



Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.



Contents lists available at ScienceDirect

Contraception

journal homepage: www.elsevier.com/locate/contraception

Original Research Article

“I just was really scared, because it’s already such an uncertain time”: Exploring women’s abortion experiences during the COVID-19 pandemic in Canada ☆☆☆

Srishti Hukku^a, Andréanne Ménard^b, Julia Kemzang^a, Erin Hastings^a, Angel M. Foster^{a,c,*}^a Faculty of Health Sciences, University of Ottawa, ON, Canada^b Faculty of Science, University of Ottawa, ON, Canada^c Institute of Population Health, University of Ottawa, ON Canada

ARTICLE INFO

Article history:

Received 31 July 2021

Received in revised form 20 January 2022

Accepted 21 January 2022

Keywords:

Abortion

Canada

COVID-19

Mifepristone

Pharmacists

Telemedicine

ABSTRACT

Objective: Travel restrictions, physical distancing and quarantine requirements, lockdowns, and stay-at-home orders due to COVID-19 have impacted abortion services across Canada. We aimed to explore the decision-making and care experiences of those who obtained abortion services during the COVID-19 pandemic and understand recent abortion patients’ perspectives on demedicalized models of medication abortion service delivery.

Study design: We conducted 23 semi-structured, in-depth interviews with women across Canada who obtained abortion care after March 15, 2020. We audio-recorded and transcribed the telephone/Skype/Zoom interviews and managed our data with ATLAS.ti. We analyzed the English-language interviews for content and themes using inductive and deductive techniques.

Results: The COVID-19 pandemic, and the associated economic and social support uncertainties, factored into many of our participants’ decisions to obtain an abortion. Participants expressed relief and gratitude for being able to secure abortion care during the pandemic. Although women in our study reflected positively on their abortion care experiences, many felt that service delivery changes initiated because of the public health emergency exacerbated pre-COVID-19 barriers to care and contributed to feelings of loneliness and isolation. Our participants expressed considerable enthusiasm for demedicalized models of medication abortion care, including telemedicine services and behind-the-counter availability of mifepristone/misoprostol.

Conclusions: For our participants, abortion care constituted an essential health service. Our findings demonstrate the importance of continuing to provide access to safe, effective, and timely abortion care during public health emergencies. Exploring additional models of demedicalized medication abortion service delivery to address persistent access barriers in Canada is warranted.

Implications: Policymakers and clinicians should consider patient experiences as well as clinical evidence when considering regulatory changes to facilitate access to abortion care during public health emergencies. Identifying a multitude of ways to offer a full range of abortion services, including demedicalized models of medication abortion care, has the potential to meet significant needs in the COVID-19 era and beyond. The COVID pandemic highlights the need for demedicalized models, not only for the sake of those seeking abortion care but also to ease the burden on medical professionals during public health emergencies.

© 2022 Elsevier Inc. All rights reserved.

* Declaration of Competing Interest: The authors declare that they have no conflicts of interest, financial or otherwise.

☆☆ Funding: A Social Sciences and Humanities Research Council Partnership Engage grant, funding from an anonymous donor, and a small grant from Cambridge Reproductive Health Consultants supported this project.

* Corresponding author.

E-mail address: angel.foster@uottawa.ca (A.M. Foster).

1. Introduction

Since March 2020, the COVID-19 pandemic has both directly and indirectly impacted healthcare systems and service delivery. In many countries, the pandemic has resulted in decreased access to sexual and reproductive health services, in general, and abortion care, in particular [1–4]. However, the pandemic has also highlighted existing structural health inequities and accelerated efforts

already underway to facilitate the provision of safe and effective medication abortion care [5].

In Canada, the Supreme Court decriminalized abortion in January 1988, and there have been no federal laws prohibiting this service for more than 3 decades [6]. Although much time had passed since decriminalization, in 2016 the United Nations indicated concern regarding disparities in access to abortion care in Canada [7], echoing Canadian researchers and advocates who had long highlighted geographic, provincial policy, and funding barriers to equitable care [8–10]. Since then, Canada has made substantial progress in introducing, deregulating, and incorporating medication abortion into the health system [5, 11–13]. In 2017, the mifepristone/misoprostol combination pack became available under the brand name Mifegymiso® [14]. Subsequently, Health Canada updated the product monograph and associated guidance to broaden eligibility to 63 days since the first day of the last menstrual period, expand prescribing authority, permit pharmacist dispensing, and allow individual clinicians to determine the need for an ultrasound [15–16]. As a result of these regulatory changes as well as the coverage of mifepristone/misoprostol by provincial and territorial health insurance schemes, medication abortion became increasingly accessible throughout most of the country [12–13, 17–19].

At the outset of the COVID-19 pandemic, the Government of Canada reaffirmed abortion care as an essential medical service [20]. Recognizing the urgency, in April 2020 the Society of Obstetricians and Gynecologists of Canada released updated guidelines for offering medication abortion via telemedicine [21]. A number of abortion providing facilities identified ways to streamline services, reduce the number of in-person patient-clinician encounters, and minimize exposure risks [22]. However, temporary closures of clinics due to staffing shortages, local, inter-provincial, and international travel restrictions, and reluctance to travel due to exposure risk have impacted access to clinic-based abortion services, particularly at later gestational ages [6, 22]. In addition, COVID-19 has resulted in interruptions in contraceptive service delivery, economic and financial instability, increases in intimate partner violence, and disruptions in social support systems. These dynamics may also impact unintended pregnancy risk, pregnancy intentions, and abortion decision-making [6, 23].

To date, no studies have rigorously documented the experiences of Canadian abortion seekers during the COVID-19 pandemic. We undertook this qualitative study to explore the decision-making and care experiences of those who obtained abortion services during the COVID-19 pandemic and understand recent abortion patients' perspectives on demedicalized models of medication abortion service delivery.

2. Methods

Between October 2020 and April 2021, we conducted semi-structured, in-depth interviews with people who obtained abortion care in Canada during the COVID-19 pandemic. In order to be eligible for the study, prospective participants had to have had at least one abortion after March 15, 2020, have resided in Canada at the time of their abortion, be sufficiently fluent in English or French to answer interview questions, and have access to a telephone, Skype, or audio-Zoom. We welcomed hearing from people who identify across the gender spectrum and recognize that not every person with the capacity for pregnancy identifies as a woman. We offered all participants a CAD40 (USD30) gift card to Amazon.ca as a token of appreciation for their time.

2.1. Recruitment

We used a multi-modal recruitment strategy that included posting on online classified sites such as Kijiji and Reddit, posting on social media outlets such as Facebook and Instagram, asking clinics and community organizations to share information about our study on their websites and listservs, and inviting early participants to refer others to the study. In order to use terms that might resonate with likely participants and be inclusive, we used parallel sets of recruitment materials with gendered and gender-inclusive language. AM and JK led the bi-lingual recruitment effort with assistance from EH and guidance from the Study Coordinator, SH, and the Principal Investigator, AMF.

2.2. Data collection

After verifying eligibility, addressing queries, and sending informed consent materials, a member of our team scheduled a mutually convenient time for the interview. AMF, an American medical anthropologist and medical doctor, and SH, a Canadian PhD candidate in Population Health, conducted the interviews. All of the interviews took place over the telephone or audio-Zoom and averaged 60 minutes in length. With participants' permission, we audio-recorded all interviews and later transcribed them. AM, JK, and EH, all Canadian undergraduate students in the sciences or health sciences, or another member of AMF's larger research group, transcribed the interviews. Interviewers took notes throughout the interviews and memoed shortly thereafter, a process that allowed for reflection and early identification of key themes [24]. AM and JK observed a number of interviews, debriefed with AMF or SH after the interview, and independently memoed.

During the interviews, we followed a semi-structured interview guide that we adapted from prior qualitative research with Canadian abortion patients [19, 25–27]. We began with a series of open-ended questions about the participant's background and general sexual and reproductive health history, including abortion and pregnancy history. We then asked participants details about their pandemic abortion experience(s), including questions related to the specific impact of COVID-19 on abortion decision-making, method choice, and disclosure. We asked participants to provide detailed information about all of their abortions during the pandemic; for those who had obtained an abortion prior to the pandemic, we asked them to compare the different experiences. We then asked participants for their thoughts on how services could be improved, in general, and in the context of COVID-19. We concluded our interviews by asking participants about their thoughts on two different medication abortion service delivery strategies: telemedicine and behind-the-counter provision of mifepristone/misoprostol. For both models of care, we provided participants with a brief description (see Fig. 1), asked them to share their initial reactions, gave them an opportunity to ask questions which we responded to, and then probed deeper into what was appealing and not appealing about each service delivery strategy.

2.3. Data analysis

We began reviewing data as we collected them and held regular team meetings throughout the project as a key part of our analytical process. During these meetings, we identified common themes as they emerged, discussed outliers, and determined when we had reached thematic saturation [28]. We believed that we had reached thematic saturation after 19 interviews and conducted four additional interviews as confirmation. Drawing on interview

Telemedicine model	Behind-the-counter model
<p>In this model, the person seeking the abortion would have a consultation with a clinician over the phone or through an online video platform. The clinician would determine if the person needed lab work, an ultrasound, a physical exam, or none of these things. If the clinician determined the patient is eligible, the person would receive a prescription for mifepristone and misoprostol and would then pick up the medications at a local pharmacy. The medications would be covered by provincial or territorial insurance.</p>	<p>In this model, the person seeking the abortion would go directly to a pharmacy. The person would have a consultation with the pharmacist. The pharmacist would determine if the person needed lab work, an ultrasound, or a physical exam – if so, the pharmacist would refer the patient to an abortion provider. If the pharmacist determined the person needed none of these things, the pharmacist would write the prescription and the person would get the mifepristone and misoprostol then and there. The medications would be covered by provincial or territorial insurance.</p>

Fig. 1. Description of the telemedicine and behind-the-counter medication abortion service delivery models provided to participants.

transcripts, notes, and memos, we conducted content and thematic analyses of the interactions using both a priori (predetermined) codes based on the research questions, interview guide, and existing literature and inductive analysis techniques to identify emerging ideas [29–30]. SH created an initial codebook and served as the principal coder for this study. We used ATLAS.ti version 9.0 to manage our data. AMF reviewed the codebook, a subset of audio recordings, and a selection of the coded transcripts. We resolved rare disagreements through discussion.

2.4. Ethical considerations

The University of Ottawa Social Sciences and Humanities Research Ethics Board approved this study. In the results section, we present our key themes and incorporate illustrative quotes and narrative vignettes to support our findings. We have removed or masked all identifying information, used pseudonyms that were either chosen by our participants or assigned by a member of the study team, and used language that conforms with the gender identity of our participants.

3. Results

3.1. Participant characteristics

Over the data collection window, we interviewed 23 participants all of whom were Canadian citizens or permanent residents living in 5 provinces at the time of their abortion(s) (see Fig. 2). Our participants ranged in age from 19 to 45 at the time of the interview, with an average age of 27.2 years. All participants identified as “women” and used she/her pronouns. A plurality of our participants identified as white ($n = 10$); we also had participants who identified as Asian ($n = 6$), Indigenous ($n = 2$), Black ($n = 1$), and bi- or multi-racial or with another racial/ethnic identity ($n = 4$).

Participants reported using medication abortion with mifepristone/misoprostol ($n = 13$) or instrumentation procedures ($n = 11$) to terminate 24 pregnancies after March 15, 2020. All abortions took place within 14 weeks gestation, with the majority in the first 10 weeks. All participants had a successful abortion, although one medication abortion user had a subsequent instrumentation procedure to complete the uterine evacuation process. Participants obtained care from freestanding abortion clinics, hospitals, and primary care clinicians. All participants had at least one in-person encounter with a health service provider as part of the abortion process.

3.2. COVID-19 influenced participants’ decision-making

As showcased in Margery’s experience (Fig. 3) the COVID-19 pandemic influenced, both directly and indirectly, many of our par-

ticipants’ decisions to have an abortion. Participants repeatedly described the uncertainties associated with the pandemic – uncertainties related to health, finances, employment, and social supports – as factoring into their decision-making. Jennifer, a 22-year-old recent graduate working two jobs who identified as a white Ontarian offered that COVID-19 was a primary concern:

I was just in shock, especially with COVID, I just was really scared, because it’s already such an uncertain time...it’s just not something to be taken lightly. So, I was really shaken up...There was no way I was going to be able to keep a baby. Just partly because, you know, I financially wasn’t in a good place, and mentally I just wasn’t in the best place. With the circumstances and everything that was going on in the world...I was just by no means ready to go through with [carrying a pregnancy to term].

Aisha, a 24-year-old bi-racial (Black-white) woman living in Quebec, explained how COVID-19 factored into her decision-making:

Yes, [COVID-19] did definitely play a role in terms of my fear. How was I going to do this and be a parent? I did entertain the idea for a couple of hours, envisioning that kind of life. For me, I kept thinking of the kind of pregnancy I would want, and the COVID situation was not anything like what I would want to be in.

However, for some, the pandemic either minimally influenced the decision to have an abortion or simply reinforced a decision that the participant felt she would have made in non-pandemic times. As Sonya, a 23-year-old white woman from Ontario who decided to have an abortion because she didn’t feel she was emotionally or financially prepared to parent, explained, “I wasn’t sure how expensive it would be because of the pandemic...That was pretty much the only thing I was nervous about in regards to COVID.”

3.3. Participants expressed relief at and gratitude for being able to access abortion services during the pandemic

Consistent with Arielle’s experience (Fig. 4) participants in our study expressed a high degree of decisional certainty in that once they chose to have an abortion, they were confident in and committed to that decision. However, because of the pandemic, participants reported that they were anxious about the availability of services and feared that abortion care would be suspended. Sara, a 28-year-old Southeast Asian retail employee from New Brunswick, explained “To find out you’re pregnant in a pandemic is not really knowing whether or not all the services you would need would be open at that time.” The reality that abortion services in other countries were deemed non-essential weighed heavily on the minds of



Fig. 2. Map of Canada with study participants' province of residence (N = 23).

Margery is a Black hairdresser who lives and works in Quebec. Because of lockdowns and restrictions on in-person indoor activities, Margery was not able to work for most of the pandemic. As a result, she had to rely financially on her boyfriend of four years. The public health measures put in place in response to COVID-19 also prevented her from seeing her family and she reported feeling out of touch with her primary sources of emotional and social support.

When Margery discovered she was pregnant in June 2020, she and her boyfriend were both in shock. Margery did not intend to become pregnant; she and her boyfriend used condoms inconsistently and she occasionally used emergency contraception to prevent pregnancy. After an initial discussion and a few days of contemplation, they decided as a couple they were not ready to become parents. As Margery explained, the pandemic featured prominently in their decision: “We considered the options...we were not financially stable at that particular time...and then with the COVID-19 pandemic I was very afraid of being pregnant...and maybe exposing myself and maybe a baby to COVID-19. I didn't know when the pandemic was going to end so I was afraid of getting committed to being pregnant and having a baby at that particular time.”

Margery was at about five weeks gestation when she took a home pregnancy test. After confirming her pregnancy with an in-person test at a local clinic she opted for a medication abortion with mifepristone/misoprostol. The overall process involved four in-person encounters with various parts of the health system over a three-week period: an initial consultation, a separate appointment for an ultrasound to exclude an ectopic pregnancy, an appointment to obtain the medication abortion drugs, and a follow-up appointment to confirm the abortion was complete. Her boyfriend supported her throughout the process and accompanied her to the appointments but because of the COVID-19 protocols there was a lot of waiting and he had to take a lot of time off work, which was financially difficult. She described the process as slow and “not smooth” but felt that the providers were compassionate and caring. She felt well-prepared for the abortion process and would recommend the facility to others. However, Margery felt strongly that streamlined services that required fewer in-person visits would be a considerable improvement on abortion services. She was extremely enthusiastic about both telemedicine and behind-the-counter modalities of medication abortion service delivery as she felt these would save time and would have allowed her to avoid in-person encounters and exposure risks.

Fig. 3. Margery's story.

Arielle is a white 28 year-old public servant living and working in Ontario with her boyfriend of more than three years. Due to COVID-19, Arielle reported being very busy at work and explained that her partner was her primary source of emotional and social support. Arielle and her partner had long used natural family planning methods as their primary pregnancy prevention strategy; Arielle explained that she had a strong desire to travel and have more life experiences before starting a family.

When Arielle discovered she was pregnant in October 2020 she felt “shock, for sure, and a little bit of panic.” She had a lengthy discussion with her partner and they agreed that they wanted “at some point, down the road, [to become] pregnant, and [have] kids.” But Arielle had “this pit” in her stomach and she decided that she was not ready to become a parent. Her partner was supportive of this decision.

Once Arielle made the decision she had a telemedicine appointment with her family physician. She said that her family doctor was very helpful and gave her a prescription for mifepristone/misoprostol. However, Arielle had to go in-person for both bloodwork and an ultrasound; she also had to wait a week for the ultrasound appointment because the facility required her to be at or beyond seven weeks gestation based on last menstrual period. When Arielle went to a local pharmacy to pick up the combination package, she was incorrectly charged CAD360 (USD270). After a series of calls and much negotiation, she was able to receive a refund because medication abortion is covered by provincial health insurance in Ontario. However, the process of getting the refund was frustrating and time consuming.

Arielle was happy to have been able to complete the abortion in her home where she was comfortable. She wishes more people knew about medication abortion; she didn't know it was an option until she spoke with her doctor. However, Arielle was not especially enthusiastic about demedicalized models of service delivery, as she found it very comforting to have tests that officially confirmed her pregnancy. The confusion at the pharmacy regarding cost coverage also undermined her confidence in the capacity of pharmacists to appropriately implement a behind-the-counter model.

Fig. 4. Arielle's story.

several of our participants. As Olivia, a 29-year-old white student working two jobs in Ontario explained:

What if the pandemic restricts that human right to access [abortion]?...Like, there have been conversations in the United States about having [abortion] restricted, and not considered essential and [I was] overjoyed that that was not the case in Canada, but certainly, like, really intensely afraid that it might be restricted.

Despite the commonality of these fears, all of our participants were able to access abortion care during the pandemic and expressed tremendous relief at and gratitude for being able to do so. Selena, a 30-year-old permanent resident and young professional residing in British Columbia said, “I didn't know what to do, I didn't know who to call...In my country [Mexico], it's about doing it silently and clandestinely. And I felt so lucky to be here. I really felt so lucky.” Olivia explained that she was “overjoyed [to be] able to access [abortion care].” Similarly, Rebecca, a white 28-year-old from New Brunswick residing in Ontario, indicated that she was expecting significant challenges but “was very grateful at how easy it was and how accessible.”

3.4. Participants reported that COVID-19 protocols exacerbated existing barriers to abortion care

Participants in our study experienced a number of barriers to accessing timely abortion services. These included cumbersome service delivery models that required multiple in-person visits to different providers (Fig. 3), confusion over the cost coverage of medication abortion care (Fig. 4), and discrimination (Fig. 5). Aisha, an Anglophone who resides in Quebec, explained, “[The intake nurse] did not speak English so she had to give me an assessment all in French which like, I speak French, but in a high-stress environment I couldn't understand all the medical terminology.” Participants felt that these barriers, which were not caused by COVID-

19, were exacerbated by the pandemic and the associated public health measures. Lily, a 23-year-old Asian student living in British Columbia faced a stressful situation as she “was under the 14-day quarantine and I was scared that I would miss the deadline to do the [medication] abortion.”

Participants also reported that in-clinic COVID-19 protocols created additional barriers. Most notably, an overwhelming majority of our participants reported that not being able to have a support person join them because of COVID-19 protocols contributed to feelings of loneliness and isolation. Pardis, a 28-year-old professional who identifies as Middle Eastern and lives in Ontario, described her experience obtaining an aspiration abortion:

Basically, there were a bunch of rules I had to follow. I couldn't bring my cellphone. I couldn't...bring somebody and I had to sit in a certain place, a certain seat that was assigned to me, I guess. And there was like no one, it was just very cold. Just a cold atmosphere. Nobody was talking. The whole place was empty so I just had to sit there with my thoughts...like I couldn't use my phone or anything.

Participants repeatedly reported a preference for having a support person with them during clinical encounters, as Olivia's experience illustrates:

[Abortion is] a really intimate and sensitive procedure to have. I would have really benefited from having someone present. In COVID-19 there is no way and I think it's probably typical practices, they wouldn't let me have a support person anyway...I would have really benefited I think from having somebody there. That was very hard.

These feelings of loneliness and isolation were especially pronounced for those participants who had to have multiple in-person encounters, including separate visits for an ultrasound and bloodwork, to obtain their abortion. Participants reported that this was both logistically and emotionally challenging. Courtney, a 25-year-

Amelie is a 38-year-old white Ontarian with a disability who works on accessibility issues. With the rolling COVID-19 lockdowns, Amelie was grateful to have stable employment. Amelie was keen to share that she and her husband of eight years had been working closely with a fertility clinic to become pregnant. Amelie explained that “this was a really purposeful pregnancy.”

Amelie successfully became pregnant for the first time in her life after in-vitro fertilization treatment. In December 2020, Amelie went for genetic testing; the results indicated that the fetus had a genetic anomaly. Given her lived experience with disability, Amelie indicated that she did not feel as though she had any option other than abortion because she “did not want to bring a child [with this condition] into this world” who would face similar challenges. As soon as Amelie spoke to the genetic counsellor, she expressed her desire to terminate the pregnancy. The genetic counsellor explained that she would have to wait a number of weeks to obtain care through the associated hospital-based service. In the hope of expediting the process, Amelie requested to go to an abortion clinic.

Upon arriving at the clinic, the clinician informed her that they could not perform the procedure for her after all, because they did not have any “safe” way to communicate with her due to her disability as neither party could remove their masks. Although Amelie faces a number of struggles due to her disability, her pandemic pregnancy significantly exacerbated feelings of frustration, and she indicated that the experience represented “true discrimination” embedded in existing systems. Amelie believes her experience exemplified the strict COVID-19 policies which were “really degrading, I didn’t like it at all. It was like they didn’t even try to compromise, they just didn’t want to.” Ultimately, Amelie was referred to another service provider and completed her abortion. Overall, given her experience, Amelie was supportive of both offering medication abortion via telemedicine and allowing pharmacists to prescribe mifepristone/misoprostol. Even though she had an instrumentation abortion, Amelie saw these models as being less time consuming and more pragmatic.

Fig 5. Amelie's story.

old Indigenous Manitoban struggling with precarious employment, expressed her frustration, “I just wanted the pill and... they put up a lot of roadblocks”.

In contrast, participants who self-administered both medication abortion drugs at home described being highly satisfied with their abortion experience because they experienced the process in a soothing environment, had better access to sources of support, and were able to exercise flexibility with respect to timing and managing other responsibilities. Olivia indicated “I was really lucky to be able to [have the abortion] at home with the support person I wanted.”

3.5. Participants expressed openness to both telemedicine and pharmacist dispensing models of medication abortion service delivery

Overall, participants expressed considerable enthusiasm for a telemedicine model of medication abortion service delivery. Participants were especially intrigued by a remote model of care that would allow eligible participants to have an initial consultation with a clinician over the telephone or video conference and then, if eligible, pick up the medication abortion drugs at a local pharmacy. As Sonya stated, “I like the accessibility of it! Talking to somebody over the phone, that would be awesome.” There were several participants, like Arielle (Fig. 4) who found the in-person clinical encounter reassuring and had a difficult time imagining being comfortable with fully remote care. However, both those who obtained medication abortions and those who obtained aspiration abortions during the pandemic felt that a streamlined service delivery model would improve access to abortion care, especially for those in rural areas, those with barriers to transportation, the immunocompromised, and those juggling multiple priorities.

Participants also expressed openness to a hypothetical behind-the-counter model of medication abortion service delivery where a pregnant person could consult directly with a pharmacist to obtain mifepristone/misoprostol. As Olivia explained:

I absolutely think there's a lot of services that don't have to be processed through a physician...it means more access because there are more people that are able to provide the ser-

vice. And if more people can provide it, not only does it normalize it...secondarily [it] makes it so that you're not waiting in those same appointment lines...a pharmacist would very likely have the lens to be able to help.

Most participants were intrigued by this model and many had questions about how this type of service would be operationalized. Participants noted that for this model to work, pharmacists would need to have sufficient training to ensure that they do not judge or stigmatize abortion seekers and there would need to be a private space for the consultation. For those participants, like Arielle (Fig. 4), who had negative experiences with a pharmacist as a part of their medication abortion care there was more skepticism that this model would work. As Arielle explained,

So, personally...I don't like going to a pharmacy or asking for over-the-counter stuff, because...I feel like in pharmacies there's always a lot of people around there that are working and people walking by...I don't like to say my business out loud like that. I enjoyed or I guess kind of enjoyed, being able to talk to my doctor who kind of knew my history even though I haven't really seen her in a while but it was over the phone, it was very confidential, that I knew that nobody was listening... I liked the process that I had better, instead of just going up to a pharmacy and saying “Hey, I would like to have an abortion.”

4. Discussion

The COVID-19 pandemic has disrupted most aspects of day-to-day life and created tremendous uncertainty. As was the case throughout the world, people in Canada continued to need comprehensive sexual and reproductive health services, including abortion care, throughout the pandemic. Indeed, for many of our participants, the public health, economic, employment, and social support implications of COVID-19 and the associated response measures factored into their decisions to obtain an abortion. Our findings reinforce the claim that abortion is an essential health service that must continue to be provided during public health emergencies [23, 31–32].

Consistent with a number of recent studies focused on those who have obtained abortion care in Canada [19, 25–27, 33] our participants had generally positive experiences with both medication and aspiration abortion care. However, many of our participants feared that they would not be able to get a desired abortion because of the pandemic and felt tremendous relief when they learned this was not the case. Our study participants' fears were not only due to the general uncertainties surrounding the availability of health services during the COVID-19 era and the evolving nature of public health measures but also because of extensive coverage of the onslaught of abortion restrictions that occurred in the United States in the first few months of the pandemic [4, 31]. Although the Canadian government reaffirmed in March 2020 that abortion care is considered an essential and medically necessary health service and provision would continue for the duration of the pandemic [20], for a number of our participants these messages were drowned out by stories from across the border. During future public health emergencies, it will be important for Canadian agencies to proactively message about the continuation of services.

Our participants also experienced a number of barriers to accessing timely and affordable care, including needing to have multiple in-person encounters, receiving incorrect information about cost coverage, being unable to receive care in their dominant language, and facing judgment or discrimination. Previous research [13, 19, 25–27, 33] has also identified these as barriers to abortion care in Canada, barriers that appear to have been amplified and exacerbated in the COVID-19 era. And that a number of our participants had to have multiple in-person encounters without a support person made navigating the system and obtaining abortion care even more difficult. In April 2021, the Canadian federal government released the 2021 federal budget that included CAD45 million (USD30 million) over three years to increase the accessibility of sexual and reproductive health information and services, including those related to abortion care [34]. Our findings suggest that this effort could address significant and persistent inequities.

However, the COVID-19 pandemic also provides a window of opportunity to consider new and innovative models of medication abortion service delivery. Providers in a number of countries, including the United Kingdom [35–36] and the United States [37–38], initiated or expanded telemedicine services that included fully remote protocols. The evidence is overwhelming that these services were safe, effective, and acceptable to both providers and patients. Participants in our study also looked favorably on telemedicine services and while efforts to expand this model of care are relatively nascent in Canada [39], exploring ways to ramp up this model of service delivery, including implementing appropriate provincial level reimbursement policies [6], are warranted. Further, Canada's regulatory environment, which classifies the mifepristone/misoprostol combination package as a typical prescription drug that can be dispensed by pharmacists, offers an opportunity to explore other demedicalized service delivery strategies, such as the provision of medication abortion care by pharmacists. Participants in our study were intrigued by this potential model of service delivery and many felt this could significantly increase timely, affordable, and accessible abortion care.

As per our study design, we only interviewed participants who obtained an abortion during the pandemic. Thus, we did not capture the experiences of individuals who sought abortion care but were unable to navigate accessibility barriers. Future research would benefit from exploring these people's experiences. Although fully remote telemedicine services did become available in several Canadian provinces during our data collection window, our participants did not use these services. Additional research to explore the experiences of this specific population is warranted. All of our participants obtained abortion care within 14 weeks gestation. Although this is consistent with a recent study that indicated that

the overwhelming majority of abortions in 2020 took place during this same gestational period [40], we did not capture the experiences of those needing care later in pregnancy. All of our participants identified as women and all of our participants, including those residing in Quebec, were Anglophone. Future research would benefit from the inclusion of people across the gender spectrum and Francophone and other language-minority populations. Finally, although qualitative research is an excellent mechanism for exploring participants' experiences, beliefs, and behaviors, it is not intended to yield generalizable or representative results. Our multimodal recruitment strategy and our inclusion of participants who resided in 5 Canadian provinces at the time of their abortion gives us confidence that the themes are transferable, but we caution against using our findings to represent broader trends.

Women who obtained abortion care in Canada during the pandemic recognized the importance of having access to this essential service. Our findings demonstrate the importance of continuing to provide access to safe, effective, and timely abortion care during public health emergencies. Exploring additional models of demedicalized medication abortion service delivery to address persistent access barriers in Canada has the potential to meet a significant need of those seeking care and ease the burden on medical professionals during public health emergencies.

Acknowledgments

We are grateful to Jill Doctoroff and the National Abortion Federation Canada for their continued partnership. We also want to acknowledge the many volunteers who assisted with the transcription of interviews. We also thank the members of the Society of Family Planning's Innovations Learning Community for their support and feedback. Finally, we want to extend our thanks to our participants for sharing their stories with us.

References

- [1] Endler M, Al-Haidari T, Bendetto C, Chowdhury S, Christilaw J, F El Kai, et al. How the coronavirus disease 2019 pandemic is impacting sexual and reproductive health and rights and response: Results from a global survey of providers, researchers, and policy-makers. *Acta Obstet Gynecol Scand* 2021;100(4):571–8. doi:10.1111/aogs.14043.
- [2] Church K, Gassner JM, Elliott M. Reproductive health under COVID-19 – Challenges of responding in a global crisis. *Sex Reprod Health Matters* 2020;28(1):1–3. doi:10.1080/26410397.2020.1773163.
- [3] Bayefsky MJ, Bartz D, Watson KL. Abortion during the Covid-19 pandemic – Ensuring access to an essential health service. *N Engl J Med* 2020;382(19):e47. doi:10.1056/NEJMp2008006.
- [4] Jones RK, Lindberg L, Witwer E. COVID-19 abortion bans and their implications for public health. *Perspect Sex Reprod Health* 2020;52(2):65–8. doi:10.1363/psrh.12139.
- [5] Mark A, Foster AM, Perritt J. The future of abortion is now: Mifepristone by mail and in-clinic abortion access in the United States. *Contraception* 2021;104(1):38–42. doi:10.1016/j.contraception.2021.03.033.
- [6] Action Canada for Sexual Health and Rights. Abortion and COVID-19 in Canada. [Internet]. <https://sexualrightsinitiative.com/resources/abortion-and-covid-19-canada> (accessed July 27, 2021).
- [7] United Nations Human Rights Office of the High Commissioner. Committee on the Elimination of Discrimination against Women. Concluding observations on the combined eighth and ninth periodic reports of Canada. CEDAW/C/CAN/CO/8-9. [Internet]. <https://digitallibrary.un.org/record/3802136?ln=en> (accessed July 27, 2021).
- [8] Erdman J, Grenon A, Harrison-Wilson L. Medication abortion in Canada: A right-to-health perspective. *Am J of Public Health* 2008;98:1764–9. doi:10.2105/AJPH.2008.134684.
- [9] Downie J, Nassar C. Barriers to access to abortion through a legal lens. *Health Law J* 2007;15:143–73.
- [10] Eggertson L. Abortion services in Canada: A patchwork quilt with many holes. *Can Med Assoc J* 2001;164(6):847–9.
- [11] Munro S, Guilbert E, Wagner M-S, Wilcox ES, Devane C, Dunn S, et al. Perspectives among Canadian physicians on factors influencing implementation of mifepristone medical abortion: A national qualitative study. *Ann Fam Med* 2020;18:413–21. doi:10.1370/afm.2562.
- [12] Yalahow A, Doctoroff J, Mark A, Foster AM. Trends in medication abortion provision before and after the introduction of mifepristone: A study of the National Abortion Federation's Canadian member services. *Contraception* 2020;102:119–21. doi:10.1016/j.contraception.2020.04.012.

- [13] LaRoche KJ, Labeca-Gordon IN, Foster AM. How did the introduction of mifepristone impact the availability of abortion care in Ottawa? A qualitative study with abortion patients. *FACETS* 2020;5:559–70. doi:10.1139/facets-2020-0019.
- [14] Dunn S, Brooks M. Mifepristone. *Can Med Assoc J* 2018;190:E688. doi:10.1503/cmaj.180047.
- [15] Health Canada. Regulatory decision summary: Mifegymiso [Internet]. Available from: <https://hpr-rps.hres.ca/reg-content/regulatory-decision-summary-detail.php?lang=en&linkID=RDS00294> (accessed July 27, 2021).
- [16] Health Canada. Health Canada approves updates to Mifegymiso prescribing information: Ultrasound no longer mandatory [Internet]. <https://healthycanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2019/69620a-eng.php> (accessed July 27, 2021).
- [17] Guilbert E, Wagner M-S, Munro S, Wilcox ES, Dunn S, Soon JA, et al. Slow implementation of mifepristone medical termination of pregnancy in Quebec, Canada: A qualitative investigation. *Eur J Contracept Reprod Health Care* 2020;25:190–8. doi:10.1080/13625187.2020.1743825.
- [18] Vogel L. More doctors providing abortion after federal rules change. *Can Med Assoc J* 2018;190:E147–8. doi:10.1503/cmaj.109-5552.
- [19] LaRoche KJ, Foster AM. It gives you autonomy over your own choices': A qualitative study of Canadian abortion patients' experiences with mifepristone and misoprostol. *Contraception* 2020;102(1):61–5. doi:10.1016/j.contraception.2020.04.007.
- [20] Gilmore, R. Abortion access will be maintained across Canada amid COVID-19 outbreak [Internet]. <https://www.ctvnews.ca/health/coronavirus/abortion-access-will-be-maintained-acrosscanada-amid-covid-19-outbreak-1.4870129> (accessed July 27, 2021).
- [21] Guilbert E, Costescu D, Wagner MS, Renner R, Norman WV, Dunn S, et al. Canadian protocol for the provision of medical abortion via telemedicine. [Internet] Society of Obstetricians and Gynaecologists of Canada. <https://www.sogc.org/common/Uploaded%20files/CANADIAN%20PROTOCOL%20FOR%20THE%20PROVISION%20OF%20MA%20VIA%20TELEMEDICINE.pdf> (accessed July 27, 2021).
- [22] Abortion Rights Coalition of Canada. Abortion rights and healthcare during COVID-19. [Internet]. <https://www.arcc-cdac.ca/covid-19/> (accessed July 27, 2021).
- [23] Cohen M. Medical abortion is an essential service during the pandemic. *Can Fam Physician* 2021;67:281–3. doi:10.46747/cfp.6704281.
- [24] Birks M, Chapman Y, Francis K. Memoing in qualitative research: Probing data and processes. *J Res Nurs* 2008;13:68–75. doi:10.1177/1744987107081254.
- [25] Cano JK, Foster AM. They made me go through like weeks of appointments and everything': Documenting women's experiences seeking abortion care in Yukon Territory, Canada. *Contraception* 2016;94:489–95. doi:10.1016/j.contraception.2016.06.015.
- [26] Foster AM, LaRoche KJ, El-Haddad J, DeGroot L, El-Mowafi IM. If I ever did have a daughter, I wouldn't raise her in New Brunswick:" Exploring women's experiences obtaining abortion care before and after policy reform. *Contraception* 2017;95:477–84. doi:10.1016/j.contraception.2017.02.016.
- [27] LaRoche KJ, Foster AM. I kind of feel like sometimes I am shoving it under the carpet": Exploring women's desire for and experiences with post-abortion support in Ontario. *FACETS* 2017;2:754–63. doi:10.1139/facets-2017-0059.
- [28] Saunders B, Sim J, Kingstone T, Baker S, Waterfield J, Bartlam B, et al. Saturation in qualitative research: Exploring its conceptualization and operationalization. *Qual Quant* 2019;52:1893–907. doi:10.1007/s11135-017-0574-8.
- [29] Denzin NK, Lincoln YS. *The Sage handbook of qualitative research editors*. Thousand Oaks, CA:: Sage Publications; 2001.
- [30] Elo S, Kyngas H. The qualitative content analysis process. *J Adv Nurs* 2008;62(1):107–15. doi:10.1111/j.1365-2648.2007.04569.x.
- [31] Donley G, Chen BA, Borrero S. The legal and medical necessity of abortion care amid the COVID-19 pandemic. *J Law Biosci* 2020;7(1):1–17. doi:10.1093/jlb/lsaa013.
- [32] Tran NT, Tappis H, Spilotros N, Krause S, Knaster S. Inter-Agency Working Group on Reproductive Health in Crises. Not a luxury: A call to maintain sexual and reproductive health in humanitarian and fragile settings during the COVID-19 pandemic. *Lancet Glob Health* 2020;8(6) e760–e-761. doi:10.1016/S2214-109X(20)30190-X.
- [33] LaRoche KJ, Foster AM. Exploring Canadian women's multiple abortion experiences: Implications for reducing stigma and improving patient-centered care. *Women's Health Issues* 2018;24:327–32. doi:10.1016/j.whi.2018.04.002.
- [34] Action Canada for Sexual Health and Rights. Canada's 2021 federal budget: Analysis. [Internet]. <https://www.actioncanadashr.org/news/2021-04-20-canadas-2021-federal-budget-analysis> (accessed July 27, 2021).
- [35] Reynolds-Wright JJ, Johnstone A, McCabe K, Evans E, Cameron S. Telemedicine medical abortion at home under 12 weeks' gestation: A prospective observational cohort study during the COVID-19 pandemic. *BMJ Sex Reprod Health* 2021. <https://doi.org/10.1136/bmjshr-2020-200976>.
- [36] Aiken A, Lohr PA, Lord J, Ghosh N, Starling J. Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: A national cohort study. *BJOG* 2021;128(9):1464–74. doi:10.1111/1471-0528.16668.
- [37] Chong E, Shochet T, Raymond E, Platais I, Anger H, Raidoo S, et al. Expansion of a direct-to-patient telemedicine abortion service in the United States and experience during the COVID-19 pandemic. *Contraception* 2021;104(1):43–8. doi:10.1016/j.contraception.2021.03.019.
- [38] Godfrey EM, Thayer EK, Fiastro AE, Aiken ARA, Gomperts R. Family medicine provision of online medication abortion in three US states during COVID-19. *Contraception* 2021;104(1):54–60. doi:10.1016/j.contraception.2021.04.026.
- [39] Wiebe ER, Campbell M, Ramasamy H, Kelly M. Comparing telemedicine to in-clinic medication abortions induced with mifepristone and misoprostol. *Contraception X* 2020. doi:10.1016/j.conx.2020.100023.
- [40] Dixit A, Doctoroff J, Mark A, Foster AM. 2022 Trends in abortion service provision in 2019 and 2020: A study of Canadian members of the National Abortion Federation (Under review).