sought out post-abortion support, either through specific post-abortion groups or peer support or through a therapist, which aligns with other research studies (Kimport et al., 2012; Monchalin, Jubinville, et al., 2023). In particular, some Ontario studies indicated that, for those who desired it, appropriate post-abortion supports can be difficult to find due to barriers in timing of services, affordability, and stigmatizing beliefs of practitioners (LaRoche & Foster, 2015, 2017). While many participants in had positive encounters with therapeutic supports, this study also demonstrated that the aforementioned barriers created similar difficulties for some participants in this study in obtaining therapeutic support, in some cases causing participants to delay or abandon post-abortion support. However, this study was unique in that it captured stigmatizing encounters that also occurred with private therapists or employee-assistance providers, not just CPCs or religious lay counsellors. It is clear that the polarization of abortion has impacted the delivery of therapeutic supports among some mental health practitioners as well. Research suggest that social workers have been largely silent on abortion rights and reproductive justice (Hyatt et al., 2022; Witt et al., 2022). Social workers may want to consider being explicit about their pro-choice stance to let prospective clients know they will be met with non-judgemental care.

Lastly, I want to frame these findings around the key proponents of reproductive justice, which advocate not only for the right to not have children but also the right to have a child and the right to parent any child(ren) (Luna & Luker, 2013). While some participants did not want children, and expressed they will never want them, others stated that they did want to have a child or would have been open to having another child but financial reasons or lack of a partner prevented them from making the decision to continue with the pregnancy at that time. Other research in abortion care both in Canada and the United States prior to the overturning of *Roe v Wade* also suggest that financial, level of support, and partner reasons are key factors to making an abortion decision, not just the desire of whether or not to have a child at that time (Biggs et al., 2013; LaRoche & Foster, 2018).

The right to abortion should be absolute. However, it is also important advocates work to ensure that programs and policies financially equip people to have children if they desire them. Provincial and federal governments should ensure policies and practices make the right to have children affordable and accessible, including, but not limited to, areas of housing, childcare, employment, and education. Ontario’s social assistance, disability, and basic income programs need to be further critiqued as to whether they can viably support the financial costs of having a child for today’s standard of living. While this study did not comprehensively analyze the impact access on abortion for racialized or gender diverse people, research has indicated that systemic barriers can disproportionately impact access for migrant workers (Cohen & Caxaj, 2018), Indigenous Peoples (Monchalin, Jubinville, et al., 2023), incarcerated individuals (Paynter et al., 2023), 2SLGBTQIA+ people (Ingraham & Hann, 2022; Monchalin, Jubinville, et al., 2023), and other diverse populations (Ennis et al., 2024). Until we deconstruct our systems, the right to choose an abortion, while still entirely valid, will never completely be a free and unhindered choice for all.

## 7.2 Strengths, Limitations, and Considerations

While this study had a diversity of participants in terms of race and gender, few conclusions can be drawn in this study on whether abortion patients experience racism or discrimination during the course of accessing and receiving abortion care. Preliminary research from other studies of people accessing abortion care in Canada suggests that racism and discrimination impacts the quality of care received (Hukku et al., 2022; Monchalin, Pérez Piñán, et al., 2023). Participants were asked in this study about how their social location (including race) may have impacted their care, but they did not explicitly attribute racism or discrimination to their negative experiences in the abortion care system. However, an intersectional, reproductive justice lens suggests that oppression and discrimination may inform negative interactions. A few young, or young-looking, racialized participants recounted patronizing interactions with doctors that may have been rooted in the overlapping intersections of gender discrimination, ageism, and racism. Furthermore, some of the most positive encounters with practitioners were recounted by white, middle-class women who often attributed their privilege as central to their ability to access care. In a similar vein, discrimination based on gender identity and transphobia was also not explicitly mentioned, although one individual who had de-transitioned wondered aloud if their low-pitched voice was a reason they were sometimes met with derision from healthcare providers when trying to access care. Further research needs to be completed that centres the experiences of Black Peoples, Indigenous Peoples, and People(s) of Colour and proposes culturally-safe changes to the abortion care system.

The interpretation of these results may also be limited by geographic factors. Participants resided and accessed services throughout rural, suburban and urban locations in Southern Ontario; however, I was unable to recruit participants in Northern Ontario where there are limited abortion providers (ARCC, 2024a; Morgan, 2021). Travel time and distance to abortion providers may be greater in this area. Participant stories were uniquely shaped by their location; their ability to find or obtain services was often based on the number and type of available abortion providers nearby. Also, as abortion care is within the provincial jurisdiction of healthcare, abortion journeys could look different across Canada, although the findings from this study do suggest possible routes of investigation for potential barriers and facilitators in other provinces and territories.

Lastly, as a study embedded in an interpretive epistemology, it relies on the interpretation of both the participant and researcher of the events that occurred (Giacomini, 2012; Riessman, 2008). It is subject to the participants' memory and how they perceived the order, coherence, and meaning of events (Giacomini, 2012; Riessman, 2008). As researcher, I added an additional interpretive layer on the meaning of events; I co-constructed the version of events during the interview and re-constructed the narratives during analysis through my own feminist lens. Service providers may have a recollection of events, documentation, and knowledge of clinical context that differs from my own or patients' interpretations. Yet, potential gaps in memory or knowledge does not diminish the validity of these participants' experiences – how patients perceive events needs to be taken into consideration when making recommendations in how to improve the abortion care system. Service providers were also not consulted when making recommendations in this research study; their valuable input on improvements in the system could augment what is already proposed by this study and other research.

With those limitations being acknowledged, the strengths of this study are that it is one of a few in Canada that explore the experiences of people accessing and receiving abortion services. With the many changes that have occurred in the abortion care system over the last decade in Ontario, it depicts current perspectives of care encounters from diverse individuals who experienced abortion(s) from 2020-2023. It demonstrates that navigating the abortion care system can be complex while still providing room for a diversity of participant emotions and meanings attached to the experience. The novel technique of healthcare journey mapping highlights gaps in the system from which recommendations for policy and practice can be drawn. The narratives conveyed alongside these maps elevates participant experiences in a world where abortion is often stigmatized and silenced.

## **Chapter 8: Conclusion**

This study aimed to understand the journeys of people receiving abortion care in hopes that it would engender in readers a sense of compassion and empathy, and perhaps a change of consciousness, for those that have received this care in the current contentious socio-political climate in Canada. While experiences were diverse, findings suggest that accessing care can be complex and challenging for some individuals. By listening to the voices of patients receiving care, this study points toward gaps in services, especially where the healthcare system and adjacent abortion services can be improved to be more patient-centred, trauma-informed, and abortion-focused. Stories where participants felt they were given options, agency, and compassion from practitioners demonstrate that there are effective ways to deliver quality care. This study has made policy and practice recommendations for addressing some of these gaps so that practitioners can be equipped to more fully attend to patients' physical and emotional needs (a full list can be found in Appendix H). While further research with patients and practitioners can help hone these recommendations, it is important that we amplify what we already know about abortion from research and reproductive healthcare services so that policy inaction, professional bias, and purposeful obscuring of services cannot prevail. Stigma and the fear of violence cannot have the last word: abortion services should not be hidden any longer.

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## Appendices

### Appendix A: Recruitment Poster

# If you are an adult who has received an abortion in the last 3 years while residing in Ontario,

Researchers at the University of Waterloo invite **you** to participate in a study on people's\* experiences in accessing an abortion.

Participation involves a 60-90 minute open-ended interview over the phone, in-person, or on Zoom/Microsoft Teams.

**In appreciation for your time, you will receive a \$20 President's Choice Grocery Gift Card**

\*We welcome people of diverse racial and gender identities to participate, including women, non-binary and transgender people

To volunteer for this study, or for more information, please contact **Kathleen** in the School of Public Health Sciences at:

**abortionstudy@uwaterloo.ca**  
**or 519-888-4567 ext. 48221**



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Health Sciences

This study has been reviewed by and received ethics clearance through a University of Waterloo Research Ethics Board.

## Appendix B: Instagram Recruitment Posts

If you are an adult who has received an abortion in the last 3 years while residing in Ontario,

Researchers at the University of Waterloo invite **you** to participate in a study on people's\* experiences in accessing an abortion.

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Participation involves a 60-90 minute open-ended interview over the phone, in-person, or on Zoom/Microsoft Teams.

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## **Appendix C: Letter of Information and Consent**

**Project Title:** Exploring the Journeys of People Accessing Abortion Care in Ontario, Canada

You are invited to participate in a research study that aims to improve understanding around people's journeys accessing abortion care in Ontario. In conducting this project, I hope to share with the public anonymized stories about people's journeys of seeking abortion care in Ontario. My overall goal is to offer recommendations for improving abortion access in the Ontario health care system.

This study will be undertaken by Kathleen Slofstra, a graduate student of the School of Public Health Sciences, University of Waterloo, under the supervision of Dr. Elena Neiterman.

### **Who May Participate in this Study:**

This study will involve up to 10-12 participants. In order to participate in this study, you must be over the age of 18, have received a medical or surgical/aspiration abortion in the past three years, and have been residing in Ontario at the time of your abortion.

### **What You Will Be Asked to Do:**

Participation in this study is voluntary. With your consent, it will involve answering demographic questions such as age, gender, type of abortion, and year of abortion to understand how your personal characteristics might have impacted the care you received. You will also be engaged in an open-ended interview that will require approximately 60-90 minutes to complete. Questions will encourage you to tell your story about accessing abortion care and the challenges you encountered during this journey. Some of the questions that I may ask could include: *Could you walk me through the process of getting the abortion? What resources or supports did you need to access your abortion? What challenges, if any, did you experience in accessing abortion care services?*

The interview can take place either in person, over the phone, or via videoconferencing on Microsoft Teams or Zoom, at a mutually agreed upon time. Microsoft Teams and Zoom have implemented technical, administrative, and physical safeguards to protect the information provided via the Services from loss, misuse, and unauthorized access, disclosure, alteration, or destruction. However, no Internet transmission is ever fully secure or error free. Please note: We do not collect or use internet protocol (IP) addresses or other information which could link your participation to your computer or electronic device.

With your permission, the interview will be audio-recorded to facilitate the collection of information and transcribed for analysis. The interview will also be video-recorded if using Microsoft Teams or Zoom. However, you may choose to have your video off for the duration of the interview. During the interview, you may decline to answer any of the interview questions and/or share your personal information with the researchers. Furthermore, you may withdraw from the study at any time by advising the researcher without any negative consequences. Participants who have withdrawn from the study will still receive remuneration in the form of a

\$20 President's Choice [PC] Grocery Gift Card. If you decide to withdraw, we will ask how you would like us to handle the data collected up to that point, whether returning it to you, destroying it, or using the data collected up to that point. If you wish for the information to be destroyed, we will erase the interview transcript and all the research notes that were taken during the interview process.

While you are sharing your story, the researcher will draw an anonymized, visual healthcare journey map to outline your steps to receiving an abortion and any challenges and facilitators you faced in accessing care. The map will be sent to you within 24 hours of the interview for your reference and for opportunity to give feedback, if you desire.

### **Confidentiality:**

Your identity will remain confidential. To protect your confidentiality, any personal identifying information will be removed after the transcription of the interview. Your name and contact information will be stored separately until the end of the project, approximately August 31<sup>st</sup>, 2024. After 6 months from the date of the interview, we will also erase the audio and, if applicable, video recording of the interview, and only the transcription with the pseudonym will remain.

You can withdraw your consent to participate and, if you wish to do so, have your data destroyed at any time during data collection and analysis. You will not be able to withdraw consent once the final thesis has been submitted or findings are shared with the public, which will occur in approximately May 2024. Your signed consent form, anonymized interview transcript, and research notes will be stored as separate encrypted files on the password-protected computers of the researchers and will be only accessed by the research team. The files will be kept for a minimum of seven years. All records are destroyed according to University of Waterloo policy.

Any quotations from transcripts used in papers, reports, publications, or presentations from this research will remain anonymous and may be presented with only the information of the participant that is important to the topic being discussed (e.g., ethnicity or gender).

### **Benefits and Risks of Participating in the Study:**

Participation in this study may not provide any personal benefit to you. We hope the data collected will advance our understanding of the experiences of people seeking abortion care in Ontario. The findings will be shared with SHORE, a non-profit organization serving as community partner in this research, who may also share them with the community.

During the interview process, there is the potential you may experience negative feelings or upsetting memories when recounting your experience of abortion access and care. As abortion is highly stigmatized, there is always the risk you may feel upset when recalling your abortion care journey. If you feel upset, let the interviewer know and you can skip questions, pause for a break, reschedule your interview, or withdraw from the study at any point during the interview. After the interview, you will also be given the option to receive a list of support resources via email, mail or over the phone.

**Remuneration:**

In appreciation of your time, you will receive remuneration in the form of a \$20.00 President's Choice [PC] Grocery Gift Card. The amount is taxable. It is your responsibility to report this amount for income tax purposes.

**Research Ethics Clearance and Further Questions:**

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Board (ORE#44518). If you have questions for the Board, contact the Office of Research Ethics at 1-519-888-4567 ext. 36005 or reb@uwaterloo.ca.

For all other questions regarding this study, or if you would like additional information to assist you in reaching a decision about participation, please contact Kathleen Slofstra at kathleen.slofstra@uwaterloo.ca, or the study supervisor, Dr. Elena Neiterman at (519) 888-4567 ext. 48221, [eneiterman@uwaterloo.ca](mailto:eneiterman@uwaterloo.ca).

I very much look forward to speaking with you and thank you in advance for your assistance in this project.

Kindly,

Kathleen Slofstra

Student Researcher

**CONSENT FORM**

By providing your consent, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

I have read the information presented in the information letter about the study being conducted by Kathleen Slofstra and Dr. Elena Neiterman with the School of Public Health Sciences, University of Waterloo. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions and any additional details.

I am aware that I have the option of allowing my interview to be audio and, if applicable, video recorded to ensure an accurate recording of my responses.

I am also aware that excerpts from the interview may be included in the thesis, publications, and/or presentations to come from this research, with the understanding that the quotations will be anonymous.

I was informed that I may withdraw my consent at any time by advising the student researcher.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Board (ORE#44518). If you have questions for the Committee, contact the Office of Research Ethics at 1-519-888-4567 ext. 36005 or reb@uwaterloo.ca.

For all other questions contact Elena Neiterman at (519) 888-4567 ext. 48221 or eneiterman@uwaterloo.ca

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.

YES  NO

I agree to have my interview audio and, if applicable, video recorded.

YES  NO

I agree to the use of anonymous quotations in the thesis and any other publications based on this research.

YES  NO

I agree to the use of anonymized excerpts from my interview (i.e. your story) in the thesis and any other publications based on this research.

YES  NO

I agree to be contacted by the researcher after the interview to be sent the visual healthcare map and to optionally give feedback.

YES  NO

Participant Name: \_\_\_\_\_ (Please print)

Participant Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Researcher's/Witness' Name: \_\_\_\_\_ (Please print)

Researcher's/Witnesses' signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **Appendix D: Verbal Consent Form**

Hello. My name is Kathleen Slofstra and I am conducting research about people who have accessed abortion in Ontario. This interview is part of my Master's studies with the School of Public Health Sciences at the University of Waterloo. I'm working under the supervision of Dr. Elena Neiterman who are also part of the School of Public Health Sciences.

Thank you for your interest in participating in my research.

*[If the LOI was provided in advance]* Have you had time to read the Letter of Information I sent you?

*[If the LOI was provided in advance and the participant responds that they have read the LOI]* Great, then I would like to take a moment to review some main points from the Letter of Information before we continue. *[Proceed to review the highlights of the LOI, including the risks and what will happen with their data, and confirm the important points about voluntary participation and withdrawal listed below.]*

*[If it is not possible to give an LOI to the participant, or if the LOI was not sent in advance, or the participant responds that they did not read the LOI in advance, then proceed to go through the full LOI in detail with the participant and confirm the important points about voluntary participation and withdrawal listed below.]*

### **Confirm the following to the participant:**

- Your participation in this study is voluntary.
- If you do not want to answer some of the questions you do not have to, but you can still be in the study.
- You can decide to stop at any time, even part-way through the interview for whatever reason.
- If you decide to stop during the interview, we will ask you how you would like us to handle the data collected up to that point, whether returning it to you, destroying it or using the data collected up to that point.
- You can ask to remove your data from the study (withdraw) up until approximately May 2024.
- This study has been reviewed and cleared by a University of Waterloo Human Research Ethics Board (ORE#44518).

Do you have any questions or want me to go over any study details again?

**Consent questions:**

1. Do you agree of your own free will, to participate in this study?
2. Do you agree to have your interview audio and, if applicable, video recorded?
3. Do you agree to the use of anonymous quotations in the thesis and any other publications based on this research?
4. Do you agree to the use of anonymized excerpts from your interview (i.e. your story) in the thesis and any other publications based on this research?
5. Do you agree to be contacted by the researcher after the interview to be sent the visual healthcare map and to provide feedback, if desired?

## Appendix E: Interview Guide

Preface: [Share about myself first]. I am interested in hearing about your journey in accessing abortion care from start to finish (i.e. point of access to follow-up care), however you may define that. Think about sharing your experiences like you're telling a story – I want you to be able to paint me a picture. I want to get to know the places you've gone to get an abortion, the people involved (whether it is professionals or other people important in the process), and the overall process of getting the abortion. If you are comfortable, I would also like to know how you felt throughout the process and if there are still any feelings that linger. I have some questions to help guide you through your story, but if you're in the flow of telling your story, I may just follow your lead only interrupting to ask questions of clarification. I will take notes from time-to-time and will be sketching out a map of your health care encounters. I also tend to paraphrase quite a bit about what I perceive you have told me about your journey. If you feel that I've gotten something incorrect or am not understanding please feel free to correct me as I really want to get an idea of your thoughts and feelings around your experiences.

### *Beginning of the Journey*

1. Can you start by telling me a little bit about yourself before you accessed an abortion?
  - a. Probe: Where are you located?
2. Can you tell me about who you first reached out to when you discovered you were pregnant?
  - a. Probe: What information did you learn? Did you feel supported? Did you feel equipped to make a decision, if you needed to?
  - b. Probe: Did you reach out to anyone else before contacting a health care provider? Pregnancy crisis centers? Google? Hotlines/helplines?
3. Can you tell me about your first interaction with a health care provider in the context of your pregnancy/abortion? (Question to be repeated if had multiple encounters with different health care providers before abortion, i.e. multiple physicians)
  - a. Probe: What resources/support did you need to access this health care provider?
  - b. Probe: Why did you reach out to this health care provider? / How did you know where to go to get an abortion?
  - c. Probe: What was the nature of the interaction? Supportive? Dismissive?
  - d. Probe: How easy/difficult was it to access this health care provider? Transportation? Wait times?
  - e. Probe: Physical, emotional, mental, cultural and spiritual challenges and facilitators
  - f. Probe: Did you get what you needed from this person? OR were there any questions, information, or assistance you still needed afterwards?
4. What was your experience accessing ultrasounds or blood tests, if needed or required?
  - a. Probe: were there any other tests or stipulations required of you before you were able to access your abortion?
  - b. Probe: what challenges existed to accessing these tests? What facilitated accessing these tests?
5. What type of abortion did you receive? Where did you receive this abortion (i.e. pharmacy, clinic or hospital)?

*For Medication abortions*

6. Picture yourself going into the clinic or pharmacy to get your prescription. What was your experience in getting your prescription fulfilled?
  - a. Probe: What resources/supports did you need to get to there? How much time elapsed between this and your last healthcare interaction? Your first healthcare interaction?
  - b. Probe: How did you feel during this process? Physically? Emotionally? Mentally?
  - c. Probe: Was there anything about your experience that either made you feel safe or uncomfortable?
  - d. Probe: Did you receive all the information you needed to take the medication? Was there anything you wish you were told?
7. How would you describe the process of having an abortion at home (or NOT in the clinic or hospital)?
  - a. Probe: How does this experience compare to other medical procedures you've had in a hospital or clinic, if any?
  - b. Probe: How did you feel during this process? Physically? Emotionally? Mentally?
  - c. Probe: Was there anything that could have made this experience better?

*For Procedural/Medication abortions*

8. Picture yourself going into the clinic/hospital to get your abortion. Walk me through the process of getting the abortion. What did you do first? What did you do next?
  - a. Probe: What resources/supports did you need to get to the clinic? What was the wait to receive this appointment? How much time elapsed between this and your last healthcare interaction? Your first healthcare interaction?
  - b. Probe: What were your interactions like with health care providers? i.e. ultrasound technician, receptionist, staff, doctor, nurses
  - c. Probe: Did you receive all the information you needed before and after getting the abortion? Was there anything you wish you were told?
  - d. Probe: How did you feel during this process? Physically? Emotionally? Mentally?
  - e. Probe: Was there anything about your experience that either made you feel safe or uncomfortable? Anything that could have been done to make this experience better?

*Follow Up Care*

9. Did you access any informal (i.e. support groups, counselling) or formal (i.e. follow up physician appointment, testing, ultrasounds) follow up care related to your abortion?
  - a. Probes: If not, was there any more information or support that you wish you had received?
  - b. What challenges, if any, did you experience in accessing these services?
  - c. What enabled you to access these services?
  - d. Where do you think your abortion health care journey ends?

*General Questions (either to be integrated into the narrative interview or asked at the end, depending on the flow of conversation)*

10. Do you think your social identity (i.e. race, gender, class, age, ability, mental health, etc.) – whichever part of your identity is important for you to talk about – affected your access to services or the quality of support you received? If yes, in what way?
  - a. Probe: Do you think it impacted your interactions with health care providers? If yes, in what way?
11. When you recall your interactions in the health care system, can you give me an example of a time where you felt valued or supported? Dismissed or judged?
12. Who supported you in your journey in accessing abortion care?
13. What do you think were the main challenges for you to access quality abortion care?
  - a. Money, travel, time off work, stigma from informal/formal supports, logistics, etc.
14. What do you think were the main facilitators for you to access quality abortion care?
  - a. Support, prior knowledge, etc.
15. How do you think abortion healthcare access and quality of care could be improved in Ontario?

#### *Conclusion of Interview*

16. If someone else were to go through a similar abortion health care journey as you, what would you want to share with them?
17. If you've consented, someone may one day read your story – whether it's your neighbour, a friend, a stranger, a policy-maker, a politician – is there anything you would like them to know about your journey?
18. Is there anything else you would like to discuss?
19. Would you like a copy of support resources for pre- or post- abortion counselling?

#### *Demographics:*

Preface: If you are comfortable sharing, I have some demographic questions I would like to ask you. These are asked to get an idea of how who you are may have affected your access to services and the care you received. If you would like not to answer a question, you can respond with, “prefer not to say.”

1. Can you please tell me your age?
2. What is your occupation?
3. What is your level of education?
4. How do you identify in terms of race? (i.e. Black, Indigenous, Person of Colour)
5. How do you identify in terms of gender? (i.e. Trans, Cis, non-binary, genderqueer)
6. How many abortions have you had?
7. What year did you have your abortion(s)?

## Appendix F: Feedback Letter

Dear Participant,

I would like to thank you for your participation in this study entitled *Exploring the Journeys of People Accessing Abortion Care in Ontario, Canada*. I greatly appreciate the time and energy you put into the interview. I know that for some people it can be a vulnerable and even stigmatized topic and so value your willingness to share your journey with me.

As a reminder, the purpose of this study is to improve understanding around people's journeys accessing abortion care in Ontario. This project hopes to share anonymized stories with the public to generate awareness of people's journeys seeking care. It also aims to offer recommendations for improving abortion access in the Ontario health care system.

This study has been reviewed by and received ethics clearance through a University of Waterloo Research Ethics Board (ORE# 44518). If you have questions for the Board, please contact the Office of Research Ethics, at 1-519-888-4567 ext. 36005 or [reb@uwaterloo.ca](mailto:reb@uwaterloo.ca).

For all other questions, please contact my supervisor, Dr. Elena Neiterman at (519) 888- 4567 ext. 48221, [eneiterman@uwaterloo.ca](mailto:eneiterman@uwaterloo.ca).

Please remember that your identity will be kept confidential. The audio record of your interview will be kept for 6 months and then deleted. Any paper records of data collected during this study will be retained for 7 years in a locked filing cabinet, to which only I will have access. Electronic data will be kept for 7 years on a secure computer, to which only researchers associated with this study have access. All identifying information will be removed from the records prior to storage.

You can withdraw your consent to participate and request to have your data destroyed at any time during data collection and analysis. You will not be able to withdraw consent once the final project paper has been submitted or findings are shared with the public, which will occur in approximately May 2024.

Once all the data are collected and analyzed for this project, I will present the findings as a thesis research project and may also share this information with the research community through seminars, conferences, presentations, policy briefs and reports, and journal articles. I will also share the findings with the SHORE Centre and work with them to publically share the results, including case examples of participants' anonymized stories and health care journey maps. The expected completion date of my final research project report is August 2024. If you would like to read my report, I would be happy to send it to you. Please provide your email or mailing address and, when the study is completed, I will send you the information.

In the meantime, if you have any questions about the study, please do not hesitate to contact me or Dr. Neiterman.

Kindly,

Kathleen Slofstra, BA, BSW, MSW

Student-Researcher, MSc Candidate in the School of Public Health Sciences

University of Waterloo LHN 3721, 200 University Ave West Waterloo, ON N2L 3G1  
Telephone: (519) 888-4567 ext. 48221  
Email: [kathleen.slofstra@uwaterloo.ca](mailto:kathleen.slofstra@uwaterloo.ca)

## Appendix G: Support Resources

University of Waterloo

[date]

Dear Participant,

I would like to thank you again for your participation in this study entitled *Exploring the Journeys of People Accessing Abortion Care in Ontario, Canada*. If you are in need of support, please consider these free support resources:

### **SHORE Centre**

*Pre- and Post-Abortion Counselling or Post-Abortion Workshop Series*

- <https://clinic.shorecentre.ca/after/>
- 519-743-9360
- OR to book online: <https://shore.inputhealth.com/ebooking#new>

### **Action Canada for Sexual Health & Rights Access Line**

*7 day a week Access Line from 9 AM – 9 PM*

*For questions about sexual health, pregnancy options, abortion and safer sex*

*Can provide information and make referrals to sexual health providers*

- <https://www.actioncanadashr.org/campaigns/call-access-line-1-888-642-2725>
- 1-888-642-2725 or text 613-800-6757

### **Planned Parenthood Ottawa**

*Pre- and Post-Abortion Counselling*

- <https://ppottawa.ca/contact-us/>
- 613-226-3234

### **Planned Parenthood Toronto (PPT) Post-Abortion or Mental Health Support**

*Pre- and Post Abortion Counselling or Mental Health Support*

- <https://ppt.on.ca/factsheets/abortion/>
- <https://ppt.on.ca/services/mental-health/>
- 416-961-0113

### **Bay Centre for Birth Control at Women's College Hospital**

*Pre- and Post-Abortion Counselling*

- <https://www.womenscollegehospital.ca/care-programs/the-bay-centre-sexual-health/>
- 416-351-3700

### **Choice in Health Clinic Post-Abortion Support**

*Pre- and Post-Abortion Counselling*

- <https://choiceinhealth.ca/services>
- 647-370-3203

- OR to book online: <https://choiceinhealth.ca/bookonline>

If you, or someone you know, would like to be connected to an abortion provider in Canada, you can also check out <https://choiceconnect.ca/>

Kindly,

Kathleen Slofstra, BA, BSW, MSW  
Student-Researcher, Candidate for MSc in Public Health  
University of Waterloo  
Email: [kslofstr@uwaterloo.ca](mailto:kslofstr@uwaterloo.ca)

Elena Neiterman, Ph. D.  
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## Appendix H: Summary of Policy and Practice Recommendations

1. Abortion services should be more explicitly advertised by care providers and through government websites. In Ontario, unlike other provinces and territories, there is no information about abortion or how to access it on their provincial website whereas other provincial and territorial governments include (Action Canada for Sexual Health and Rights & Women's Legal Action and Education Fund (LEAF), 2024) despite the medication and procedure being covered by provincial health insurance (OHIP) (Ministry of Health, 2024) While there are websites that list or connect individuals with Ontario-based abortion providers (ARCC, 2024a; Planned Parenthood Toronto, 2024; SHORE Centre, n.d.), not all of these abortion providers list their services on their own websites.
2. Sexual and reproductive health non-profit organizations that help patients navigate how to access an abortion care should be further funded and supported to do so. Two national organizations that provide these services include the National Abortion Federation (NAF) Canada and Action Canada for Sexual Health and Rights. The NAF provides case management, financial assistance, and evidence-based information through a free hotline for patients or those seeking an abortion. Action Canada also has an access line for information and referrals.
3. All freestanding clinics need to be licensed and fully funded in the *Integrated Community Health Services Act*. Currently only 4 of Ontario's freestanding clinics are fully funded (Health Canada, 2024). Increased funding to cover operational costs would decrease the need for service fees from patients. In a list of abortion providers on Planned Parenthood Toronto's website, administration fees range from \$50-\$400 and fees for uninsured patients range from \$340-\$2300 depending on type of procedure and gestational age (Planned Parenthood Toronto, 2024).
4. Increase the number of providers that are covered by safe access zones and the radius of safe access zones to prevent harassment and reduce patients' fears in interacting with protestors (Ennis et al., 2023; Foster et al., 2020) The status of applications should be further examined as those that have been submitted may not have yet been approved (ARCC, 2024b).
5. Participants need to be given informed choices regarding how they want to proceed with assessments and care that are person-centred and trauma-informed. Where possible, these choices could include opting out of having an ultrasound, choosing one abortion method over the other, viewing the ultrasound or not viewing it, receiving contraceptive advice or option out of contraceptive advise, or choosing for support persons to be present at appointments and/or during procedures as congruent with research studies and reviews (Baraitser et al., 2022; Monchalin, Jubinville, et al., 2023) and the National Abortion Federation's clinical guidelines (National Abortion Federation, 2024).
6. Support persons should be allowed into facilities, even in the procedure room, if desired. A support person as a companion or advocate could help patients feel more secure and culturally safe (Monchalin, Jubinville, et al., 2023)
7. Standardized pain relief options need to be presented to all patients (Baraitser et al., 2022). Practitioners should consider setting realistic expectations of pain and discuss with patients how and where they can access support, information, and emergency care if needed. Pain management strategies beyond pharmacological options should also be given when appropriate (Baraitser, 2022)

8. Options for pre- and post-abortion counselling should be expanded with further funding given to sexual and health reproductive organizations and/or clinics that provide these services. Independent mental health practitioners should consider making explicit their stance on abortion to indicate where patients can seek out safe, non-judgemental post-abortion care.
9. Healthcare practitioners should consider abortion care professional development, even when they are not working directly in abortion services (i.e. University of British Columbia's "We All Have a Role to Play"). A range of professionals (i.e. ultrasound technicians, midwives, therapists, receptionists, primary care physicians) may come into contact with someone who is seeking an abortion and could benefit from training on how to navigate the abortion care system and provide sensitive, abortion-specific care.
10. Abortion care policies and practices need to be further examined to determine if they are culturally safe for diverse populations such as people(s) of colour, Indigenous Peoples, transgender, and gender diverse people (Monchalin, Jubinville, et al., 2023; Ennis et al., 2024) and accessible for populations facing barriers to healthcare such as migrant workers (Cohen & Caxaj, 2018) and incarcerated individuals (Paynter et al., 2023). In particular, services or policies that refer to abortion services as "women's services" or as a "women's clinic" need to revise their terminology or names to be more inclusive.