Breaking Barriers: Improving Access to Abortion Care in Rural Alberta

by

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Abstract

An estimated one in three Canadian women will terminate a pregnancy during their reproductive years. Access to induced abortion is essential to the reproductive health of women, non-binary, and two-spirit individuals. Despite this, barriers to accessing abortion care exist for individuals seeking these services and health care providers who offer these services. After reviewing the literature and conducting a case study analysis to determine the most significant barriers that hinder access to abortion care in rural Alberta, this study proposes three policy options for increasing access to abortion care in rural Alberta that are then analyzed using a multi-criteria analysis (MCA). Ultimately, this study recommends expanding the pool of providers to independently prescribe medical abortions in the short-term and the adoption of a large-scale telemedicine abortion program in the medium-term.

Keywords: abortion; equitable access; health policy; Alberta; rural communities; reproductive choice

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List of Acronyms

AB	Alberta
ANM	Auxiliary Nurse Midwife
APC	Advanced Practice Clinician
CAM	Canadian Association of Midwives
CMA	Canadian Medical Association
CNM	Certified Nurse Midwife
CPC	Crisis Pregnancy Centre
GP	General Practitioner
HRBA	Human Rights-Based Approach
ICM	International Confederation of Midwives
OB/GYN	Obstetrics and Gynecology
OECD	Organisation for Economic Co-operation and Development
PA	Physician Assistant
RN	Registered Nurse
SRHR	Sexual and Reproductive Health and Rights
UN	United Nations
UCP	United Conservative Party
VCW	Values Clarification Workshop
WHO	World Health Organization

Glossary

Abortion	The termination of a pregnancy.
Abortion Care	The medical and emotional support provided to an individual who is seeking an abortion. Involves a range of services such as counseling, medical assessment, medication, surgical procedures, and follow-up care.
Abortion Services	The specific medical procedures or treatments used to terminate a pregnancy. Includes both medical abortion and surgical abortion.
Anti-Choice	Individuals or groups who are opposed to abortion and who support legal restrictions on abortion.
Crisis Pregnancy Centre	Non-profit organizations established by anti-abortion groups primarily to persuade pregnant women against having an abortion.
Medical Abortion	Also referred to as ‘medication abortion’. Involves the use of medication to terminate a pregnancy.
Mifegymiso	Canadian brand name for the combination of the medications Mifepristone and Misoprostol.
Mifepristone	Medication used in combination with Misoprostol to bring about a medical abortion during pregnancy and manage early miscarriage.
Misoprostol	Medication used in combination with Mifepristone to about a medical abortion during pregnancy and manage early miscarriage.
Non-Binary	Gender identities that are not solely male or female. For the purposes of this paper, an individual with a uterus whose identity falls outside of the gender binary.
Pro-Choice	Individuals or groups who believe that a person should have the right to choose whether or not to have an abortion.
Pro-Life	Individuals or groups who believe that human life begins at conception and that abortion is morally wrong.
Roe v. Wade	Landmark decision of the US Supreme Court in which the Court ruled that the Constitution of the United States conferred the right to choose to have an abortion. This decision was overturned in 2022.
R v. Morgentaler	Landmark decision of the Canadian Supreme Court which ruled that the Criminal Code provisions relating to abortion were unconstitutional because they violated women’s Charter guarantee of security of the person.

Rural	Generally, a geographic area outside of urban and suburban areas. Services and amenities in these areas are limited and far from those in urban areas. Due to the lack of abortion services across all of Alberta, the term ‘rural’ will include all towns and cities in Alberta that do not have a designated abortion clinic.
Surgical Abortion	Removal of pregnancy tissue from the uterus by a clinician to terminate a pregnancy.
Telehealth	The provision of healthcare remotely by means of telecommunications technology.
Telemedicine	The remote diagnosis and treatment of patients by means of telecommunications technology.
Two-Spirit	An individual who identifies as having both a masculine and feminine spirit. Used by some Indigenous peoples to describe their sexual, gender, and/or spiritual identity. For the purposes of this paper, an individual with a uterus whose identity is not characterized by traditional sexual, gender, or spiritual characteristics.

Executive Summary

There are various barriers to accessing abortion care for women, non-binary, and two-spirit individuals residing in rural Alberta. This study utilizes a systematic literature review and a case study analysis to understand abortion care in Alberta and the major barriers to access which include distance, stigma and misinformation, and provider restrictions. The study evaluates potential policy options through a multi-criteria analysis and offers recommendations to reduce barriers and improve access to abortion care in rural Alberta; ultimately advancing reproductive health rights and promoting better outcomes for abortion seekers and providers.

Working with abortion organizations and networks will reduce stigma and increase the incentive for future policies and innovations. The recommended policy bundle in this study is designed to reduce barriers to abortion care using an implementation timeline of short, medium, and long-term. This study recommends that, in the short-term, Alberta should expand the pool of providers to allow mid-level providers to independently prescribe Mifegymiso, the medication approved for usage by Health Canada to terminate pregnancies via medical abortion. In the medium-term, Alberta should work to develop and adopt a large-scale telemedicine abortion program. The province can also consider adopting comprehensive abortion care training in medical school curricula in the long-term.

Chapter 1. Introduction

Abortion was fully decriminalized in Canada in 1988. Although the Government of Canada recognizes that everyone should have access to safe and consistent reproductive health services – including abortion – it also acknowledges significant barriers to access. In Alberta, abortion services are available at clinics and hospitals, with abortion clinics serving as the primary site for these services. In 2020, 10,902 of the abortions that took place in Alberta occurred in a clinic setting while only 1,081 abortions took place in a hospital setting (Statista, 2022). However, there are only three abortion clinics in all of Alberta: in Calgary, Edmonton, and Red Deer. Given that abortion providers are largely concentrated in urban areas, the policy problem being addressed by this study is: **women, non-binary, and two-spirit individuals residing in rural Alberta face too many barriers to accessing abortion care**. This study seeks to better understand the causes of this policy problem and to offer a range of policy recommendations to address existing barriers that prevent equitable access to abortion care for those residing in rural Alberta.

This study utilizes a systematic literature review to understand abortion care in Alberta and the relevant legal, structural, political, and cultural factors that have created barriers to accessing abortion care. A review and synthesis of existing literature reveals the following major barriers: distance, stigma and misinformation, and provider restrictions. A case study analysis is also utilized in this study to determine initiatives being undertaken in other jurisdictions that can be applied in the context of rural Alberta. Through a multi-criteria analysis (MCA), potential policy options are evaluated and scored according to a set of objectives, criteria, and measures to improve upon existing initiatives. The overall purpose of this study is to reduce barriers to accessing abortion care in rural Alberta which may, ultimately, improve access to care, advance reproductive health rights, and promote better outcomes for abortion seekers and providers.

Chapter 2.

Background

2.1. Sexual and Reproductive Health and Rights

The World Health Organization (WHO) defines reproductive health as,

> *A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes* (n.d.).

Further, reproductive health care includes access to a range of high-quality information and services, including prevention of unsafe abortion and management of the consequences of abortion. According to the Government of Canada, women and girls have the right to decide what to do with their bodies without question (2022). Sexual and reproductive health and rights (SRHR) are considered essential for gender equality and health. The Government believes that, to encourage the SRHR of women and girls, a comprehensive approach to advancing SRHR is necessary to support interventions that apply equity in access to, and quality of, care without discrimination (2022). As part of a ten-year commitment made in 2019, Canada is scaling up investments in under-funded areas of SRHR, including expanding access to safe abortions and post-abortion care.

2.2. Understanding Abortion

The term *abortion* refers to the early termination of a pregnancy. Abortions can fall under two categories: medical and surgical (National Library of Medicine, 2022). Medical abortions involve the use of medication to terminate a pregnancy. In Canada, the combination of Mifepristone and Misoprostol – available under the name Mifegymiso and colloquially referred to as the “abortion pill” – is approved for usage by Health Canada. Surgical abortions, which are one of the most common surgical procedures in Canada, refer to the removal of pregnancy tissue from the uterus by a clinician to terminate a pregnancy. Abortions are legal at all stages of pregnancy for women, non-binary, and two-spirit individuals and are publicly funded as a medical procedure under

the federal Canada Health Act and provincial health-care systems. It is estimated that one in three Canadian women will have an abortion during their reproductive years, most commonly during the first trimester (Dunn and Cook, 2014). Abortion remains a critical sexual and reproductive right. As noted by the World Health Organization (2022),

> *Lack of access to safe, timely, affordable and respectful abortion care poses a risk not only to the physical, but also the mental and social well-being of women and girls.*

Despite being one of the only countries to have fully decriminalized abortion, there remains a lack of accessible and affordable abortion care for pregnant individuals residing in rural areas that are seeking abortion care. For the purpose of this paper, the working definition of "rural" will include all towns and cities in Alberta that do not have a designated abortion clinic.

2.3. Abortion in Canada

The decriminalization of abortion was the result of the landmark Supreme Court case *R v. Morgentaler* (1988), in which Canada struck down section 287(1) of the Criminal Code.

> 287(1) *Every one who, with intent to procure the miscarriage of a female person, whether or not she is pregnant, uses any means for the purpose of carrying out his intention is guilty of an indictable offence and liable to imprisonment for life.*

The nonexistence of abortion legislation in Canada has culminated in abortion being recognized as a matter of health care, which falls predominately under provincial and territorial jurisdiction (Johnstone, 2017). As a result, access to abortion differs across the country, and the medical community – including abortion providers – in each region largely determines how care is provided. For example, British Columbia has 9 abortion clinics and, in Québec, abortion care is integrated into the primary health care network (Abortion Rights Coalition of Canada, 2023; Government of Québec, 2016).

Support for abortion in Canada is quite far reaching. Public opinion, which helps to maintain this political norm, is one important factor. Data from 2020 shows that nearly

90 percent of Canadians agree or strongly agree that abortion is a health issue, not a moral one, while only 1 percent strongly disagree with this sentiment (Macfarlane, 2022). Support for abortion has increased over the last three years, with a poll from March 2022 showing that 56 percent of Conservative party voters prefer that the next leader support abortion rights (Fournier, 2022). However, according to the Abortion Rights Coalition of Canada, 71.5% of Conservative MPs versus 3.2% of Liberal MPs are anti-choice. The following criteria are used to assess if an MP is anti-choice: voted in favour of an anti-choice bill or motion; opposed the Order of Canada for Dr. Henry Morgentaler in 2008; made public anti-choice or "pro-life" statements; participated publicly in anti-choice events or campaigns; or were rated as "pro-life" (green) by the Campaign Life Coalition (Abortion Rights Coalition of Canada, 2022). Although Canada does face some susceptibility to the rise of right-wing extremism, there is a general consensus among Canadians that abortion is a matter of health care and should be treated as such.

2.4. Socio-Political Relevance

On June 24, 2022, the United States Supreme Court revoked the constitutional right to seek safe abortion care by overturning the landmark decision in *Roe v. Wade*. As a result of this decision, abortion has increasingly become a global topic of interest. Although the legal, structural, political, and cultural factors that differentiate Canada from the US mitigate the likelihood of a criminal ban on abortion, such as in Alabama and Texas, there remain concerns about existing and future accessibility considerations (Macfarlane, 2022). Overall, it is unnecessarily difficult to create a clear map of access to abortion care across Canada as abortion is still considered a taboo topic and information about care is often not publicly accessible (Johnstone and Macfarlane, 2015).

2.4.1. Distance

The Organisation for Economic Co-operation and Development (OECD) recognizes that service delivery in rural areas is more costly than in urban areas and is, overall, a key challenge for governments at all levels. Notably, rural regions face the following major challenges: lower density populations, larger distances that have to be traveled by service users and service providers, and small numbers of people in any location that preclude economies of scale (OECD, n.d.). Rural policy must then

coordinate resources to guarantee access to services and to identify public goods that are conducive to economic development. Abortion can be considered a public good as access to reproductive health services should be made available to all members of society that wish to access them. Abortion as a public good is also conducive to economic development because, as the Institute for Women's Policy Research notes, various studies have demonstrated associations between abortion use and economic outcomes such as educational attainment and employment status (Zabin, Hirsch, and Emerson, 1989; Fergusson, Boden, and Horwood, 2007; Foster et al., 2018).

The OECD (n.d.) highlights seven key strategies to improve rural service delivery, as described in Table 1.

Table 1. Strategies to improve rural service delivery

1.	Placing end users at the community level – better odds of providing services that are useful in the community and of providing them in a cost-effective way
2.	Consolidation of services – concentrating customers on a smaller number of service locations
3.	Co-location of services – basic overhead costs such as energy, security, and administrative expenses can be pooled, generating economies of scale
4.	Merging similar services – merge similar or substitute services and combine them into a single entity
5.	Alternative delivery options – where the demand for services is widely dispersed, it may be more efficient to bring the service to the user, e.g., mobile library services, dental clinics, and doctors
6.	Community-based solutions for different types of providers – e.g., volunteer fire departments and community owned shops
7.	Geolocation facilities matching between the supply of, and demand for, services

Arthur (2020) notes that less than 17% of Canadian hospitals perform abortions. Further, there has been a downward trend in abortions performed in hospital settings – from 91% to 43%. This can be seen in the significant shift in abortions being performed at clinics as opposed to at hospitals. This decline in the proportion of abortions performed in hospital settings represents at least a 58% decline in the number of abortions performed in rural areas (Arthur, 2020). Further, regardless of the setting, both hospitals and clinics that offer abortion services are primarily located in larger urban areas, with accessibility varying from province to province. As such, people living in remote and rural areas often must travel long distances to terminate a pregnancy. The further an individual lives from abortion services, the further they must travel to access these services which decreases the likelihood of being successful in procuring an abortion (Sethna & Doull, 2013).

Physicians in rural communities have also reported how distance has negatively impacted their ability to provide abortions. For example, when a physician is the only abortion provider in their community, they will be required to serve a large catchment area and take on the responsibility of serving more individuals seeking abortion care than they can realistically be of service to (Dressler et al., 2013). Further, physicians have reported a lack of professional education opportunities in their proximity, making it increasingly difficult to stay up to date in their service provision. Not being able to discuss issues with fellow abortion providers can also lead to feeling a lack of support in their work (Dressler et al., 2013).

In the November 2016 report of the Committee on the Elimination of Discrimination against Women, the United Nations High Commissioner for Human Rights expressed concerns about these inequities and called upon the Government of Canada to improve access to abortion care (CEDAW, 2016). Following this, the abortion medication Mifegymiso became available in 2017 and, as a result, medical abortions have become increasingly available. A survey undertaken by Renner et al. (2022) found that the increased availability of medical abortion facilitates abortion access, especially in primary care and rural settings. However, Renner et al. also note that the rejuvenation of the workforce is a critical contributor to equitable access, which is supported by Arthur's (2020) finding that more general practitioners (GPs) are required to prescribe the drug in order to improve equitable access. With the introduction and expansion of telemedicine, Mifegymiso can be prescribed by physicians and nurse practitioners via

phone or video call. This has had a positive impact on rural access, as ultrasounds are not required in all cases prior to ingesting the medication, and patients can take Mifegymiso from the comfort of their own homes.

2.4.2. Stigma and Misinformation

Kumar, Hessini, and Mitchell (2009) define abortion stigma as a "negative attribute ascribed to women who seek to terminate a pregnancy, that marks them, internally or externally, as inferior to the ideals of womanhood". Stigmatization of abortion may be a result of religious traditions that do not permit abortion, the belief that abortion is morally equivalent to killing a born person, or that abortion leads women to deviate from traditional maternal, life-giving roles (Seewald et al., 2021). Negative stereotypes attributed to those who seek abortion care can include selfishness, promiscuity, and irresponsibility. Stigmatization may make women, non-binary, and two-spirit individuals reluctant to disclose abortion experiences as doing so may lead to social judgment and ostracism, discrimination, loss of status, and/or exclusion from social groups and institutions. For example, some individuals may not feel comfortable disclosing their intention to obtain an abortion to their employer, making it difficult to take time off work.

The marginalization that transpires from stigmatization often contributes to negative public health outcomes, which disproportionately impacts vulnerable populations. Stigma can be enforced through external social norms and policies as well as internally directed attitudes. Misinformation can increase stigmatization through the perpetuation of inaccurate information to the greater public, leading to biases rooted in misconceptions. Policies that reduce or eliminate stigma are widely considered ethical as they can encourage positive health outcomes (Chen and Courtwright, 2016).

Although access to abortion has increased with the introduction of Mifegymiso and telemedicine, a qualitative study undertaken by Munro et al. (2020) found that conscientious objection and anti-choice attitudes have actively prevented physicians from implementing abortions using Mifegymiso. Physicians who participated in this study noted instances where hospital staff refused to clean clinic rooms where abortion care was provided, hospital administrators ignored requests to implement a medical abortion protocol, and community pharmacists refused to dispense the drug. When looking at

Southern Alberta, Mitchell (2016) explains that finding reliable abortion resources and information can be particularly challenging. Underlying this finding is Southern Alberta's longstanding history as a site of contention over the provision of reproductive health services and information. Only a limited number of openly available resources for abortion information exist, while sources that condemn or spread misinformation about abortion are widely advertised.

Of particular concern are crisis pregnancy centres (CPCs), which present themselves as neutral organizations that provide non-judgmental information about all available options related to pregnancy. For example, the Lethbridge Pregnancy Care Centre (LPCC) is one of the most prominently advertised resources for abortion information. However, CPCs are "pro-life" organizations that offer misleading information about abortion and other reproductive issues. In an interview on the state of reproductive health in Alberta, Dr. Carol Williams notes that there are no self-identified or easily identifiable abortion providers or clinics in Southern Alberta (Enough for All, 2022). She also explains how practitioners in small towns often refuse to provide non-judgemental guidance when consulted on matters related to sexual and reproductive health, including abortion. This could be linked to the fact that every riding outside of Calgary and Edmonton – with the exception of Lethbridge-West – voted for the United Conservative Party (UCP) in Alberta's 2019 general election. At the time, the UCP leader was Jason Kenney who has a history of supporting anti-choice beliefs. For example, Kenney appointed Adrianna LaGrange, the former president of Red Deer Pro-Life, as Education Minister.

Often, individuals seeking abortion care in Alberta encounter various medical professionals before being able to access a medical abortion. For those without a family doctor, or with an anti-choice doctor, finding out where services are available is particularly difficult. The Canadian Medical Association's (CMA) current policy permits physicians to refuse to refer patients for abortion care. If this situation arises, the physician is required to refer the patient to another physician who will provide this service. However, in addition to restricting critical information, physicians may also refer patients to a CPC where access to abortion will not be an option. Even if the individual can obtain a Mifegymiso prescription from their doctor, pharmacists can also act as gatekeepers to access by not stocking and/or refusing to fill the prescription.

2.4.3. Provider Restrictions

The World Health Organization (WHO) found that provider restrictions can have negative implications for health outcomes, health systems, and human rights (de Londras et al., 2022). A review published in 2022 highlights that the right to sexual and reproductive health obliges states to ensure that health-care facilities, goods, and services are available, accessible, acceptable, and of good quality (de Londras et al., 2022). Evidence from this review further suggests that provider restrictions can negatively impact individuals seeking abortion care and medical professionals providing this care, as well as undermining sexual and reproductive health rights. To address these outcomes, the WHO advocates for a human rights-based approach (HRBA) to abortion regulation which would require the removal of overtly constrictive provider restrictions. Possible ways to achieve this include expanding the health workforce involved in abortion-related care and expanding health workers' roles. Doing so may result in improving timely access to abortions, reducing costs, saving time, and reducing the need for travel.

In a national qualitative study undertaken by Munro et al. (2020), many abortion providers flagged persistent organizational barriers as making it difficult to implement Mifegymiso in their local settings. Funding was noted as an additional challenge, which included provincial variation in patient subsidies for the cost of the drug and in physician billing codes. The study also found that, in rural communities, prescribers were responsible for caring for patients distributed across vast geographic catchments and faced overwhelming barriers to access for all primary care services, not just abortion. Participants expressed a need for more public communication about Mifepristone as a standard of care and, before adopting Mifegymiso as part of their practice, they would require up-to-date information about any changes made by Health Canada to clearly understand how adopting the pill would benefit their practice and patient population. As participants noted, their confidence in prescribing the pill increased during early use as they honed their skills and knowledge with each successful abortion.

In many cases, rural facilities are unable to provide medical abortions at all. Medical abortions are often favoured over surgical abortions as no general anesthesia is required, fewer staff are needed, costs are lower, chances for complications are lower, and they require fewer appointments (Sethna & Doull, 2013). Rural hospitals also tend to

have limited equipment and technology, which makes it difficult for individuals seeking surgical abortions to have timely ultrasounds (Paradise, 2017; Dressler et al., 2013). Arthur (2020) expands on these concerns by explaining that rural hospital operating rooms are heavily booked, and abortion cases often get bumped for more acute/urgent cases. He argues that all provinces and territories must increase the number of clinics and hospitals that provide surgical abortions and must ensure that enough local doctors prescribe Mifegymiso to ensure safe and timely access to abortion. Efforts to improve access to abortion have also included decentralizing abortion provision beyond traditional hospital and clinic settings via telemedicine options (Rocca et al., 2018). To increase the effectiveness of this method, the pool of providers qualified to offer this service would need to expand.

Chapter 3.

Methodology

The research question used to guide this study is: **how can barriers be reduced to improve access to abortion care for women, non-binary, and two-spirit individuals residing in rural Alberta?** Informed by a systematic review of the literature and qualitative research methods – including a case study analysis and a multi-criteria analysis (MCA) – this study assesses three policy options. An exemption from Simon Fraser University's Ethics board for this study was obtained on January 20, 2023, as the research design only necessitates the use of secondary sources – including reports, official documents, grey literature, and statistics – to inform the MCA and subsequent recommendations.

3.1. Literature Review

An extensive review of existing literature on barriers to abortion in rural and remote areas and related policies was conducted as part of the research for this paper. Literature was found via Google, Google Scholar, and the online Simon Fraser University Library search engine. Search terms included "barriers to abortion", "abortion access", "rural abortion barriers", "abortion barriers in rural Canada", "abortion barriers in rural Alberta", "abortion and midwives", "abortion and mid-level providers", "abortion and medical school", "abortion and telemedicine", and "abortion and telehealth". This information was used to identify significant barriers to accessing abortion care in rural Alberta and to subsequently inform the case study analysis.

3.2. Case Study Analysis

Rural Alberta was selected as the primary case for this study as there have been no comparable studies undertaken on this particular jurisdiction within the last ten years. Further, the socio-political context of Alberta – in which the majority of the province tends to vote in a socially and economically conservative manner – means that this jurisdiction is susceptible to anti-choice attitudes. The prominence of Crisis Pregnancy Centres in the province is also a justification for selecting rural Alberta as the primary case for this

analysis. An extensive review of existing literature, some of which was synthesized in Chapter 2, was used to identify feasible and realistic policy interventions and to explore how these interventions were utilized in different cases.

3.3. Multi-Criteria Analysis

A multi-criteria analysis was conducted to evaluate potential policy options that address the policy problem: **women, non-binary, and two-spirit individuals residing in rural Alberta face too many barriers to accessing abortion care.** Five objectives, seven criteria, and twenty-one measures were determined based on the literature reviewed and the case study analysis.

3.4. Limitations

The scope of this study was limited by a lack of accessible information. This subsequently influenced the research design itself. In addition, a lack of resources disallowed for formal interviews with experts and those with lived experience. Given that the content of this study is sensitive in nature – where vulnerable populations, including potential victims of sexual abuse, domestic violence, incest, and other non-consensual forms of impregnation are involved – a policy assessment involving direct actors would require a team of researchers with more time and resources. For the purpose of this study, secondary sources that reflect the current situation are ideal to inform the policy analysis. As a result, the methodology relied on a literature review, which brings its own limitations.

Chapter 4.

Case Study Analysis

This chapter presents case studies of policy interventions undertaken in various jurisdictions that have worked to address the barriers outlined in Chapter 2. These case studies provide insights into policies that Alberta could adopt to address abortion barriers in rural communities and will be used to inform the options delineated in the multi-criteria analysis.

4.1. Expanding the Pool of Mid-Level Providers

Research suggests that mid-level providers, such as nurse practitioners (NP), registered nurses (RN), physician assistants (PA), and certified nurse midwives (CNM) can provide abortions with no increased risk to patients (Berer, 2009). Nurses make up the largest group of regulated health professionals in Canada, representing approximately half of the total health workforce (Canadian Federation of Nurses Unions, n.d.). In 2021, there were 459,005 regulated nurses eligible to practice. Of this number, 312,382 were RNs and 7,400 were NPs. Nurse practitioners can prescribe medication and act as primary care providers for counseling, resources about pregnancy options, and abortion follow-up care throughout the country (Carson et al., 2022). Currently, RNs, CNMs, and PAs are not authorized to prescribe Mifegymiso. Expanding the scope of abortion providers may increase the availability, accessibility, and affordability of abortion care. The International Confederation of Midwives (ICM) includes abortion provision in their definition of the midwifery scope of practice, and midwives around the world provide abortions and post-abortion care (Fullerton et al. 2018; Tillman, 2020). The Canadian midwifery model of care, scope of practice, and training are ideally suited to support improved access to all forms of abortion care (Canadian Association of Midwives, 2022). A synthesis of evidence from various jurisdictions, with respect to expanding the pool of mid-level providers, is discussed in the following subsections.

4.1.1. Nepal

Abortion was decriminalized in Nepal and, ever since, access to abortion services has expanded throughout the country. Provision of medical abortions using Mifepristone-Misoprostol is permitted by nurses and auxiliary nurse midwives (ANM). In a study undertaken by Rocca et al. (2018), ANMs were trained to provide medication abortion through twelve pharmacies and government-certified public health facilities as part of a demonstration project in two districts. Pharmacies were the selected location as they are often the first point of contact for women seeking abortions while simultaneously serving as an important source for information and referrals. Pharmacies are also more accessible in rural areas than clinics. In this study, sites were in both semi-urban and remote regions of the country. The results of the study show that early Mifepristone-Misoprostol medication abortions provided by ANMs at pharmacies are effective and safe compared to the provision of comparable services by ANMs at government-certified health facilities. This study not only provides evidence that ANMs can successfully provide medication abortion services, but it also emphasizes the importance of expanding the abortion provider base. Allowing ANMs with the appropriate training to provide medication abortion care in a variety of settings, including pharmacies, presents an opportunity to reduce barriers to access in rural areas.

In a multi-country case study which included Bangladesh, Ethiopia, Nepal, South Africa, and Uruguay, Glenton et al. (2016) identified various factors that appear to have influenced the inclusion of non-physician health care providers in the delivery of abortion care. The identified factors are presented in Table 2.

Table 2. Factors influencing health workers' inclusion in the delivery of abortion care

1.	Willingness to provide abortion care
2.	Health workers' knowledge about abortion legislation and services
3.	Managers' and coworkers' attitudes towards role expansion
4.	Women's attitudes to and experiences of different types of health workers

5.	Health systems factors, including workloads and incentives, health worker training and supervision, supply chains and referral systems, and monitoring and evaluation

The authors note that the successful expansion of the pool of mid-level providers will likely be influenced by health workers' willingness to take on new tasks. Across the five countries reviewed in the study by Glenton et al. (2016), health workers' willingness to provide abortion services varied. Personal views and beliefs held by health workers was of significance in this variation. In Nepal, specialist and non-specialist doctors, nurses, and ANMs were reported as being generally supportive of the provision of safe abortion services. These providers viewed these services as being important to women's health. Further, they viewed their participation in the provision of these services as a way to help women in need. Similar sentiments were expressed by some doctors, nurses, and midwives in South Africa. These providers referred to the following as influential factors: prior exposure to the consequences of unsafe abortion, either professionally or personally; the consequences of raising children in difficult socioeconomic circumstances; and their support of the woman's right to choose. However, reluctance to provide abortion care resulting from moral or religious beliefs was also a common theme among providers in South Africa.

In Ethiopia, some heath workers agreed that unsafe abortion was a serious problem. However, their willingness to provide these services varied. This is similar to sentiments in Bangladesh, where some doctors reported support for abortion services as a way to achieve the government's population control objectives but preferred not having to perform these services themselves. Health care workers' willingness to provide abortion care was also influenced by the method of abortion and stage of the pregnancy. Generally, nurses and other health workers in Nepal, South, Africa, and Ethiopia regarded medical abortion as simpler to perform than other methods of abortion.

Regarding perceptions of their professional roles, ANMs in Nepal who were trained to provide medical abortions expressed confidence in their skills and a desire to further broaden their skills in abortion care. Similarly, in South Africa, some health workers viewed the provision of abortion as natural to their career trajectory and as an

opportunity to broaden their skills base. Values clarification workshops (VCW) in Nepal, Ethiopia, South Africa, and Bangladesh were used to garner support for abortion services by educating participants through the following: teaching about current abortion legislation; allowing for participants to clarify their values and attitudes; encouraging changes in attitudes and behaviours towards women seeking abortions; and ultimately achieving support for the provision of abortion services. Health workers who participated in these workshops noted that they were useful in offering a better understanding of abortion, were helpful in being able to acknowledge clients' rights and needs, assisted those opposed to abortion in 'viewing things differently', and made talking about abortion more comfortable. After some Nepalese health workers wrongly believed that women needed their husbands' permission to obtain an abortion, particular efforts were undertaken via training programs for ANMs to ensure that services would be provided to all women regardless of age, marital status, or other factors.

Expanding the pool of providers also affects the coworkers of health workers providing abortion services, particularly those responsible for managing or supervising health care workers. In Nepal, Bangladesh, and Ethiopia, specialist and non-specialist doctors, health officers, and others generally reported positive attitudes towards the use of non-physician providers in the provision of abortion services. In one Nepalese report, facility managers also held positive attitudes towards the use of nurses in the provision of first trimester abortion care services. The facility managers indicated that this could improve continuity of care, decrease the burden on doctors, increase retention of nurses, and increase patient satisfaction with health services. There appeared to be no variation among women in all five countries who sought abortion services with respect to the category of health worker providing the services. Patients were generally satisfied with the abortion services they received and the providers themselves. This study concludes that, when appropriate strategies build willingness and motivation among health care workers, the likelihood of expanding the pool of abortion service providers increases.

4.1.2. Sweden

In Sweden, permission was granted by the National Board of Health and Welfare and by the Ethical Review Board of Stockholm to allow midwives to independently perform medical abortions. A study undertaken by Kallner et al. (2015) aimed to assess nurse-midwife provision of early medical abortion in a high-resource setting where

ultrasound examination for dating of pregnancy was part of the protocol. The researchers found that shifting abortion service provision to midwives in this context was highly effective. Nurse-midwives also spent a shorter amount of time on the consultation process, which arguably has a positive economic impact on the healthcare system. This finding is supported by a Swedish study undertaken by Sjöström et al. (2016), who found that early medical abortions provided by nurse-midwives are more cost effective than the procedure provided by physicians. The researchers calculated the average direct and indirect costs and the incremental cost-effectiveness ratio (ICER). The calculation for the ICER considered changes in effectiveness and cost of treatment using the following formula.

[*Cost of Intervention – Cost of Standard Treatment*] *Effectiveness Intervention – Effectiveness of Standard Treatment*][1]

Through this calculation, it was determined that the average direct costs per procedure were EUR 45 for the intervention compared to EUR 58.3 for the standard procedure. Both the cost and efficacy of the intervention were found to be superior to the standard treatment. This resulted in a negative incremental cost-effectiveness ratio at EUR -831 based on direct costs and EUR -1769 considering total costs per surgical intervention were avoided. Further, for every 100 patients (procedures), the intervention treatment resulted in 1.6 fewer follow-up surgical abortions compared to the standard treatment. The evidence from this study suggests that the provision of medical abortions by nurse-midwives has positive economic benefits and is equally as effective as provision by physicians in a high resource setting. Of important consideration is whether these results could be replicated in lower resource settings, such as in rural communities. However, the generalized benefits of expanding service provision to include mid-level providers is evident through this case study.

4.1.3. New York State

Although access to abortion care throughout the United States since the overturning of *Roe v. Wade* has become increasingly difficult, and in some cases virtually impossible, individual states can act to uphold reproductive rights and remove

[1] Intervention refers to provision of medical abortion by a nurse-midwife while standard treatment refers to the provision of medical abortion by a physician.

barriers to access. On January 22, 2019, the New York State Reproductive Health Act (RHA) (A.1748 / S.2796) amended New York legislation to expand abortion rights, decriminalize abortion, and eliminate restrictions on abortion. Vis-à-vis the RHA, advanced practice clinicians (APC) including physician assistants, nurse practitioners, and licensed midwives can lawfully provide abortion services given that they have the appropriate qualifications and that such services fall within their scope of practice. According to the New York State Association of Licensed Midwives (New York Midwives), the RHA amendment improved abortion access to traditionally underserved areas such as rural and low-income communities (New York State Association of Licensed Midwives, 2022). Mifepristone and Misoprostol can be prescribed by midwives and other APCs through mail order or through physical pharmacies, and the State has no limitations on medical abortion provision via telehealth services.

Through their work with allied organizations, New York Midwives has committed to the following interventions to expand their reach in the provision of abortion services: pinpoint care deserts within New York State and connect providers with those who choose abortion care; when hospitals and systems work against free choice, advocate that a public-facing roster of those entities be maintained on a state website to ensure that people know where they can receive supportive care; increase training opportunities for midwives in the State to provide surgical and medication abortion procedures to increase the provider workforce; and participate with state agencies and allied organizations to allocate and distribute the $35 million dollars in funding offered by the governor (New York State Association of Licensed Midwives, 2022). This emphasizes that expanding the provider pool to include mid-level providers can result in collaborative efforts to improve access to abortion care in remote and rural communities that are traditionally underserved.

4.2. Standardized Education in Medical Schools

Despite being an essential topic in medical student education, abortion care is currently limited, inconsistent, and – in some cases – non-existent. Abortion care is within the scope of family medicine, however, there are few curricula in family medicine programs that routinely include training in these skills. Learning about the technical aspects of different abortion procedures – in addition to learning about the social, global, and public health considerations involved in abortion provision – should be integrated

into medical school curricula as comprehensive reproductive health training can contribute to the ability of family physicians to provide better continuity of care (Koyana and Williams, 2005).

A study undertaken by Myran et al. (2018) examined the quantity of exposure and education that Canadian family medicine residents receive on abortion during training, and their preparation to provide abortions. The study also assesses residents' attitudes, intentions, and expressed competency to provide abortions in their future practice as well as the association between medical training and changes in these factors. As noted in the study, family doctors perform the majority of abortions in Canada, and the percentage of abortions performed by this group is increasing over time. However, the researchers found that Canadian family medicine residents receive little education or exposure to abortion care and practice during training.

Currently, the Canadian College of Family Physicians curriculum does not include abortion as a training objective. According to Myran et al. (2018), most residents do not feel competent to provide abortion services and expressed strong support for receiving abortion training to achieve this competency. 57% of residents reported having received no formal education on abortion and 80.2% received less than one hour of training. When comparing across universities, only 13% of participants from the University of Alberta reported having assisted with, or observed, one or more abortion. 37% of respondents from the University of British Columbia, 37% of respondents from the University of Saskatchewan, and 31% of respondents from the University of Toronto reported having had this exposure during their residency training programs.

4.2.1. Australia

Abortion care appears to be taught in most Australian medical schools. A study undertaken by Cheng and deCosta (2021) sought to understand the teaching and learning experiences of abortion care among Australian medical students. Despite receiving some training, students' confidence levels around abortion care once in practice were found to be low, and the majority of students showed a strong desire to have more direct placement exposure. Only 22.8% of students reported having had a direct placement related to abortion. This research also indicates that the existence of training programs is not enough. The authors suggest that structured and standardized

abortion education should incorporate sensitive counseling, multidisciplinary team involvement, and psychological support; elements that are currently lacking in the medical school curriculum of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

4.2.2. United States

An American study by Burns and Shaw (2020) looked at standardizing abortion education as an important way to foster and train abortion providers to ultimately ensure and expand access to safe abortion. As the authors note, exposure to abortion during medical school influences providers' attitudes around abortion care. In a survey of 250 medical students, Burns and Shaw found that, upon completing their obstetrics and gynecology (OB/GYN) clinical rotations, students who worked with an abortion provider felt more comfortable discussing abortion with patients, referring patients for an abortion, and were more likely to want to provide abortions in the future. Many medical students who did not receive any abortion training indicated their dissatisfaction.

> *I wanted to provide abortions for my patients. My med school wouldn't teach me how* (Stephanie Ho, family physician).

Anti-abortion sentiments that stem from religious beliefs have been cited as a reason to omit abortion care education and training in medical schools. However, Burns and Shaw's (2020) survey also found that, in faith-based medical schools, 70% of students reported dissatisfaction with their current exposure to clinical abortion training. The authors also suggest that, throughout the preclinical and clinical years in medical school, there are various opportunities to incorporate abortion education into the curriculum. Even though a procedural abortion is three times more common than an appendectomy in the United States, the indications of care for the latter procedure is taught to every medical student. To address this discrepancy, the authors suggest that standardized exams for medical students – by which their understanding of abortion care is evaluated – can hold schools accountable in ensuring that their students have appropriate abortion education. One method of achieving this is through the Accreditation Council for Graduate Medical Education (ACGME) mandate regarding opt-out abortion training, which has proven successful in standardizing expectations to

increase abortion training for residents. To ensure universal integration of this standardization method, departmental support from within medical schools is critical.

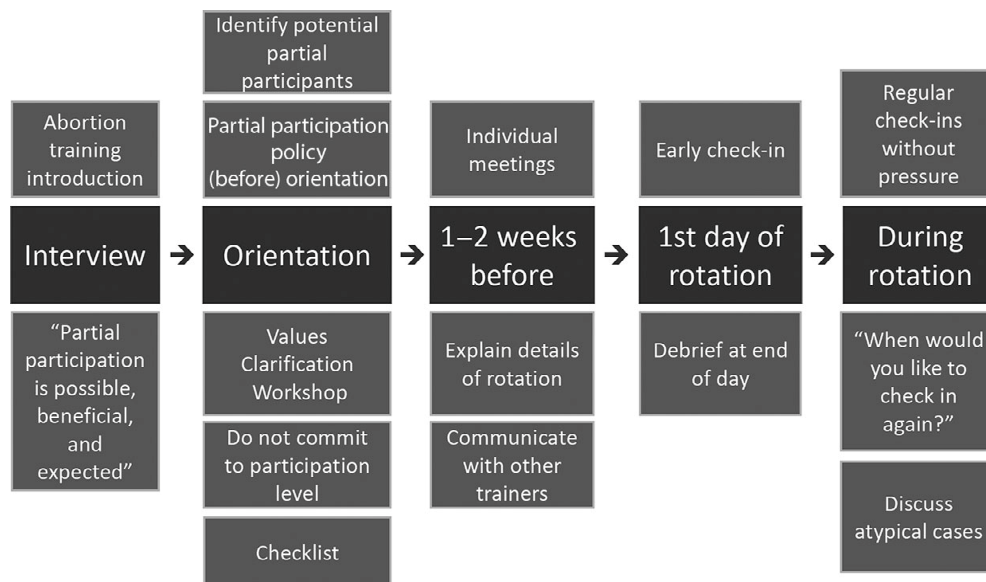
In Chapter 23 of the book *Medical Education in Sexual and Reproductive Health: A Systems Approach in Family Planning and Abortion*, Steinauer and Turk (2021) discuss different ways in which abortion training can be integrated into residency programs. The American College of Obstetricians and Gynecologists (ACOG) recommended in its 2014 committee opinion on abortion training and education that all OB/GYN programs provide opt-out abortion training where "abortion is routinely integrated into medical education as a critical element of women's reproductive health care" (Steinauer and Turk, 2021). Such programs should be aimed at destigmatizing abortion and integrating abortion education into medical school curricula. Abortion training can be fully integrated into residency programs in that it is routinely scheduled for students. Those who do not wish to participate in the training can either completely or partially opt-out. Studies of OB/GYN training in the US have measured a correlation between the program's expectations for, and availability of, training. For example, Darney et al. (1987) found that more residents fully participated in programs with integrated, routine abortion training compared to those in programs with optional training. This indicates that the choice to participate in abortion programs goes beyond the individual's personal beliefs. Departmental culture and faculty attitudes may also define the expectations for resident participation.

The option to partially opt-out has proven to be more beneficial than opting-out of family planning training all together. For example, a quantitative study of OB/GYN residents found that 92% of residents who partially opted-out of their family planning rotation reported a positive impact and highly valued the skills they acquired, including counseling skills (i.e., contraceptive counseling), pre-operative skills (i.e., ultrasound for pregnancy dating), and procedural skills (i.e., cervical anesthesia) (Steinauer et al., 2013). The benefits of partial participation have also been supported by qualitative research, in which participants gained skills in interacting with patients facing unintended pregnancies, improved counseling skills, and learned to prioritize the care that their patients required over their own views or beliefs (Steinauer et al., 2014). Residents also described greater acceptance of women seeking abortions, abortion providers, abortion in general, and a greater sense of comfort when counseling about, and referring for, an abortion. Further, residents who began their family planning training with intentions to

fully opt-out felt the training better prepared them for their future careers in women's health, specifically in areas related to managing abortion complications and caring for women experiencing miscarriages. Overall, all residents in this study described more favourable attitudes towards all aspects of the abortion experience following their partial participation in the program.

Steinauer and Turk (2021) use the Ryan Program, a national initiative based at the Bixby Center for Global Reproductive Health at the University of California (San Francisco), as a guideline for what other programs can achieve. One best practice utilized by the Ryan Program is that the residency program leadership disseminates their program's partial participation policy before training commences. This is useful as the process of deciding whether or not to participate can be challenging for students due to varying levels of comfort towards different aspects of family planning care. Figure 1 is an example of a partial participation overview for training facilitators.

Figure 1. Example of a Partial Participation Overview for Training Facilitators



Note. Figure from Steinauer, J., & Turk, J. (2021). The Benefits of and Strategies for Supporting Residents Partial Participation in Abortion Training. *Medical Education in Sexual and Reproductive Health: A Systems Approach in Family Planning and Abortion,* 229.

Offering a model with flexibility from the very beginning benefits residents who are unsure about the level of participation they are comfortable with by allowing the extent of participation to shift during different periods of training. This requires that faculty members are fully transparent about the options available to participants and requires that alternatives are offered for residents who choose to partially opt-out. Steinauer and Turk (2021) recommend that faculty meet with residents to review learning objectives for the rotation and then develop a plan to meet these objectives and to help residents gain competence in skills while simultaneously respecting personal limits. Values clarification workshops (VCW) can be helpful in guiding students in their participation decisions. Such workshops typically involve small group discussions, case studies, expressive activities, and self-administered worksheets. Workshop facilitators aim to create a safe environment where participants are encouraged to engage in reflection. The use of VCWs has been proven successful on an international scale, as previously discussed in the cases of Nepal, Ethiopia, South Africa, and Bangladesh (Rocca et al., 2018). Given that residents make decisions about their participation both before and during the family planning rotation, Steinauer and Turk (2021) created a recommended protocol and guide to support partial participation (See Appendix A).

4.3. Telemedicine

Telemedicine refers to the provision of healthcare services remotely by means of telecommunications technology (i.e., phone, videoconference, email, and text). In the context of abortion care, services may include counseling, eligibility assessment, medication provision, guidance through the process, and follow-up assessments (Chong et al., 2021). Various studies, including those undertaken by Jones et al. (2017) and Grossman et al. (2020), have identified benefits to telemedicine abortion such as the ability for individuals to obtain abortions at an earlier gestational age, improved access to care for rural patients, and a potential association with decreases in travel time and travel distance for appointments. Research out of the COVID-19 pandemic has also emphasized the growing importance of offering telemedicine options. Barriers to accessing abortion care that were exacerbated by the pandemic include the ability to pay for the service (due to loss of income) and limited mobility resulting from childcare needs, stay-at-home orders, and the imperative to limit in-person interactions (Chong et al., 2021).

Since the introduction of Mifegymiso in 2016, telemedicine medical abortion has emerged across Canada. Research has indicated that telemedicine provision of first trimester medical abortions is safe, effective, and acceptable (Fiastro et al., 2022; Chong et al., 2021; Donovan, 2019). However, there is limited Canadian data on the use of telemedicine for abortions, the number of existing abortion providers, and barriers to providing this care. One study conducted by Renner et al. (2022) surveyed physicians and nurse practitioners who provided abortion care via telemedicine. The largest barrier identified – by 54.9% of telemedicine providers – was a lack of ability to confirm gestational age with ultrasounds where the patient resides. In the Prairie provinces (Alberta, Manitoba, and Saskatchewan), 47.2% of respondents also reported the lack of a telemedicine abortion fee code from provincial health system practitioner payment mechanisms as a barrier. Given these barriers, and others such as facility regulations and no close access to emergency services, the authors suggest refining the Canadian medical abortion guidelines to include a hybrid in-person and low-/no-test protocol for eligible patients. However, they also note that testing will always be required for some patients, signifying the importance of increasing access to testing.

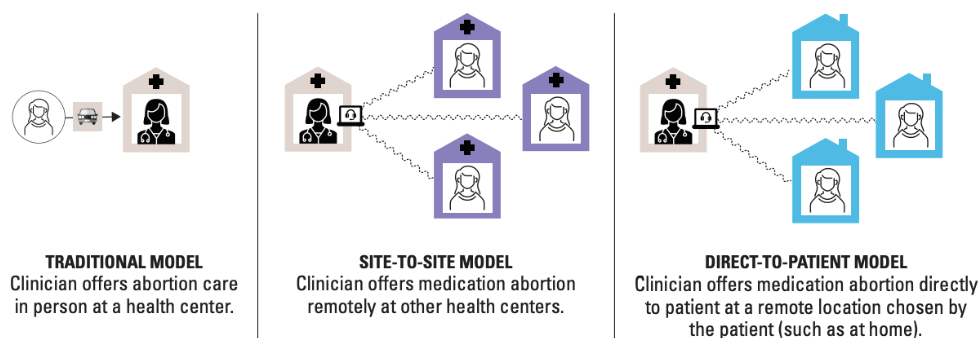
4.3.1. United States

Existing health metrics have confirmed the ability of telehealth to transform the provision of health care. For example, 76% of US hospitals use some form of telemedicine to connect with patients (American Hospital Association, n.d.). One tested model of telemedicine abortion is a site-to-site model where a clinician offers medication abortion remotely at other health centers. This model is similar to the current in-person model as patients must still visit a health center for a consultation and screening. Patients who are deemed eligible, and opt for medication abortion, are then connected to a clinician at another health center via videoconference. During the call, the clinician reviews the patient's medical records, answers questions, and authorizes the medication. In Alaska, providers operating under this model indicated that it increased patient choice and resulted in patients being seen sooner and closer to home. Similar results emerged out of Iowa, where this model was developed, particularly for patients living more than 50 miles (approximately 80 kilometers) from the nearest clinic offering surgical abortion (Donovan, 2019). There was also an increase in the odds of obtaining abortion care in the first trimester.

Another innovative model of telemedicine abortion is the TelAbortion study, piloted by Gynuity Health Projects, which launched in 2016. This is a direct-to-patient model where the clinician offers medication abortion directly to the patient at a remote location chosen by the patient (i.e., at home). The TelAbortion study is widespread and offered at 10 sites that provide the service in 13 states and in Washington, DC. Individuals seeking abortion care do not need to visit a health center and, instead, consult with a clinician via videoconference. If tests are required, they can be completed at a local laboratory or health care facility. Following this, the medication is mailed directly from the study clinician to the patient. After the medication has been taken, the patient locally completes follow-up testing to ensure the termination of pregnancy. Finally, the patient has another video consultation with their abortion provider.

As of 2021, this model has been deemed safe, efficacious, and acceptable; indicating that Mifepristone and Misoprostol can safely be dispensed by mail. Over the course of the study, participants did not need to visit any facilities to obtain the service. Further, the requirement imposed by the Food and Drug Administration (FDA) that Mifepristone be dispensed in person was identified as possibly having the opposite of its intended effect. The potential of direct-to-patient services is underscored by the finding that a substantial proportion of participants lived significantly far from their providers. Of the 83% of abortions for which outcome information was obtained, 95% were completed without a procedure (Chong et al., 2021).

Figure 2. Models of Telehealth Abortion



Note. Figure from. Donovan, M. (2019). Improving access to abortion via telehealth. *Guttmacher Policy Rev, 22,* 23-28.

4.3.2. Australia

In 2011, telehealth was first used in Australia and is now used to deliver a wide variety of services, particularly to those living in rural and remote areas. A study undertaken by Thompson et al. (2022) compares the experience of accessing an abortion via telehealth-at-home to accessing care in-clinic. In 2015, a non-profit private healthcare organization launched a telehealth-at-home medical abortion service available up to 63 days' gestation. Under this model, patients require a referral from their GP, an ultrasound to determine gestational age and pregnancy location, and blood testing. Consultations with a nurse and doctor take place via web conference or telephone and medications are received via courier. Medication can be obtained from a local pharmacy if issues with the courier service or privacy concerns arise. Two weeks after taking the medication, patients take a follow-up hCG test at a local laboratory and consult with a nurse on the phone to confirm successful abortion. A 24-hour helpline is also available throughout the entire process.

Respondents frequently cited long distances to visit a provider in person (42%), ability to schedule around personal responsibilities (38%), and comfortability (35%) as reasons they chose telemedicine over in-person abortion care. 92% of respondents also reported receiving enough information about what to expect from the telehealth visit when they called to schedule their appointment. Regarding accessibility, there was no difference in median time from discovering pregnancy to first contact between telehealth and in-clinic respondents. When respondents were asked to estimate their travel time, the median distance was 5 kilometers for telehealth patients and 15 kilometers for in-clinic patients. There was also a reduction in barriers to accessing services. For example, 55% of in-clinic respondents had difficulties taking time off work compared to 42% of telehealth respondents. Overall, 45% of telehealth respondents indicated experiencing no barriers to receiving abortion care compared to 24% of in-clinic respondents.

Chapter 5.

Policy Criteria, Measures, and Options

5.1. Policy Criteria and Measures

A multi-criteria analysis was conducted to evaluate potential policy options that address the policy problem: **women, non-binary, and two-spirit individuals residing in rural Alberta face too many barriers to accessing abortion care**. Five objectives, seven criteria, and twenty-one measures were determined through the above research and are summarized in Table 3. The criteria and measures will be presented in detail within this chapter to outline how the policy options were evaluated.

Table 3. Policy Criteria and Measures Summary

Objective	Criterion	Measure	Coding
Equity	Degree to which the policy supports equitable access to abortion care for those residing in rural Alberta	High ability to support equity	Good (4)
		Moderate ability to support equity	Moderate (3)
		Low ability to support equity	Poor (1)
Cost	Cost in Canadian dollars	Low cost	Good (3)
		Moderate cost	Moderate (2)
		High cost	Poor (1)

Ease of Implementation	Complexity of implementing the policy	Low degree of complexity	Good (3)
		Moderate degree of complexity	Moderate (2)
		High degree of complexity	Poor (1)
Destigmatization	Degree to which the policy decreases stigmatization towards abortion seekers	High ability to support stigma reduction	Good (3)
		Moderate ability to support stigma reduction	Moderate (2)
		Low ability to support stigma reduction	Poor (1)
	Degree to which the policy decreases stigmatization towards abortion providers	High ability to support stigma reduction	Good (3)
		Moderate ability to support stigma reduction	Moderate (2)
		Low ability to support stigma reduction	Poor (1)

Stakeholder Acceptance	Degree of acceptability among abortion seekers	High acceptability	Good (3)
		Moderate acceptability	Moderate (2)
		Low acceptability	Poor (1)
	Degree of acceptability among abortion providers	High acceptability	Good (3)
		Moderate acceptability	Moderate (2)
		Low acceptability	Poor (1)

5.1.1. Equity

The analysis identified that abortion care is less accessible for Albertans residing in rural areas compared to Albertans residing in urban areas. The criterion to assess how well each policy option addresses this inequitable access is equity. Equity is measured by the degree to which each policy option supports equitable access for Albertans residing in rural areas. This criterion will be measured by good, moderate, or poor levels of equity, with policies that support more equitable access earning a better score. Equity is the **key objective** for this analysis and, as such, policies will be scored on a higher scale relative to other objectives.

5.1.2. Cost

Cost will factor into the willingness of the government to implement a given policy. Cost will be measured in Canadian dollars and will consider upfront and ongoing costs as well as return on investment. This criterion will be measured by good, moderate, or poor levels of cost, with lower costs earning a better score.

5.1.3. Ease of Implementation

Ease of implementation evaluates the level of complexity required to implement the proposed policies. Factors such as changes in legislation, coordination among government and non-government agencies, stakeholder involvement, and a long implementation period will increase complexity and decrease ease. This criterion will be measured by good, moderate, or poor levels of complexity, with greater complexity earning a lower score.

5.1.4. Destigmatization

The analysis identified stigma towards abortion seekers and abortion providers as a significant barrier to accessing abortion care, particularly in rural areas. Thus, the two measures of destigmatization include stigma reduction towards abortion seekers and stigma reduction towards abortion providers. This criterion will be measured by good, moderate, or poor levels of stigma reduction, with greater stigma reduction earning a better score.

5.1.5. Stakeholder Acceptance

To improve accessibility to abortion care in rural Alberta, there must be acceptance of the programs and policies being made available to those accessing the supports and services (abortion seekers) and those providing the supports and services (abortion providers). Thus, the two measures of stakeholder acceptance include the degree to which abortion seekers accept the policy and the degree to which abortion providers accept the policy. This criterion will be measured by good, moderate, or poor levels of acceptability, with greater acceptability earning a better score.

5.2. Policy Options

Three policy options were derived from the research and are described in the following subsections. All three options aim to effectively decrease barriers to abortion access in rural Alberta, so that accessibility increases. Given that the provincial government has jurisdiction over the healthcare system, the policies are directed

towards actions that the Government of Alberta could implement or could use to expand on existing programs and services.

5.2.1. Expanding the Pool of Providers

Expanding the pool of abortion care providers to include mid-level providers – such as certified nurse midwives (CNM) and physician assistants (PA) – is a globally recognized method of increasing access to abortion care. The College of Midwives of Alberta (CMA) regulates the practice of CNMs in the province and sets the scope of practice for CNMs. Similarly, the College of Physicians and Surgeons of Alberta (CPSA) regulates the practice of PAs in the province and sets the scope of practice for PAs. Authorizing these health care professionals to independently prescribe Mifegymiso would require changes to the regulations and laws that govern their practices in addition to professional liability and malpractice insurance. Education and training that meet the standards of identified best practices would also need to be developed and available to practitioners interested in providing services. Offering clinical experience through a rotation in an abortion clinic or other opportunities to observe and participate in abortion procedures could also encourage mid-level providers to include the provision of abortion care as part of their scope of practice.

5.2.2. Medical School Curricula

Including comprehensive abortion education in medical school curricula can improve the ability of physicians to provide better care and increase access to abortion care for patients. This policy option would involve curricular changes with instructive and clinical components such as in-class lectures and supervised clinical experience. Medical school faculty would also require training on the most recent evidence and best practices in abortion care to ensure that students are receiving appropriate education. Collaboration with the College of Physicians and Surgeons of Alberta (CPSA), which is responsible for setting and enforcing standards of practice and providing education and support for OB/GYNs, would be useful in setting standards and expectations for how the curricula is designed and what should be included, as well as best practices for the faculty responsible for delivering the curricula.

5.2.3. Improving Telemedicine

Improving and expanding telemedicine services presents an opportunity to increase access to abortion care in Alberta. It is currently difficult to find information online regarding the availability of telemedicine options in the province. As such, the government of Alberta could implement a uniform telemedicine program. This would likely involve creating a comprehensive strategy that outlines the goals, objectives, and expected outcomes of the program along with performance indicators to measure whether the program is achieving what it has set out to achieve. Identifying the most up-to-date technology required to support such services would also be a necessary consideration. Collaborating with professional organizations to provide training for healthcare providers so that they can offer virtual services and developing educational resources for the public that are easily accessible would also be required as part of this policy.

Chapter 6.

Analysis of Policy Options

6.1. Policy Criteria and Measures

This chapter provides an analysis of the policy options proposed in Chapter 5. Table 4 provides a summary of this analysis.

Table 4. Analysis of Policy Options

Objective	Expanding the Pool of Providers	Medical School Curricula	Improving Telemedicine
Equity	Good (4)	Poor (1)	Good (4)
Cost	Good (3)	Good (3)	Good (3)
Ease of Implementation	Moderate (2)	Moderate (2)	Poor (1)
Destigmatization	Moderate (2)	Moderate (2)	Moderate (2)
Stakeholder Acceptance	Good (3)	Good (3)	Moderate/Good (2.5)
Total	**14**	**11**	**12.5**

6.2. Ranking Policy Options

6.2.1. Expanding the Pool of Providers

6.2.1.1. Equity

Expanding the pool of abortion providers to include mid-level providers presents an opportunity to support equitable access to abortion care for individuals residing in rural Alberta. In September 2019, the government of Alberta announced an increase in spending to hire nurse practitioners to work in primary care settings in rural and underserved areas including Bonnyville Primary Care Network (PCN), the Aspen PCN in northern Alberta, and the Bow Valley PCN (Myers-Connors, 2020). Projected increases in the availability of mid-level providers in rural communities emphasizes the ability of this policy option to increase access to services among rural Albertans. As such, this policy receives an overall equity rating of **good**.

6.2.1.2. Cost

Expanding the provision of abortion care to mid-level providers will not require a significant number of financial resources. Certified nurse midwives and physician assistants already provide healthcare services and, therefore, would only need to be trained and authorized to provide abortion services. Training for physicians to provide these services has already been developed and could be easily utilized to train mid-level providers. As such, this policy receives an overall cost rating of **good**.

6.2.1.3. Ease of Implementation

There are a few major steps that would likely be required to expand the provision of abortion care to mid-level providers. Firstly, the socio-political context of the province will largely determine acceptability of this policy. Consultations with professional organizations, including the College of Registered Nurses of Alberta and the College of Midwives of Alberta, would be necessary to update regulations and set an appropriate scope of practice. Offering training and ongoing support to ensure that the provision of abortion care by these providers is safe would also be a requirement. Throughout the policy cycle, the healthcare community and general public would need to be informed of

the changes through some type of educational campaign to ensure awareness and accessibility. As such, this policy receives an overall ease of implementation rating of **moderate**.

6.2.1.4. Destigmatization

Expanding the pool of providers to include mid-level providers may aid in decreasing stigma towards abortion seekers in rural Alberta. As the number of trained providers increases, the procedure itself will become more normalized and, thus, stigma is expected to decrease. This may mean that abortion seekers feel less shame and judgment when accessing services. Therefore, there is expected to be an increase in demand for equitable access programs as stigmatization among abortion seekers decreases. A greater demand for abortion services equates to a greater demand for future policies as reduced stigmatization will enable more Albertans to access abortion care. As the volume of abortion seekers grows in Alberta, so does the need for additional policies to compensate for greater access. One example could be increasing the abortion budget allowance to financially compensate for a higher demand in services. Stigma towards abortion providers would also be expected to decrease to some extent as the provision of abortion care becomes more commonplace in the medical community. Evidently, destigmatization is a long process that involves many interrelated factors. As such, this policy receives an overall destigmatization rating of **moderate.**

6.2.1.5. Stakeholder Acceptance

Acceptability of expanding the pool of providers to include mid-level providers among abortion seekers is expected to be relatively high. This policy would likely increase access to abortion care in areas of the province where services are currently limited. With an increased number of providers available, abortion seekers will have a greater range of options to choose from. Regarding abortion providers, the acceptance of this policy is also expected to be relatively high. On March 7, 2022, the Canadian Association of Midwives released a statement calling on midwives and reproductive health care providers to work to ensure access to abortion care in Canada. This emphasizes receptiveness towards further expanding the scope of practice of mid-level

providers to offer a wide range of abortion services. As such, this policy receives an overall stakeholder acceptance rating of **good.**

6.2.2. Medical School Curricula

6.2.2.1. Equity

Incorporating comprehensive abortion education and training into medical school curricula would mean that students are better equipped to provide safe and effective abortion services upon graduating. Participating in abortion training is proven to increase practitioners' comfortability with providing abortion services, which may mean more physicians will be interested in, and comfortable with, providing such services. Increasing the number of physicians that provide abortion services could improve access for abortion seekers in rural parts of the province. Nevertheless, incorporating abortion education into curricula is unlikely to have a direct impact on supporting equitable access to abortion services for those residing in rural areas. As such, this policy receives an overall equity rating of **poor**.

6.2.2.2. Cost

The cost of implementing comprehensive abortion education and training into medical school curricula would depend on a few factors. The cost of developing the curriculum could likely be done with existing faculty in partnership with organizations such as the Abortion Rights Coalition of Canada. Faculty would also require training to deliver the program appropriately and to keep up-to-date with changes in legislation and best practices. Additionally, there may be additional costs associated with offering clinical placements in abortion clinics or hospitals for students. However, it is likely that this cost would be offset by the student pursuing an abortion related placement instead of another potential placement. Generally speaking, the cost of implementing abortion education in medical school curricula could be largely done with existing resources and within the existing educational institution. As such, this policy receives an overall cost rating of **good**.

6.2.2.3. Ease of Implementation

Implementing a new abortion education and training program would involve the development of a new curriculum for the different elements of the program (i.e., coursework, clinical placement, etc.), requiring collaboration between existing faculty, professional colleges, and regulatory bodies. A wide range of topics would need to be included in the program including abortion methods, counseling, patient-centred care, and ethical and legal considerations. Medical schools would also need to ensure that the program meets the standards set by the College of Physicians & Surgeons of Alberta; the regulatory body established for the health profession of medicine. The most difficult aspect of implementation would be ensuring that all medical schools in the province are offering training that is consistent across the board. As such, this policy receives an overall ease of implementation rating of **moderate**.

6.2.2.4. Destigmatization

Incorporating comprehensive abortion education and training into medical school curricula may aid in decreasing stigma towards abortion seekers in rural Alberta. If this policy were to increase the number of physicians offering abortion care, individuals may feel less apprehensive about seeking these services. As the number of trained providers increases, the procedure itself will become more normalized and, thus, stigma is expected to decrease. This policy is more likely to decrease stigma towards abortion providers – at the very least within the medical community – as learning about and providing abortion care becomes more commonplace among physicians. Destigmatization is a long process with many interrelated factors and introducing comprehensive abortion education and training will not have a direct influence on stigmatizing attitudes. As such, this policy receives an overall destigmatization rating of **moderate**.

6.2.2.5. Stakeholder Acceptance

Acceptability of incorporating comprehensive abortion education and training into medical school curricula among abortion seekers is expected to be high. There is no apparent reason that abortion seekers would be opposed to the training of future physicians that are qualified to provide abortion care. Regarding abortion providers, the

acceptance of this policy is also expected to be relatively high. The supply of abortion providers is low relative to demand of abortion services, so there should be no apprehension among existing providers about competition in this area of service provision. As such, this policy receives an overall stakeholder acceptance rating of **good**.

6.2.3. Improving Telemedicine

6.2.3.1. Equity

Adopting a telemedicine abortion program in the province of Alberta could support equitable access to abortion services for those residing in rural areas by increasing the number of healthcare providers who are able to provide abortion services remotely. Remote care via telemedicine would help to ensure that individuals residing in rural areas have access to the same level of care as those residing in urban areas or in areas with physical healthcare facilities that provide the needed services. By making it possible to access abortion without having to travel long distances, telemedicine would reduce barriers such as transportation and accommodation costs and time away from work and family obligations. An important consideration that must be taken into account when developing a telemedicine program is lack of access to internet and/or technology in some rural and remote areas of the province. Overall, improving telemedicine options and adopting a provincial program would increase access to abortion services for those residing in rural Alberta. As such, this policy receives an equity rating of **good**.

6.2.3.2. Cost

The cost of adopting a telemedicine program in Alberta would depend on a few factors. Basic costs would include technology infrastructure and ongoing maintenance and support. Internet access should be another cost that the government considers as broadband may need to be expanded to some rural and remote areas of the province without internet access. However, the cost savings of a telemedicine program are likely to outweigh the upfront and ongoing costs of adopting and maintaining the program by increasing the efficiency of care delivery. As such, this policy receives a cost rating of **good**.

6.2.3.3. Ease of Implementation

Implementing a telemedicine program would likely require significant planning, coordination, and resources. Collaboration among healthcare providers, government, and technology companies would be required to set a scope for the project. A clear outline of the telemedicine services that will be available, in accordance with existing scopes of practice for abortion providers, would need to be established and clearly communicated. Ensuring compliance with relevant laws and regulations such as privacy and security laws would also be a requirement. Funding for the program would need to be secured – which could come from the federal government, provincial government, private organizations, and/or private investors – and up-to-date technology and equipment would need to be procured. Training for healthcare providers and staff would also be necessary. As such, this policy receives an overall ease of implementation rating of **poor**.

6.2.3.4. Destigmatization

Adopting a telemedicine program in Alberta may help decrease stigmatization towards abortion seekers in Alberta. Telemedicine increases access to safe and confidential abortion services while also providing a more private and convenient way for individuals to access abortion care. In addition to privacy, patients may be more comfortable receiving care and counselling from the safety and comfort of their own homes. In terms of reducing stigmatization towards abortion providers in Alberta, this policy may help further normalize the provision of abortion care and increase opportunities for physicians and other mid-level providers to offer abortion services in a more flexible way. As such, this policy receives an overall destigmatization rating of **moderate**.

6.2.3.5. Stakeholder Acceptance

Acceptability of adopting a telemedicine program in the province is expected to be relatively high. It is unlikely that abortion seekers would be opposed to having the option to access abortion care via telemedicine. However, there may be some concerns about the quality of care and other logistics among abortion seekers in the initial stages of the program. Information and educational resources that use non-technical language

and are easily accessible to the public should be readily available when the program launches. Acceptability among abortion providers is also expected to be relatively high. Health care providers with abortion care in their scope of practice must be knowledgeable of best practices and have access to up-to-date information on the laws and legislation governing the provision of telemedicine services for abortion. As such, this policy receives an overall stakeholder acceptance rating of **moderate/good**.

Chapter 7.

Recommendations

Given the analysis presented in Chapter 6, this study recommends the implementation of the following bundle of policies using a multi-stage approach. This approach is dependent on the direct empowerment of grassroots organizations and advocacy networks, as the sensitive and complex nature of abortion can only be properly addressed through the support of expert channels with pre-existing connections and the ability to properly serve individuals who are planning to terminate their pregnancies. Once sufficient support of these communities has been established, Alberta should begin to enact a series of policy changes.

First, in the short-term, Alberta should expand the pool of providers to allow mid-level providers to independently prescribe Mifegymiso. With proper training, registered nurses, physician assistants, and certified nurse midwives can provide medication abortion with no increased risk to patients. Adding mid-level providers to the provider pool may help reduce stigma associated with abortion seeking. The process itself will become more commonplace as the number of skilled providers rises and, as a result, stigma is anticipated to decrease as patient guilt decreases and exposure of abortion cases among medical staff increases. This option addresses the shortage of abortion providers across Alberta, which would directly address the key objective for this study: the degree to which the policy supports equitable access to abortion care for women, non-binary, and two-spirit individuals residing in rural Alberta. Other benefits of this policy include low costs, high stakeholder acceptance, and decreased wait-times for services. Additionally, mid-level providers are less costly than physicians, meaning that the health system would also experience savings (Paradise, 2017). Furthermore, this policy's role in combating stigma will serve as the main driver to introduce later term policies as the reduction of stigma will create a higher demand for the willingness of Albertans to access this service. This also creates the future possibility of additional budget allowances in Alberta due to the increased volume of abortion seekers. As such, this policy should be prioritized in the short-term as it is the most effective intervention.

In the medium-term, Alberta should work to develop and adopt a large-scale telemedicine abortion program. Similar to expanding the pool of providers to include mid-level providers, this policy would positively affect equitable access to abortion care for women, non-binary, and two-spirit individuals residing in rural Alberta. This policy is more administratively complex and would require coordination and collaboration among multiple stakeholders. However, the overall benefits and cost savings would greatly outweigh the complexities and upfront costs associated with the adoption of this policy. As such, this policy should be strongly considered as a medium-term intervention.

Although adopting comprehensive abortion care training in medical school curricula would not have a direct or immediate influence on improving equitable access to abortion care for women, non-binary, and two-spirit individuals residing in rural Alberta, it is still an important policy that can help support destigmatization and increase the pool of abortion providers in the long-term. Despite this policy not being included in this recommendation, it is still an important intervention that should be considered in the future.

Chapter 8.

Conclusion

Abortion was fully decriminalized in Canada in 1988. The nonexistence of abortion legislation in Canada has culminated in abortion being recognized as a matter of health care, which falls predominately under provincial and territorial jurisdiction. As a result, access to abortion care differs across each province and territory. This study has determined that there are various barriers to accessing abortion care for women, non-binary, and two-spirit individuals residing in rural Alberta. Significant barriers include distance, stigma and misinformation, and provider restrictions. Case studies in other jurisdictions have provided insights into how Alberta can reshape its policies to better serve rural abortion seekers and abortion providers. Given the complexities of the health care system and the state of reproductive health care in Alberta, innovative solutions that are informed by principles of equity should ultimately be prioritized. A multi-criteria analysis was undertaken to assess three policy options against a set of criteria and measures, and the subsequent policy bundle that was recommended aligns with the given objectives outlined in this analysis. Ultimately, these policies allow for the reduction of barriers to abortion services in rural Alberta across the short-term, medium-term, and long-term.

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Appendix A.

Partial Participation Protocol Template

Figure A.1. Partial Participation Protocol Template

PROCEDURE FOR OPTING OUT OF A PORTION OF RESIDENCY TRAINING

We have developed a mechanism for helping residents who are struggling with the dilemma of whether they hold a moral objection to a particular procedure, or whether they are just disturbed by or uncomfortable with the procedure itself.

It is the department's *expectation* that all residents will receive instruction in all aspects of residency training, including but not limited to:

- contraception including tubal ligation
- abortion counseling and techniques

It is not the department's policy that residents will be required to perform procedures that violate their beliefs.

1. The resident will meet with the key faculty member for the rotation and the program director. The purpose of this panel will be to be supportive and constructive and not directive and ooercive.
2. The resident will discuss their beliefs and concerns about this portion of their residency training.
3. The resident will delineate precisely what aspects of the rotation or training they do not want to participate in.
4. Faculty will help the resident identify key skills that are learned during this portion of their training, including career opportunities and limitations.
5. The resident will present alternative opportunities for obtaining these skills, if applicable.
6. Faculty will implement a process to ensure that the resident learns the critical skills via other opportunities.
7. A summary of the meeting with the faculty member and the program director will be signed by all three physicians and will be placed in the resident's file.
8. Permission to opt out of a portion of training will be approved by the program director after the above steps are taken.

Note. Figure from Steinauer, J., & Turk, J. (2021). The Benefits of and Strategies for Supporting Residents Partial Participation in Abortion Training. *Medical Education in Sexual and Reproductive Health: A Systems Approach in Family Planning and Abortion,* 229.