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RESEARCH ARTICLE

How did the introduction of mifepristone impact the availability of abortion care in Ottawa? A qualitative study with abortion patients

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Abstract

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

Key words: Canada, health services, medication abortion, mifepristone, patient experiences

Introduction

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

Prior to the introduction of mifepristone, Ottawa had two primary abortion providers: one freestanding clinic and one hospital, both of which provided instrumentation procedures. For anyone

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

In 2015, Health Canada approved mifepristone as part of a combination pack with misoprostol under the trade name Mifegymiso® for early abortion (Health Canada 2016). The mifepristone–misoprostol regimen became available in Ottawa in February 2017; provincial cost coverage was announced in August 2017 (Population Institute Canada 2017). Thus for nearly seven months, patients were required to pay approximately CAD$400 out-of-pocket for a medication abortion while aspiration procedures were available free-of-charge for those with provincial health insurance (Kaposy 2009; Foster et al. 2013).

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

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

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

Materials and methods

We conducted 40 semi-structured, in-depth interviews with Ottawa residents who had abortions before the mifepristone–misoprostol combination product became available ($n = 20$) and after the

regimen's introduction in February 2017 ($n = 20$). To be eligible for the study, we required participants to: have had at least one abortion while residing in Ottawa before 2013 (Phase 1) or after 1 February 2017 (Phase 2), be sufficiently fluent in English or French to answer interview questions, and have access to a telephone or Skype. We interviewed Phase 1 participants over a one-year period in 2012–2013 and interviewed Phase 2 participants over an 18-month period in 2017–2019. All the interviews took place within five years (Phase 1) or one year (Phase 2) of the index abortion. We offered all participants a CAD$40 gift card.

Recruitment

We used a multi-modal, community-based strategy to recruit Ottawa residents who had abortions before and after mifepristone became available. Our recruitment strategy included creating a study website, posting on social media (such as Facebook, Instagram, and Reddit), posting on online classifieds sites (such as Kijiji and Craigslist), and distributing flyers around the city. Anyone interested in participating reached out to the Study Coordinator (KL) who then responded to any questions, ensured eligibility, and scheduled a mutually convenient time for the interview.

Data collection

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

At the time that we conducted interviews for Phase 1 of the study, mifepristone was not yet available in Canada. However, we provided participants with information about the regimen through nine weeks' gestation and asked whether they would have considered receiving this kind of an abortion. We have previously published about a broader sample of Canadian abortion patients' thoughts on mifepristone (Vogel et al. 2016).

Data analysis

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

We managed our data from both phases of the study in ATLAS.ti. (Berlin, Germany) KL created an initial codebook and served as the principal coder. INL-G transcribed Phase 2 interviews and assisted with coding. AF reviewed a subset of audio recordings, full transcripts, and coded transcripts.

We initially analyzed interviews from each phase of the study separately. In the final analytic stage, we integrated the findings, paying specific attention to concordance and discordance.

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

Results

Participant characteristics

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

Phase 1: before the introduction of mifepristone

Phase 1 participants reported on 23 aspiration and surgical abortion experiences that took place between 2008 and 2012. All participants reported obtaining care at one of two facilities:

Table 1. Demographic and abortion characteristics of Phase 1 and Phase 2 participants in Ottawa ($n = 40$).

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

one freestanding clinic and one hospital. As mifepristone was unavailable in Canada at the time, few participants that we interviewed had any prior knowledge of medication abortion. However, the vast majority responded favorably when we presented them with information about the mifepristone–misoprostol regimen. In addition, participants were receptive to the idea of obtaining abortion care in a variety of settings from a range of health service professionals.

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

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

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

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

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

Those who accessed care at the freestanding clinic reported the most streamlined process and, in most instances, these patients had one appointment during which they received an ultrasound, counselling, and their abortion in the same place over the course of 1 d. Phase 1 participants generally reported most favorably on this streamlined model of care.

In Phase 1, only one participant reported paying a direct out-of-pocket cost for her abortion. She had recently moved to Ottawa at the time she became pregnant and while she had provincial health insurance from another Canadian province, she was not yet enrolled in the Ontario Health Insurance Plan. The CAD$500 bill came as a surprise to Hannah and she said that it was difficult for her to come up

with the money. "And I didn't realise until I went there and they said, 'Oh, you have [health insurance from a different province]? Oh well … this is what we have to do.' … It was—it was difficult. But it was one of those things where I just put it on my line of credit and you know, it took me a while to pay it back." Although other participants did not report direct costs associated with their abortion, most Phase 1 participants reported incurring out-of-pocket costs related to childcare or taking time off work for their abortion. Those who had long wait times associated with their abortion were more likely to report that they took time off work and that this had a negative financial impact.

Phase 2: after the introduction of mifepristone

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

Some participants who had instrumentation procedures stated that they would have preferred to have a medication abortion, but they were either unable to locate a provider or the price of mifepristone before provincial cost coverage was prohibitive. Alexis, aged 27, who had a aspiration abortion at the freestanding clinic in April 2017, explained:

> "At the time, the process [of trying to get a medication abortion] seemed pretty overwhelming to me … So, I didn't want to start the process of trying to get the pill and then find out that my pregnancy was too far along for it … I think there was some conflicting information about whether or not it was covered in Ontario yet or, you know, how available it was."

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

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

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

through to obtain additional misoprostol and (or) a surgical intervention was often unclear and involved additional wait times.

More participants in Phase 2 reported having a direct out-of-pocket cost for their abortion. In most cases, the cost was associated with obtaining mifepristone–misoprostol before provincial cost coverage was announced. Participants reported paying between CAD$0 and CAD$400 for their abortions. For those who accessed care before cost coverage, the combined regimen's price tag was a significant barrier. No participants reported a direct cost for instrumentation procedures.

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

Discussion and conclusions

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

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

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

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

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

Limitations

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

Conclusions

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

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Author contributions

KJL and AMF conceived and designed the study. KJL and AMF performed the experiments/collected the data. KJL, INL-G, and AMF analyzed and interpreted the data. AMF contributed resources. KJL, INL-G, and AMF drafted or revised the manuscript.

Competing interests

The authors declare that they have no competing interests, financial or otherwise.

Data availability statement

All relevant data are within the paper.

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