Original research article

Exploring Canadian women's knowledge of and interest in mifepristone: results from a national qualitative study with abortion patients☆,☆☆

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Abstract

Introduction: Although Canada decriminalized abortion in 1988, significant disparities in access to services and an uneven geographic distribution of providers persists. Health Canada registered mifepristone, the gold standard of medication abortion, in July 2015. Our study explored Canadian women's knowledge of, interest in, and perspectives on mifepristone prior to registration.

Methods: From November 2012 through July 2015 we conducted in-depth interviews with 174 Anglophone and Francophone women from Alberta, Manitoba, New Brunswick, Ontario, and Quebec about their abortion experiences and their opinions about medication abortion. We purposively recruited participants from different age cohorts and different regions within each study province to explore a range of perspectives. We analyzed these interviews for content and themes related to mifepristone using both deductive and inductive analytic techniques.

Results: The overwhelming majority of participants had no knowledge of mifepristone at the time of the interview. However, after providing a brief description of an evidence-based mifepristone/misoprostol regimen, more than half of the participants reported that they would have considered this method had it been available at the time of their abortion and most would have been comfortable receiving medication abortion care from a family physician or nurse practitioner. Most women supported the approval of mifepristone and felt Canadian women would benefit from having more options for early pregnancy termination.

Conclusion: Although knowledge of mifepristone among recent abortion patients was low, considerable interest in medication abortion exists. Expanding awareness-raising efforts and supporting the approval of evidence-based regimens and provision of mifepristone appears warranted.

Implications: The approval and introduction of mifepristone for early abortion in Canada promises to increase options and access. Creating tailored and culturally and contextually resonant messages about mifepristone is of high priority. Promoting evidence-based protocols and the inclusion of a full range of qualified professionals in service provision is also warranted.

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1. Introduction

In January 1988, the Supreme Court of Canada decriminalized abortion in the landmark *R. v. Morgentaler* decision. Although there are no federal laws regulating abortion in Canada, disparities in abortion access persist. A body of research has demonstrated that young women, recent immigrants, First Nations women, poor women, and rural residents face significant barriers to obtaining timely abortion care [1–4]. That these women are at greater risk of unintended pregnancy reflects compounded vulnerabilities with respect to reproductive health. Nearly one in three Canadian women will have an abortion over the course of

their reproductive lives [5], yet geographic disparities continue to characterize the abortion landscape. The majority of procedures are performed in free-standing abortion clinics which are concentrated in large urban centers within 150 miles of the US-Canada border [6]. Regulatory, political, public funding, and health systems barriers have resulted in considerable differences both between and within provinces [7–10]. For many women in Canada, timely abortion care can be difficult to obtain [11].

Although Canada participated in the North American mifepristone clinical trials, as of early 2016 the gold standard medication abortion regimen was not yet available. The overwhelming majority of abortion procedures in Canada take place in the first trimester with aspiration techniques; only a small percentage are performed using methotrexate/misoprostol [5]. That mifepristone is safe, effective, and acceptable to women and can be provided by a range of health service professionals has been well documented [12–15]. Incorporation of mifepristone into the Canadian health system has the potential to greatly expand access to early abortion services and promises to make a significant contribution to reducing geographic disparities in access throughout the country [10,16,17].

In 2011, a dossier to register mifepristone was submitted to Health Canada and approval was granted in July 2015 [18]. However, registration of mifepristone alone is not sufficient to expand access. Provincial regulations, insurance coverage, provision protocols, scope of care guidelines, provider training, and political champions will all shape the introduction of mifepristone at both the federal and provincial levels. Further, women's knowledge of and interest in mifepristone will condition demand for expanding medication abortion services.

Over the last three years our research group has undertaken a large-scale national qualitative study to document Canadian women's abortion experiences, explore geographic-, age-, socio-economic-, and language minority status-related barriers to abortion access, and identify avenues by which services could be improved at the provincial and territorial levels. As part of this study we asked women about their knowledge of, attitudes toward, and interest in mifepristone. In this article, we report on the mifepristone-related findings from women who resided in one of five provinces at the time of their abortion.

2. Methods

From November 2012 through July 2015 our study team conducted in-depth, open-ended telephone/Skype interviews with English- and French-speaking women who had obtained an abortion within five years of the interview. Participants were eligible if they were residents of Alberta, Manitoba, New Brunswick, Ontario, or Quebec at the time of termination and age 18 or older at the time of the interview. We used a multi-modal community-based recruitment strategy which included posting flyers, circulating study information on listservs, establishing a study website, and placing social media ads. One of our Study Coordinators (KL, JE, or AC) screened women who contacted the study team for eligibility, provided potential participants with the consent form, and scheduled the interview on a first come/first served basis.

The PI (AF), a qualitative researcher with nearly 20 years of experience, and/or a trained member of the all-woman study team comprised of graduate and advanced undergraduate students, conducted all interviews. Interviewers used the same guide which we developed specifically for this study. Our interviews began with questions related to participant demographics, reproductive and pregnancy history, and general experiences accessing health services. The interview then turned to the participant's abortion experience(s) and ways in which services could be improved.

In the final section of the interview, we asked participants about mifepristone. We began by asking participants if they had heard about mifepristone, by name and with prompts (RU486, the abortion pill, and medication/medical abortion). If the participant indicated awareness of mifepristone (with or without prompts) we probed to ascertain the participant's knowledge of timeframe for use, eligibility, process/side effects/complications, and legal/regulatory status. We then provided all participants, irrespective of expressed knowledge, with general information about mifepristone, including the history of use in other countries, a description of the regimen (with misoprostol) through nine weeks gestation, the physical abortion process, efficacy, and possible side effects and complications. We then asked participants to reflect on whether or not they would have considered using mifepristone/misoprostol had they been eligible and had the regimen been available. We also asked if they would have been receptive to obtaining medication abortion care from a family physician and/or a nurse practitioner. We concluded by asking participants to reflect on the possible acceptability of mifepristone.

We used a pre-determined sampling matrix to ensure inclusion of participants of different age cohorts (18–24 inclusive and 25 and above), in-province geographic locations, and language minority status (New Brunswick, Ontario, and Quebec). Interviews averaged one hour in length and participants received a CAD40 gift card to www.amazon.ca. With permission we audio-recorded and later transcribed all interviews. Interviewers also took notes during the interview and formally memoed after each interaction, a process that both aided our analysis and fostered reflexivity.

We analyzed our data for content and themes, an iterative process that began during data collection and was informed by regular team meetings. Using ATLAS.ti to manage the data, KV served as the primary coder employing both *a priori* and inductive codes and categories [19]. AF and KL reviewed coding and we resolved disagreements through discussion. This article focuses on significant findings using