Abortion in Nova Scotia: Defining and Operationalizing Access

by

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Abstract

It has been over thirty years since the decriminalization of abortion across Canada, however, many in need continue to face barriers accessing the healthservice (Erdman, 2017). Maritime provinces are known across the literature to have poor access to abortion services (Eggertson, 2001; Sethna & Doull, 2012; Sethna & Doull, 2013), yet little academic research has been conducted on the state of abortion acesss within the Nova Scotian context. This study seeks to provide an overview of the current state of abortion access across the province, identify prevalent barriers that impede patient access to abortion services and review the effectiveness of guiding legislation and policy, such as the Nova Scotia Department of Health and Wellness' Framework for a High Perfoming Health and Wellness System (NS DHW Framework) and the Canada Health Act (CHA), in operationalizing access to healthcare services such as abortion. Barriers present within the current operations of the public healthcare system were identified by study participants as the most prominent barriers to abortion access in Nova Scotia. The study also identified significant disparities in abortion access between those living within rural and urban areas of Nova Scotia. Study participants made several recommendations to improve abortion access across the province, the majority of which concerned changes to be made within the current opertations and policies of the public healthcare system in Nova Scotia. The lack of primary care physicians across the province directly contributes not only to the poor access of abortion services but of all healthservices across Nova Scotia. Future studies concerning patient-identified barriers to abortion services specifically focused on marginalized populations are recommended for developping a better understanding of abortion access across Nova Scotia.

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Chapter 1: Introduction

Problem Statement

Abortion has been legally available for decades in Canada, yet operationally the health care service remains in accessible to many (Erdman, 2017; La Roche & Foster, 2018; Palley, 2006; Norman, 2012; Sethna & Doull, 2013; Shaw, 2013). Women, girls, trans, nonbinary and Two Spirit people require access to abortion care (Paynter, Norman & Martin-Misener, 2019), however many continue to encounter significant barriers accessing the healthcare service (Erdman, 2017; La Roche & Foster, 2018; Palley, 2006; Norman, 2012; Sethna & Doull, 2013; Shaw, 2013). Barriers pertaining to geographic location, age, socio economic status, and language minority status often impacts one's access to abortion services and therefore their ability to excert their reproductive rights (Vogel, La Roche, El-Haddad, Chaumont and Foster, 2016). Namely, young people, recent immigrants, Indigenous people, and rural residents face significant barriers accessing timely abortion services (Erdman and Cook, 2006; Vogel et al., 2016). The provision of abortion services in Canada has been described as a 'patchwork quilt with many holes' (Eggertson, 2001, p. 847), painting a vivid image of the disparities in abortion services that exist across the country (Eggertson, 2001; Norman, 2012; Sethna & Doull, 2013). Abortion access in Atlantic Canada is notably underserviced according to serveral abortion scholars (Eggertson, 2001; Sethna & Doull, 2012; Sethna & Doull, 2013). Those accessing abortion services in Atlantic Canada are likely to travel long distances and face long waits times in hopes of obtaining the service (Dunn & Cook, 2014). Academic literature on abortion access in Atlantic Canada has been primairly focused on the contexts of New Brunswick and Prince

Edward Island. There has been little academic scholarship based on the state of abortion access in Nova Scotia.

Contemporary Abortion Access in Canada

Contemporary abortion reform in Canada began with the 1969 criminal reform law that decriminalized hospital based abortions (Erdman, 2017; Norman 2012). However, this reform allowed individuals to access abortion services only if a committee of three physicians deemed the pregnancy life threatening (Erdman 2017; Norman, 2012). The accessibility of abortion services under this reform favoured middle class white women who could afford family physicians in good standing as they faired better approval rates (Erdman, 2017). The 1969 abortion reform law failed to protect the repoductive rights of Indigenous people and other racilialized minorities, who consequently were forced into coercive stertilisation or pressured to undergo abortive procedures (Erdman, 2017; Stote, 2015). The controversies surrouding the 1969 abortion law reform and pressures from the 1970s women's movement, which focused on reproductive rights, prompted change (Erdman, 2017). ln 1977, the Report on the Commitee of the Operation of the Abortion Law, also known as the Bagley Repor, was released (Erdman, 2017). The Bagley Report revealed that hospital-based abortions exempt from the Criminal Code were inaccessible to many (Erdman, 2017). During the 1960s and 1970s, Dr. Henry Morgentaler had been providing clandestine abortion services in his Toronto-based clinic on the basis that greater harms were being inflicted on individuals by obeying the law (Erdman, 2017). Morgentaler argued that the current provision of abortion services across Canada were mitigated by class (Erdman, 2017). The 1988 the R v. Morgentaler case made its way to the Supreme Court of Canada and dismantled the 1969 abortion law reform on the basis that under the current structure, the provision of abortion services,

enfringed on section 7 of the *Charter of Rights and Freedoms* as it denied an individual's right to "the security of the person" (Erdman, 2017). This Supreme Court ruling set a precedent for the legal access of abortion services in Canada, however over thirty years after the decriminalization of abortion services, physical access continues to be out of reach for many (Erdman, 2017; La Roche & Foster, 2018; Palley, 2006; Norman, 2012; Sethna & Doull, 2013; Shaw, 2013).

The Canadian Health Care System and The Provision of Abortion Services

The foundation of the Canadian health care system is held within the *Canada Health Act*, in which its primary objective states to "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers." (*Health Canada,* 2018, p. 7). The *Canada Health Act* lays out federal legislation for the publicly funded health care insurance, which is comprised of " 13 interlocking provincial and territorial health care insurance plans, ...designed to ensure that all eligible residents of Canadian provinces and territories have reasonable access to medically necessary hospital and physician services" (*Health Canada,* 2018, p.39). There are five principles that govern the Canadian health insurance system which includes public administration, comprehensiveness, universality, portability, and accessibility (*Health Canada, 2018).* The administration and delivery of health services is operationalized under provincial/territorial jurisdiction following the criteria and conditions established by the federal government under the *Canada Health Act.* (*Health Canada,* 2018). The federal government can impose financial sanctions onto provincial/territorial governments if they do not comply with the criteria and conditions set by the Act (*Health Canada,* 2018). Abortion services are insured under all provincial/territorial health insurance plans yet access to the service varies greatly within and between jurisdictions (*Health Canada,* 2018).

Abortion Services in Nova Scotia

In 1989, Morgentaler opened the first dedicated abortion clinic in Nova Scotia ("Morgentaler closes," 2003). The same year, the Nova Scotia government banned abortion access outside of hospital settings ("Abortion rights," 2009), prompting Morgentaler to challenge the province in court. The province fined the clinic for failing to comply with the 'Medical Services Act' (Stevenson, Taylor and Rolf, 2019). In 1993, Dr. Henry Morgentaler challenged the province's 'Medical Services Act' for providing restrictions on abortion services (Stevenson et al., 2019). The case made it way to the Supreme Court of Canada, in which the courts found that the restriction on abortion services was outside of provincial jurisdiction (Stevenson et al., 2019), forcing the province to allow the opertation of private abortion clinics ("Abortion rights," 2009). In 2003, Morgentaler closed his Halifax based clinic, as abortion became available at the Queen Elizabeth Health Science Centre, making it the only site providing the service across the province ("Morgentaler closes," 2003). Access has since grown, and both medical and surgical abortion procedures are available in Nova Scotia, both of which are covered under provincial health plans (Nova Scotia Health Authority, 2018a).

The Nova Scotia Health Authority (NSHA) provides health services to people across the province through the operation of hospitals, health centres and community-based healthcare programs across the province (Nova Scotia Health Authority, 2020a). The NSHA is therefore responsible for the provision of abortion services across the province. The province of Nova Scotia is divided into the four following management zones: Northern Zone; Central Zone; Western Zone; Eastern Zone (see Figure 1). In 2018, the self referral line was created given those seeking abortion services

Figure 1

NSHA Management Zones **(NSHA, 2020b)**

the option to self-refer (Nova Scotia Health Authority, 2018b). The toll-free number operates from 8am to 4pm, Monday through Friday, where a referral clerk or a nurse provides education to prospective patients and can make arrangements for diagnostic testing and connect them to an abortion provider within their community or schedule an appoitnment for surgical abortion at the Queen Elizabeth II Health Sciences Centre in Halifax (NSHA, 2018b). Patients may also request a referral from their family physician (Stevenson et al., 2019). Those seeking abortions in Nova Scotia must obtain diagnotic testing comprised of a blood test to confirm the pregnancy and confirm the patient's blood type (Stevenson et al., 2019). Ultrasound testing may also be required in order to

date the pregnancy and to ensure that the pregnancy is occurring within the uterus (Stevenson et al., 2019). Though Health Canada does not require ultrasound testing prior to prescribing Mifegymiso, some abortion providers may request that the test is completed prior to providing a prescription (Stevenson et al., 2019).

Surgical Abortion

Surgical abortion is available at four hospitals located in Halifax, Bridgewater, Kentville and Truro (Stevenson et al., 2019). Most abortions within the province are provided at the Queen Elizabeth Health Sciences in Halifax (Stevenson et al., 2019). There are no private clinics offering abortion services in the province (Stevenson et al., 2019). A surgical abortion is a short low risk procedure procedure that uses suction to remove pregnancy tissue and terminate the pregnancy (Nova Scotia Health Authority 2018c). The entire procedure can last anywhere between 3-10 minutes (Stevenson et al., 2019). A surgical abortion can be performed up to fifteen weeks and six days since the date of one's last mentrual period (Nova Scotia Health Authority, 2018c). If the pregnancy is past the set time limit in Nova Scotia, the closest clinic offering abortion services up to 23 weeks and 6 days is located in Southern Ontario (Action Canada for Sexual Health and Rights, 2019). No abortion services are available in Canada past that point (Action Canada SHR, 2019). Surgical abortion has a 99% success rate and requires only one clinic visit. The option of conscious sedation is available to patients during the procedure, a similar type of sedation that is available at many dentists (Stevenson et al., 2019). The NSHA recommends that patients make a check-up appointment with their family doctor two weeks following their abortion (Stevenson et al., 2019). Patients are not permitted to have loved one's with them for support as they undergo the procedure as they are not allowed within the clinic (Nova Scotia Health Authority, 2018c)

Medical Abortion

In 2017, coverage was made available for Mifegymiso, the medical abortion pill, for all those in Nova Scotia with a valid health insurance number (Nova Scotia, 2019). Prescriptions are available from both registered physicians and nurse practioners across the province, which has significantly increased the access to abortion services particularly for those living within rural and remote areas (Paynter et al., 2019). A medical abortion uses a combination of medications which are taken orally, comprised of 1 tablet of mifepristone and 4 tablets of misoprostal, called Mifegymiso, to terminate the pregnancy Nova Scotia Health Authority, 2018c). Patients are able to obtain a medical abortion if their pregnancy is less than 9 weeks from their last menstrual period (Nova Scotia Health Authority, 2018c). Before receiving the medication, patients are required to have an ultrasound to confirm they are eligible for the procedure and have blood work to check their blood type and hormone level (Nova Scotia Health Authority, 2018c). Patients are then required to meet with their prescriber and receive a prescription for Mifegymiso, which is covered under the provincial health care plan (Nova Scotia Health Authority, 2018c). With medical aboriton, patients have the liberty of taking the prescription at home and terminating their pregnancy without surgery or hospitalization (Stevenson et al., 2019). After the treatment, the patient is then required to take a blood test to confirm if the procedure was successful (Nova Scotia Health Authority, 2018c). If unsuccessful, patients must be willing to undergo a surgical abortion which requires the suction of uterine contents as medical abortions cause fetal damage (Nova Scotia Health Authourity, 2018c). A medical abortion can be done in the comfort of one's home and has a 95%-98% success rate (Nova Scotia Health Authority, 2018c). However, the risk of continued pregnancy is 1 in 20 and one may

not know that the procedure was successful until the followup appointment scheduled one to two weeks later (Nova Scotia Health Authority, 2018c).

Purpose of the Study

This study seeks to assess the state of abortion access across Nova Scotia and identify prevalent barriers impede patient access to the health service. By examining the ways in which healthcare access is defined through healthcare policy and academic literature, and how access is operationalized by abortion providers/suppourt workers in Nova Scotia, this study seeks to provide an overview of the availability of abortion services across the province and what barriers impede access.

Research Questions

- What is the current state of abortion access across Nova Scotia?
- What provider-identified barriers are perceived to significantly impede abortion access to the public?
- How effective are guiding legislation and frameworks such as the Canada Health Act (CHA) and the Quality Framework for a High Performing Health and Wellness System in Nova Scotia (NS DHW Framework) in operationalizing accessible healthcare services such as abortion?
- What measures can be implemented to improve abortion access in Nova Scotia?

Research Design

A mixed-methods approach will be implemented to analyze the current state of abortion access across Nova Scotia guided by an intersectional framework. The intersectional framework will be implemented on a systems levels, which will identify intersections between relevant barriers to

abortion services while highlighting ways in which multiple barriers creating aggravating circumstances, impeding abortion access to those who face the most systemic marginalization. Barriers to abortion access will be identified throughout a series of semi-structured interviews conducted with informants currently employed in the provision of abortion services, abortion support services, or abortion advocacy in the province. Interview participants will also be asked a series of questions on the operational impact of both the Canada Health Act and the Framework for A High Performing Health and Wellness System in Nova Scotia. Data will be collected during the semi-structured interviews which will inform the geographic information systems (GIS) analysis of this study. The GIS analysis will create a visual representation of the current availability of both medical and surgical abortion across the province. Prominent barriers identified by interview participants related to the geographic location of abortion services will be integrated into the GIS analysis, enriching the data. This mixed-method approach will allow for an in depth analysis on the current state of abortion access across Nova Scotia, identify key barriers impeding access to the healthservice, review the operational impact of current legislation and policy pertaining to healthcare access, and establish a series of recommendations for improving abortion access across the province.

Outline of Thesis

This thesis will be divided into two primary sections, one dedicated to a literature review and the second dedicated to original research. The literature review will be divided into two primary sections. The first section will analyse the definitions of 'accessibility' in terms of the provision of healthcare services within healthcare policy and academic literature. The second will review inequities related to the provision of abortion services across Canada and identify barriers

that are seemingly relevant to abortion access in Nova Scotia. The second section of the thesis will be dedicated to original research on the provision of abortion services within a Nova Scotian context. A breakdown of the methodology used, which will include a mixed methods approach comprising semi-conducted interviews and a GIS analysis, followed by an analysis and discussion of the results, will be included in this section. The thesis will conclude with an outline of the findings and suggestions for further research.

Chapter 2: Literature Review

Abortion is a common medical procedure in Canada, where approximately 1 in 3 people capable of pregnancy will have an abortion in their lifetime (Dunn & Cook, 2014). Though discourses surrounding abortion are often politized and subjected to moral judgement, abortion is recognized as a necessary medical service that is insured publicly within every province and territory in Canada (Health Canada, 2018). Access to abortion services varies drastically throughout the country, with abortion access in Atlantic Canada recognized as being particularly sparse (Dunn & Cook, 2014; Doran & Nancarrow, 2015; Sethna & Doull, 2013). Though there is frequent mention of abortion service disparities within Maritime provinces (Dunn & Cook, 2014; Doran & Nancarrow, 2015; Sethna & Doull, 2013), there is little scholarship focused on abortion access within the Nova Scotian context. The concept of 'access' in itself is disputed across the literature (Khan & Bhardwaj, 1994; Gulzar, 1999) and definitions held within healthcare policy and legislation adds to the ambiguity. In order to effectively study the operationalizationof abortion 'access' in Nova Scotia, the literature surrounding defintions of healthcare 'access' held within academic literature and relevant government policy and legislation must be examined. Identifying how the 'accessibility' of abortion services is operationalized in Nova Scotia, cannot be done without a clear definition of the term. Furthermore, as there is little scholarship on the Nova Scotian context, identifying the challenges that impact other parts of the country will give insight on what challenges may arise in the provision of abortion services within the province. Understanding the concept of access in relation to the operalization of healthcare services allows one to think critically of how policies are addressing or reinforcing inequities in the provision of health services, such as abortion.

Definitions and the Operationalization of Healthcare Access

Prior to 1969, all abortion was illegal in Canada.(Erdman, 2017). In 1969, the Criminal Law Amendment Act (1968–69) legalized abortion, as long as a committee of doctors certified that continuing the pregnancy would likely endanger the woman's life or health (Erdman, 2017). In 1988, the Supreme Court of Canada ruled in R. v. Morgentaler that the existing law was unconstitutional, and struck down the 1969 law, creating the legacy of modern day abortion access across the counry (Erdman, 2017). Current controversies surrounding the provision of abortion services in Canada are often framed around the lack of 'access' individuals have to the medical service (Erdman, 2017; La Roche & Foster, 2018; Palley, 2006; Norman, 2012; Sethna & Doull, 2013; Shaw, 2013). However, there is a lack of consensus within the field of academic literature and government policy regarding the definition of 'access' pertaining to the provision of health services (Khan & Bhardwaj, 1994; Gulzar, 1999). 'Access' is often affiliated with the term 'equity', implying that everyone requiring a given health service should have the same level of 'access' (Gulzar, 1999). The ambiguity surrounding healthcare 'access' makes it difficult to assess how the health care needs of individuals are and are not being met (Carrillo et al., 2011; Khan & Bhardwaj, 1994; Gulzar, 1999). Failures to properly define and operationalize health care 'access' inhibit the development of healthcare reform that may lead to effective responses to prevalent health service disparities such as abortion access (Carrillo et al., 2011; Khan & Bhardwaj, 1994; Gulzar, 1999). Policy frameworks that govern the operationalization of healthcare services in Nova Scotia, such as the Canada Health Act (CHA) and the Nova Scotia Department of Health and Wellness' (NS DHW) Quality Framework for a High Performing Health and Wellness System, employ simplistic and broad language when

defining terms pertaining to the accessibility of healthcare which raises concerns on their ability to effectively address disparities in the provision of health care services such as abortion. For example, both the CHA and the Nova Scotian framework use similar language promising to 'ensure' the 'accessibility' of healthcare services (Canada Health Act, 2018, p. 10; Nova Scotia Department of Health and Wellness, 2013, p. 11) but fail to provide a tangible action plan.

The notion that 'access' refers to one's ability to obtain a required health service is widely accepted throughout the literature (Khan & Bharwaj, 1994). However, methods on how to evaluate the 'accessibility' of healthcare services and how to effectively implement 'access', are widely disputed across health scholarship (Khan & Bharwaj, 1994). Framing health care access in terms of spatial and non-spatial barriers, is often used as a measure of evaluating the equitable nature of healthcare 'access' in health research (Gulzar, 1999; Khan & Bharwaj, 1994; Wang & Luo, 2005). Spatial access refers to geographic barriers, such as distance and time, that exist between the service provider and the consumer of the healthcare service (Wang & Luo, 2005; Khan & Bharwaj, 1994; Gulzar, 1999). Non-spatial access consists of user characteristics, such as age, income, culture and social class, that enable or impede an individual's ability to obtain a given health service due to systemic or social discrimination (Wang & Luo, 2005; Khan & Bharwaj, 1994; Gulzar, 1999). In relation to the provision of abortion services across Canada, spatial barriers are frequently mentioned in terms of the physical lack of abortion services available across vast geographic spaces (Eggertson, 2001; Kaposy, 2010; La Roche et al., 2018; Norman, 2012; Sethna & Doull, 2012; Sethna & Doull, 2013; Vogel et al, 2013). Prevalent non-spatial factors mentioned throughout the literature refer to experiences of discrimination and marginalization users undergo in attempting to obtain an abortion in Canada (Doran & Nancarrow, 2015; Erdman & Cook, 2006; Sabourin &

Burnett, 2012; Sethna & Doull, 2013; Shaw, 2013). Both spatial and non-spatial factors of access can facilitate or impede one's ability to obtain necessary healthcare services like abortion, and often act in accordance with one another creating aggravating circumstances, by impeding one's access to a given health service (Gulzard, 1999).

As an insured health service across all provinces and territories in Canada, (Health Canada, 2018), all individuals in Nova Scotia and across the country should have 'resonable access' to abortion services 'where and when available' on 'uniform terms and conditions' without being 'impeded, directly or indirectly, by charges or other means' such as 'discrimination on the basis of age, health status or financial services'. (Health Canada, 2018, p.10). Violations of the accessibility and universality clause of the Canadian Health Act (CHA) presented through the annual report from 2017-2018 in regard to the provision of abortion services, are primarily concerned with financial and geographic access (Health Canada, 2018). However as observed throughout the literature, many other barriers exist impacting one's ability to obtain healthcare services like abortion (Gulzar, 1999; Khan & Bhadwarj, 1994; Wang & Luo, 2005). Barriers such as geographic location and proximity to healthcare services, and factors of social identity such as age, income, social class, and education can inhibit or facilitate one's ability to obtain required health services (Wang & Luo, 2005). As nearly half of Nova Scotia's population resides in rural areas (Gibson, Fitsgibbons & Nunez, 2015), geographic barriers to abortion access is an area of significant concern.

As the operationalization of public health services is held under provincial jurisdiction, the operationalization of health care access is therefore implemented by the province or territory (Canada Health, 2018; Palley, 2006). The federal government however has the capacity to sanction provincial and territorial governments through fiscal measures when they do not abide by the

standards set by the CHA(Canada Health, 2018; Palley, 2006). Despite, ongoing barriers individuals face when obtaining abortion services, and clear violations of the 'universality' and 'accessibility' clauses of the CHA, provincial and territorial governments are rarely sanctioned and held accountable for discrepancies in the provision of health care services (Palley, 2006; Shaw, 2013). However, the CHA has been utilized as a tool for holding provincial governments accountable for failing to provide adequate access to abortion services. Since 2015, Clinic 544 located in Fredericton, New Brunswick, has been advocating for the provincial funding of abortion in private clinics (Jones, 2020). Abortion in New Brunswick is only covered by provincial insurance when performed in a hospital setting and not a private clinic (Health Canada, 2020) and the cost of an abortion at Clinic 544 is between 750-800$ (Clinic 544, n.d. This discrepancy in abortion funding in New Brunswick has been viewed by federal governemnt as a breach of the 'accessibility' and 'comprehensiveness' critieria listed under the Canada Health Act (Health Canada, 2020). New Brunswick's failure to provide public funding for abortion procedures within private clinics resulted in a 140 216$transfer payment suspension from the federal governemnt, seeking to pressure the province to change its policy regarding abortion coverage (Jones, 2020). However, the federal government has since reimbursed the province in order to maximize healthcare resources in the midst of the global COVID 19 pandemic (Jones, 2020). Discussions regarding abortion coverage in New Brunswick are ongoing, and abortion procedures at Clinc 544 remain uncovered. The clinic had been absorbing the costs of abortion procedures for patients who could not afford the service, however, it has taken a significant financial toll and the clinic has faced several threats of closure since opening in 2015 (Jones, 2020). In order to remain open, Clinic 544 now redirects patients with financial need to the National Abortion Federation (Clinic 544, n.d.). The measures imposed

by the CHA, did not prompt a change in abortion policy in New Brunswick, but rather temporairly underfunded an overburdened healthcare system, leaving the public to suffer the consequences of government inaction. As large healthcare disparities in the provision of abortion services continue to persist across the country, the CHA has proven to be ineffective in ensuring that indivuals have access to abortion services in 'uniform terms and conditions when and where available' (Palley, 2006; Shaw, 2013).

The framework set by the Nova Scotia Department of Health and Wellness seeks to guide the quality of healthcare services across the province (2013). The framework defines "accessible" in terms of "providing timely services" in which the desired outcome allows individuals to "get safe quality health and wellness services when needed." (Nova Scotia Department of Health and Wellness, 2013, p.11). Timely access to services is incredibly important in the provision of abortion due to the time sensitivity of pregnancy and the fact that surgical abortion is only available in Nova Scotia for up to 15 weeks and 6 days of pregnancy (Stevenson, Taylor & Rolf, 2019). Under the "Respectful diversity and equity" criteria of the framework there is mention of reducing health disparities, promoting health equity, providing culturally competent healthcare services and responding to the needs of marginalized populations (Nova Scotia Department of Health and Wellness, 2013, p.10). The quality dimension of "accessible" refers to spatial factors of healthcare access whereas the "respectful diversity and equity" clause refers to non-spatial factors. The integration of spatial and non-spatial access within policy is integral for the operationalization of assessing healthcare access as they are often intertwined (Wang & Luo, 2005). For example, being forced to travel outside of one's home community in order to gain access to abortion services, may create financial barriers such as travel and accomodation costs which may impede those of

low-income status from accessing the required health service (Wang & Luo, 2005). The separation of both dimensions under the provincial framework is therefore problematic as it may impact the ways the concepts are interpreted and operationalized, impacting the effectiveness of the healthcare policy as regulatory planning often adopts simplistic approaches to address complex health disparities (Khan & Bhadwarj, 1994).

Inequities in the Provision of Abortion Services in Canada

The provisioning of abortion services in Canada is accompanied by various barriers, both spatial and non-spatial, that impede an individual's ability to gain access to the service (Sethna & Doull, 2013; La Roche et al, 2018; Shaw, 2013; Vogel et al, 2013). The sparsity of abortion services in Atlantic Canada is frequently mentioned throughout the literature as being incredibly problematic (Dunn & Cook, 2014; Doran & Nancarrow, 2015; Sethna & Doull, 2013), yet there is little scholarship focused on the Nova Scotian context. Examining the ways in which abortion services are currently operationalized in Canada by identifying spatial and non-spatial factors impacting one's ability to access the service, provides insight on the challenges facing the equitable provision of abortion services. This insight will prove to be useful in identifying how accessibility is being operationalized in Nova Scotia and the challenges the province may face in providing equitable access to abortion.

Spatial Factors

The sparsity of physical abortion services available over vast geographic distances is frequently mentioned throughout the literature as an obstacle in abortion access across Canada (Kaposy, 2010; Sethna & Doull 2013; Shaw, 2013; Vogel et al, 2013). Longer wait times and and the lack physical abortion services are mentioned as being significant barriers present within Maritime

provinces (Cook & Dunn, 2014; Doran & Nancarrow, 2015; Sethna & Doull, 2013).There is a significant rural/urban divide in the provisioning of abortion services across the country as there is a concentration of abortion services within urban areas and a sparsity within rural areas (Sethna & Doull, 2013). This concentration of services in urban centres explains why many individuals must travel long distances to access abortion services (Sethna & Doull, 2013).

As there is a general lack of abortion services in rural areas across the country, rural medical practioners offering abortion services are often overworked and under resourced and face difficulty meeting the demands of their communities (Dressler et al, 2013). As a large percentage of Nova Scotians live outside of urban Halifax (Statistics Canada, 2017), the challenges presented throughout the literature impacting rural communities are important to consider when conducting further research in the operationalization of abortion access in Nova Scotia. Geographic barriers often lead to non-spatial factors such as challenges provisioning childcare as well as the emotional and financial implications that are experienced by individuals who are forced to travel from home to gain abortion services. (Sethna & Doull, 2012). Those most likely to travel the farthest distances are often young, and marginalized (Sethna & Doull, 2013). Spatial barriers are often closely related to non-spatial barriers and act in aggravating circumstances, further impeding one's access to healthcare services (Wang & Luo, 2005), such as abortion.

Non-Spatial Factors

Non-spatial factors mentionned throughout the literature on the provision of abortion services in Canada include economic barriers, structural barriers, stigma, and citizenship status (Doran & Nancarrow, 2015; Erdman & Cook, 2006; Sabourin & Burnett, 2012; Sethna & Doull, 2013). Identity factors such as age, socio-economic status and race also play a crucial role in

impeding or facilitating one's ability to obtain abortion services in Canada, and often act in an aggravating manner (Doran & Nancarrow, 2015; Erdman & Cook, 2006; Mann, 2013; Sethna & Doull, 2013). Individuals who are low-income, young, Indigenous or racialized are identified throughout the literature as those who face the greatest challenges in accessing abortion services in Canada (Doran & Nancarrow, 2015; Erdman & Cook, 2006; Mann, 2013; Sethna & Doull, 2013). Economic barriers to abortion services were at the heart of the infamous 1988 Supreme Court case *R v. Morgentaler,* in which the plaintiff argued that access to abortion services was mitigated by class (Erdman, 2017). Although it has been over thirty years since the decriminalization of abortion services, economic barriers continue to mitigate one's access to abortion services in Canada (Doran & Nancarrow, 2015; Erdman & Cook, 2006; Sabourin & Burnett, 2012; Sethna & Doull, 2013). In areas where spatial access is sparse, individuals seeking abortion services must have the means to travel in order to gain access to the service (Doran & Nancarrow, 2015).

Hospital policies such as gestation limits and age of consent, and long wait times also limit one's access to abortion services (Sabourin & Burnett, 2012). Difficulties navigating the healthcare system in search of abortion services or other contraceptive needs has also been cited as a barrier to abortion access (Lanys et al., 2018). Citizenship status also creates barriers to abortion services through the ineligibility of public health insurance posing significant challenges for undocumented migrants, refugees and migrants (Magalhaes, Carrasco & Gastaldo, 2010). Without provincial health insurance, the cost of a prescrition for medical abortion in Nova Scotia is approximately 350$ (Stevenson, Taylor & Rolf, 2019), while the surgical abortion procedure costs approximately 1900$ (Martha Paynter, *personal communication,* January 22nd, 2020). Other structural barriers held within the delivery of abortion services such as a lack of adequate training for midlevel healthcare

practicioners and midwifes to increase availability of the service are also recognized as being barrier-inducing policies (Sabourin & Burnett, 2012; Paynter, Norman & Martin-Misener, 2019). Nurse practitioners with adequate licensing are able to prescribe Mifegymiso, the medical abortion pill, across Canada, including the province of Nova Scotia (Paynter, Norman & Martin-Misener, 2019). This is an important measure in increasing access to abortion care across the province as nurse practioners are often the only prescribers of those in rural and remote areas (Paynet, Norman & Martin-Misener, 2019).

Stigma is frequently mentioned throughout the literature as an impeding factor on the provision ofabortion services (Doran & Nancarrow, 2015; Sabourin & Burnett, 2012). Stigma barriers can be perpetuated by healthcare professionals, community and family members impacting those seeking abortion services and can even be inflicted upon those providing the service impacting their willingness to provide abortion services in the future (Doran & Nancarrow, 2015; Dressler et al., 2013; Sabourin & Burnett, 2012). Abortion stigma is prominently experience by those receiving subsequent abortions and individuals living in rural areas (Doran & Nancarrow, 2015; Sabourin & Burnett, 2012; Laroche & Foster, 2018). Age is highlighted as a factor that can impede one's abortion access, as young people tend to have less exposure to sexual health information and are more likely to end up with unwanted pregnancies (Mann, 2013). Death during pregnancy and childbirth is also two times more likely for people aged 15-19 than those in their 20s (Mann, 2013). Young people living in low income rural areas with limited access to quality education are also more likely to experience teen pregnancy (Campbell, 2018). Survivors of sexual assault and gender-minorities such as trans, non-binary and 2 Spirit people face challenges in accessing culturally competent healthcare, which impact their access to abrotion care (Halifax

Sexual Health Centre, n.d.; Martha Paynter, *personal communication,* January 22nd, 2019).Indigenous individuals also face additional barriers when accessing abortion services due to a lack of culturally sensitive health services, and may experience a mistrust of the healthcare system due the legacy of discriminatory colonial policies implemented within the Canadian healthcare system (Mann, 2013). Many Indigenous communities are also located in underserviced areas with limited access to quality sex education and sexual health ressources (Mann, 2013). Indigenous youth have significantly higher pregnancy rates than their non-Indigenous peers, putting them at a higher risk of unwanted pregnancy and in higher need of abortion care (Mann, 2013).

Conclusion

Abortion is considered an required medical service in Nova Scotia and across the country, as it is publicly funded through provincial insurance coverage and recongnized as a 'necessary health service' (Health Canada, 2018). Despite the public funding of the service, abortion remains inaccessible to many across the country (Dunn & Cook, 2014; Doran & Nancarrow, 2015; Sethna & Doull, 2013). The state of abortion access in Nova Scotia is not discussed throughout the literature as little scholarship has been focused within the context of the province. Both the CHA and the NS DHW's Framework specifically address healthcare 'access' and can be applied to the Nova Scotian context. However the use of ambiguous language within the policy and legislation, and flawed processes of their application, leave many to critique their effectiveness in ensuring that healthcare services such as abortion are indeed 'accessible' to the public. Furthermore, the presence of barriers, whether they are spatial or non-spatial, often act in accordance with each other, creating aggravating circumstances that lessen one's access to healthcare services like abortion (Carrillo et al, 2011). One's societal marginalization is further exemplified through the health inequity they face

exhibited by the spatial and non spatial barriers that impede their access to a required health service (Carrillo et al, 2011; Gulzar, 1999). The examples provided throughout the literature on non-spatial access barriers to abortion services are not exhaustive for the possibilities one can experience discrimination are endless. In examining the operationalization of healthcare 'access' through the provisioning of abortion services within a Nova Scotian context, and evaluating the effective nature of the CHA and the NS DHW's Framework, the needs of those who face the most barriers in accessing abortion services must be carefully considered. As there is limited literature focused on abortion access in Nova Scotia, the application of an intersectional approach will be essential in evaluating the state of abortion access for all those requiring the service across the province.

Chapter 3: Methodology

Transformative Mixed Methods Approach

This study was conducted through the use of a transformative mixed methods approach, which consisted of a series of semi-structured interviews and a spatial analysis using geographic information systems (GIS). This study provides an over of abortion access, identifies significant access barriers in Nova Scotia and reviews the impact of governing legislation and policy on establishing access to healthcare services such as abortion across the province. Each research method was guided by an intersectional framework, applied on a system's level, in which the intersections between identified themes were carefully examined. Semi-structured interviews were conducted with informants from the healthcare sector, the non-profit sector and the legal profession, who actively work in the provision of abortion services, suppourt services and abortion advocacy across Nova Scotia. The interviews helped inform the chosen data used in the GIS analysis, which provides a visual representation of the current state of abortion access in Nova Scotia at the time of writting. Transformative mixed methods approaches are often applied when conducting research impacting marginalized populations using a theoretical framework to guide aspects of mixed methods study, such as the framing of the research problem, questions, data collection and analysis, interpretation and calls to action (Creswell, 2014). Fully understanding health inequalities, such as access to health services, requires the considerations of how the interactions between multiple factors of identity shape the lives and health statuses of people both on the individual and structural level (Dhamoon & Hankivsky, 2011). As the access to abortion services is dependent on both identity and structural factors, the use of a transformative mixed methods approach using an intersectional framework is essential. Such an approach will allow for

an increased understanding of the complex nature of health inequities, such as the access to abortion services in Nova Scotia, and provide insight on how to best address them.

Intersectional Framework

The application of an intersectional framework in the study of healthcare access is essential for understanding the complex nature of health disparities (Dhamoon & Hankivsky, 2011). Intersectionality is the study of how multiple factors of identity intersect and construct systems of power, privilege and oppression (Reid et al, 2011). Intersectional approaches consider how social identities such as race, class, gender, ability, geographic location and age interact with one another to construct inequity or establish privilege(Hankivsky & Cormier, 2011). Applying an intersectional framework to review current policy offers criticism on how inequities experienced by various individuals are currently being addressed (Hankivsky & Cormier, 2011). Both the Canada Health Act (CHA) and the Nova Scotia Department of Health and Wellness (NS DHW) Quality Framework for a High Performing Health and Wellness System were examined through an intersectional lens over the course of this study. Such an approach reveals that the ambiguity surrounding concepts of access and the use of simplistic language, leaves little guidance for tangible measures of how universal access to medical services, such as abortion. Intersectional policy acknowledges the complexities of identity and how a 'one size fits all solution' is ineffective in addressing inequality (Hankivsky & Cormier, 2011) The application of an intersectional framework within this study allows for an in depth analysis into the state of abortion access in Nova Scotia and the spatial and non spatial barriers that impede access.

An intersectional lens was applied to both the semi-structured interviews and the GIS analysis. The intersections between identified barriers were carefully considered through the

interviews, and themes that were directly related to geographic location were input into the GIS analysis. Coding processes and interview questions were focused on which access barriers are being identified and how barriers intersect creating aggravating circumstances of access. Although a single project focused on perceptions of service providers is unlikely to identify all of the barriers that may impact one's access to medical services (Dhamoon & Hankivsky, 2011), this study examined which forms of inequality are currently being addressed and acknowledged in regards to the provision of abortion services in Nova Scotia.

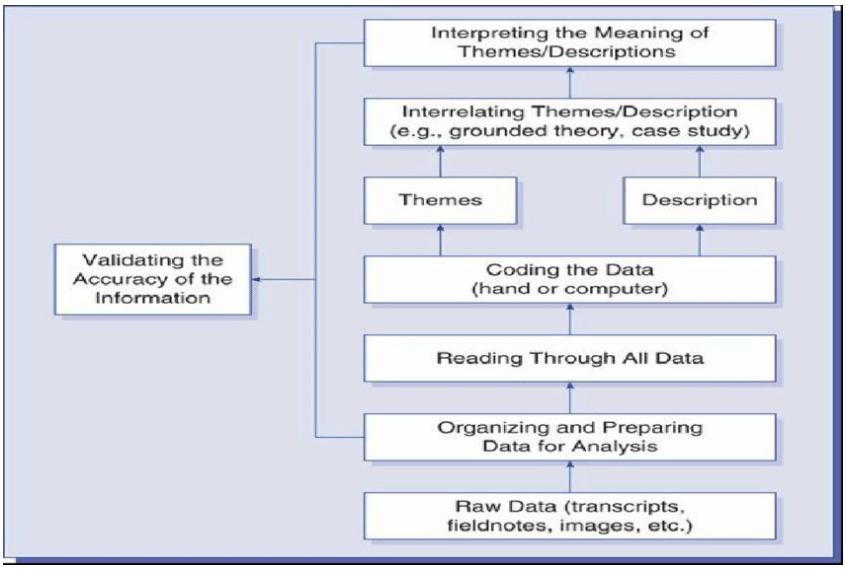
Qualitative Method: Semi-Structured Interviews

This portion of the research seeks to determine the current state of abortion access in Nova Scotia, identify significant barriers impeding abortion access and determine whether the CHA or the NSDHW Framework are indeed effectively opertionalizing abortion access across the province. A series of interviews were conducted with individuals from both the nonprofit sector, the legal profession and the healthcare sector. Participants were recruited through snowball sampling. Snowball sampling or referral sampling consists of the researcher identifying an individual who possesses characteristics required by the research design (Trotter, 2012). The researcher then asks the individual to nominate others with similar characteristics within their networks (Trotter, 2012). Though snowball sampling is commonly used in research to identify potential participants in marginalized or hard to reach populations (Heckathorn 2011; Trotter II, 2012), it was employed in the context of this study to identify key actors involved in abortion support and services in Nova Scotia and gatekeepers of knowledge regarding abortion access. Interview questions focused on the participants' professional roles and expertise, which does not require the approval of an ethic's board as stated under section 2.1 of the Tri-Policy Statement for Ethical Conduct for Research

Involving Humans (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2018, p.15). A total of 9 participants were recruited for the study. Interviews were conducted in person or over the phone, using the interview guide listed under Appendix 1. Participants were provided with definitions from the CHA and the NSDHW Framework as background information for question #5 (see Appendix 2).

Figure 2

Data Analysis in Qualitative Research created by Creswell (2011).



Interviews were recorded and transcribed with the participants' permission, using the online transcription software, Amberscript (https://www.amberscript.com/en). The coding of the interviews was then done through Microsoft Word, with a focus on key spatial and non spatial access barriers to abortion services in Nova Scotia. . The coding process for these interviews followed the process laid out in Creswell (2011) as seen in Figure 1, while applying an intersectional

lens to identify relationships between themes and systems of power. Access barriers were then weighted in terms of their importance based on the number of participants that mentioned them throughout the interviews.

Quantitative Method: GIS Analysis

GIS analysis is a useful tool, often employed in the study of health care access (Higgs, 2004; McLafferty, 2003; Phillips et al, 2000). The use of spatial analysis in relation to healthcare services is predominantly concerned with aspects of spatial access such as travel distances and waitimes, but can also be utilized to better understand non-spatial access factors and how they intersect (Phillips et al, 2000). The data gathered through the interview phase of this study helped to inform the spatial analysis of Phase 2. The use of a GIS analysis will result in a comprehensive understanding of spatial access factors in the provision of abortion services in Nova Scotia and the interconnection between relevant non spatial factors of access.

The GIS analysis was conducted through the use of ArcMaps 10.1. The study area consisted of the province of Nova Scotia. Census subdivision datasets from the National 2016 Census were retrieved from the University of Toronto Computing in the Humanities and Social Sciences database (http://dc.chass.utoronto.ca/), and converted into shapefiles which were imported into ArcMap 10.1. Additional datasets inputted into the analysis such as *Atlantic Ocean* and *Roads, Trails and Rails,* were downloaded from the Nova Scotia GIS database (https://nsgi.novascotia.ca/gdd/). A single spatial analysis was conducted as part of this project.

Two maps were created as a result of the analysis. The first map includes information regarding the prevalence of low income households across the province and the location and spatial accessibility of abortion services. Map 1 also includes the geographic location of both medical and surgical abortion sites in Nova Scotia provided from information gathered by gate keepers who

participated in the interviews. Sites were identified by the name of the municipality in which they are located. Income was highlighted throughout the interview phase as being one of the leading indcators of abortion access as it was mentionned by all eight interview participants. The prevalence of low income in the province was measured by the percentage of low-income private households within a census subdivision based upon the after-tax low-income measure (AT-LIM). AT-LIM is employed by Statistics Canada as a comprehensive measure in identifying low income households as they take into consideration household income after-tax and the number of individuals within each private household (Statistics Canada, 2012).A thirty-minute catchment area was overlayed onto the map, indicating the range of access of each abortion service. The thirty minute travel radius was created through Arc Pro, which analyzed thirty minute travel distances by car extending outside of the identified abortion sites. The catchment area is based upon Wang & Luo's (2005) study, which determined that those residing outside of the thirty minute radius, do not have adequate access to healthcare services. The second map created as part of this study, includes data for the 2016 Census regarding the population density of Nova Scotia, the location of both surgical and medical abortion services, as well as the NSHA Mangement Zones.

Chapter 4: Results & Discussion

Results

Semi-Structured Interviews

Participants

Nine (9) individuals who are actively involved in abortion provision and support services in Nova Scotia participated in this study. The majority were healthcare providers (4), including gynecologists, nurses and general practitioners. The remaining participants were employed in the legal sector (2) and the nonprofit sector (3). Several participants also had previous experience with government work in health administration. At the time of the interviews, all interview participants were currently involved in the provision of abortion, support services and advocacy for increasing abortion access across the province. Interview participants were located across the province, the majority concentrated within urban Halifax (5) located in the NSHA's Central Zone, and the rest located in rural areas within the NSHA's Northern and Western Zones. No individuals were available from the NSHA's Eastern zone for an interview. Throughout the interviews, participants identified barriers and challenges related to abortion access in Nova Scotia. These observations were then analysed through the use of an intersectional lens employed on a systems level. Participants also reflected on the impact of both the Canada Health Act and the NS DHW Framework on the operationalization of abortion access in Nova Scotia, and offered recommendations for how the state of abortion access could be approved across the province.

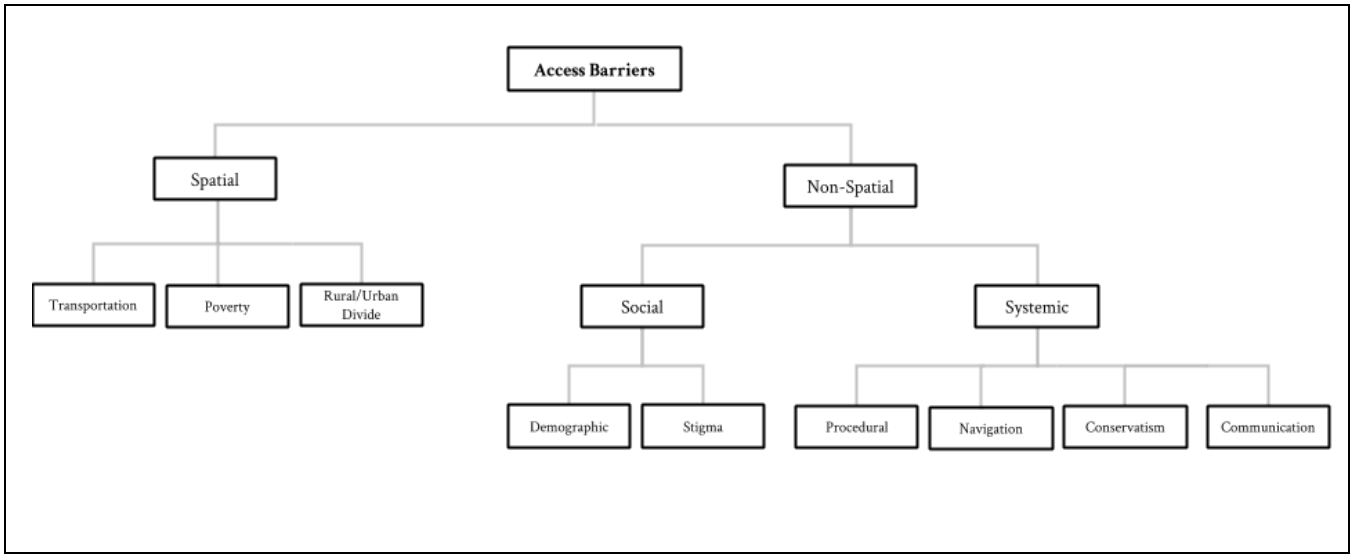
Emergent Themes: Access Barriers

Themes related to abortion access barriers that were prominently mentionned thoroughout the interviews were organized into two primary categories: spatial and non-spatial. The category 'Spatial' included three subcategories related to spatial barriers: transportation; poverty; rural/urban divide. Interview participants mentioned several different themes that were then listed under 'non-Spatial'. The 'non-Spatial' category was divided into two main categories: social and systemic. Both categories were then further divided into their own subcategories. The following categories were listed under systemic: procedural; navigation; conservatism; communication. Under 'social', both demographic and stigma were listed as categories. The organization of themes can also be seen

in Figure 3.

Figure 3:

Themes Identified by Participants Pertaining to Access Barriers



1. **Spatial**

Participants with relevant knowledge identified locations across Nova Scotia with abortion services (see Figure 4).

Figure 4

Locations of Abortion Services in Nova Scotia

Surgical Abortion	***Medical Abortion***
Bridgewater, Halifax, Kentville, Truro	Annapolis Royal, Bedford, Berwick, Bridgewater, Eskasoni, Greenwood, Halifax, Kentville, Meteghan, Sydney, Tantallon, Truro, Wolfville, Yarmouth

All surgical abortion sites are located within the NSHA's Southern Zone (2), the Central Zone (1) and the Western Zone (1). There is no surgical abortion available in the NSHA's Northern Zone. All of the surgical abortion sites also provide medical abortion. There are a total of 14 medical abortion providers located across the province. In Nova Scotia, both licensed physicians and nurse

practitioners are able to prescribe Mifegymiso (Stevenson et al., 2019). This network of abortion providers is constantly growing and is subject to change.

Transportation, rural-urban divide, and poverty were identified as being the most prominent themes related to spatial access barriers. Participants also noted that these barriers are closely linked.

1.1 Transportation

Barriers associated with transportation dominated many discussions aroundspatial barriers to abortion access. Many clinics require surgical abortion patients to have someone to drive them home after their appointment, and this can be a challenge for patients who may want to maintain privacy or otherwise cannot access a ride. Abortion Services Atlantic (ASA), is a non-profit organization that provides services for patients in need of a ride home, however not all are reported to be comfortable using the service. ASA operates on a volunteer basis, and cannot always meet the demand of patients requiring transportation. Furthermore, many patients live outside of the provision areas of public transportation and may face difficulties finding transportation to and from appointments and pre procedure tests. Transportation needs have also been noted by study participants to be directly associated with low-income areas and rural poverty, as not everyone can afford private transportation or has access to a vehicle. Furthermore, individuals living in rural areas may need to commute several hours to access abortion services, and may be required to pay for overnight lodging. NGOs such as ASA, Our House (Shelbourne, NS), Action Canada and the National Abortion Federation provide housing assistance for individuals requiring transportion, however, many are still left without access to transportation and consequently cannot access abortion services.

1.2 Rural-Urban Divide

There are significant access disparities in abortion access between urban and rural areas across the province. Access to abortion decreases based on an individuals rurality. For example, Abortion access is seen to be reasonably good within metro Halifax whereas outside of the city, abortion services are significantly less accessible. Those residing in regional centres or semi-rural areas like the Annapolis Valley and the South Shore region, face greater access than those within smaller isolated communities or sparsely populated areas. One informant described this matter as

"geographic marginalization", as individuals do not have access to other services facilitating their abortion access such as public transportation, and a concentration of medical services within their home community.

"If you live in Halifax I think abortion services are fairly well accessible but if you're in a rural area, it's definitely not the case" - M, healthcare.

1.3 Poverty

Informants described poverty as a significant barrier as it exacerbates geographic-related circumstances that impede access to abortion services. For example, those living in poverty are also those who are in need of transportation, and may live in underserviced areas.

"Overall in Nova Scotia, there remain really really significant wealth disparities...socioeconomic disparities. And we see that constantly playing out on the ground. I'm definitely struck by the poverty of a lot of the patients in family medicine." - L, service provider.

2. Non Spatial Barriers

A variety of factors were identified as impeding abortion access. They were broken down into the two following categories: systemic barriers, and social barriers. Sytemic barriers include obstacles present within the current healthcare system, in which the following subcategories were identified: procedural (pertaining to the procedures involved in obtaining an abortion); navigation (pertaining to an individual's ability to navigate the healthcare system); conservatism (the presence of socially conservative views within healthcare policy and operations); and communication (between service providers and patients). Social barriers included all other factors that exist outside of the healthcare system that can impede one's access to abortion services. Social barriers were divided into two primary categories: demographic and stigma.

2.1 Systemic Barriers

Figure 5

Examples of Systemic Barriers Cited by Participants
Procedural: wait times, time limits, insurance, fee for service policies, confidentiality (especially in rural areas), lack of primary care providers, overburdened healthcare system, physician's reluctance to provide abortion services (fear of ostracization)
Navigation: patient difficulties navigating the system, presence of gatekeeper through toll free number, language barriers, lack of standard procedure
Conservatism: 'right to refuse' policy, anti-choice healthcare practitioners, absence of policy on abortion access), fiscal restraints
Communication: patient mistrust of health care system, lack of public and practitioner knowledge regarding availbility of abortion services and suppourt services, poor between providers and poor provider-patient communication presence of gatekeeper (toll free number)

The systemic barriers that were most often identified by participants were: lack of primary care providers and standard procedure; lack of practioner and public knowledge regarding the availability of abortion servcies; poor provider-provider/provider-patient communication; fiscal retraints; the presence of antichoice practioners; reluctance of physicians to provide abortion servcices; patient difficulties navigating the system; long wait times; and clinic time limit policies. These are explained in more detail below.

2.1a Procedural:

" I want to ensure that every step taken is a medical necessity not just something that a bureaucrat or a policy writer thinks would be a good thing to have...." -R, service provider.

The majority of participants described current procedures surrounding abortion care as incredibly inefficient and barrier-enducing. Lack of insurance coverage for patients from out of province or without citizenship status, create financial barriers for individuals seeking abortion services.The Fee-for-service also creates barriers for those accessing abortion services. The fee-for-service model is a volume driven system in which physicians are paid based on the amount

of patients they see, versus a set salary (Bradley, 2018). In Nova Scotia, some physicians are paid through the fee-for-service model and while others are paid under the 'alternative payment plan' (APP), which offers physicians a guaranteed funding level and income stability (Doctors, Nova Scotia, n.d.). Depending on the payment method, certain abortion providers must provide a consultation with a patient prior to their abortion in order to get paid for their services. This creates an additional step for patients to navigate prior to obtain an abortion.

Different abortion providers have different policies regarding what testing is required prior to an abortion, and these testing requirements may require patients to attend multiple appointments before actually obtaining an abortion. Multiple appointments cause delays which is noted as being especially problematic for a time=senstive procedure like abortion:

"You have these timelines that happen very quickly especially if people are not aware that they're pregnant until maybe 9 weeks which happen sometimes or later, so that can really be a struggle to get the investigations done in time, like bloodwork and oftentimes an ultrasound before the next step can happen and then that next step might take a few days to a week to happen" -L, healthcare.

The lack of primary care practitioners across Nova Scotia paired with a high demand on health services and funding constraints, reduces the access for not only abortion services in Nova Scotia, but for all health services across the province. Family physicians are incredibly important for abortion services, as they are the first line of care a patient will receive. A strong trusting relationship between a patient and their primary care provider is critical, as it creates a safe space for patients to seek the services they need without fear of judgement. However, abortion often is not considered a priority in terms of necessary healthcare services, with many other required health services take precedent.

"we also have to realize that we are against the backdrop of a health care crisis where we do not have enough doctors in Nova Scotia" -R, support services.

Furthermore, participants acknowledged that many primary health care providers may be reluctant to offer abortion services for reasons beyond consciencious objection. As family doctors face pressure within the province to provide a broad range of services to numerous patients, many may be reluctant to provide abortion in addition to services they already offer. Furthermore, fear of ostracization both from their community and professional network due to the stigma of abortion services, may also reduce a potential provider's willingness to include abortion within their practice. Confidentiality concerns within small communities and rural areas were also noted as a factor that could impede one's willingness to provide abortion services.

"I think there must be stigma because I am afraid to talk openly about it like I don't really bring it up a lot or I wouldn't be prone to talk openly about it if I don't already know that my colleagues or the other people I with her are pro-choice or supportive. So definitely the stigma is still there around it." L, service provider.

2.1b Navigation:

Many noted that patients often have trouble navigating the system which may impede their access to abortion services. The lack of a standardized procedure regarding abortion makes it difficult for patients to take the necessary steps required before they can obtain an abortion, which often causes unnecessary delays. For example, certain providers require diagnostic testing such as an ultrasound or bloodwork to be completed prior to the intial consultation with the patient regarding their abortion, however others may offer the services during the first appointment.

"And we know that there is a window right that they need to be able to confirm that pregnancy. For them to get things lined up... And number one things keep changing... and they are changing what they need what they don't need... whether they need an ultrasound or not..."-R, suppourt services

Though the centralized toll-free phone line has been praised by many participants for aiding patients to navigate the system, others questioned the ongoing need for a gatekeeper. The centralized phoneline is available from 8am - 4pm, Monday through Friday, where patients can call

to self-refer for an appointment to see an abortion provider or ask any questions regarding their options for termination and access to abortion in their area (NSHA, 2020). Participants noted that making the information solely available via phone creates barriers for those who may not have access, or cannot safely call within the given time frame.

"When I Google abortion in Nova Scotia I should not have to be like a 'Google genius' going into the darkweb... The first thing that pops up should be the Health Authority (NSHA) with every clinic and every (hospital that offers abortion).You're on a website that tells you to phone the referral line. How about the website just gives you the information. Why does there need to be a gatekeeper?" -H, support services.

2.1c Conservatism:

Another sytemic barrier to abortion is the presence of social conservatism within healthcare policy and practices surrounding abortion services.Policies such as a healthcare practitioner's 'right to refuse', the lack of policy requiring regional hospitals to offer abortion services, and tolerance of practioner bias, impact a patient's access to abortion services. Several noted that bias against abortion is often more present within regional hospitals, as they are not specialized in abortion care and do not gurantee a pro-choice environment:

"They (healthcare practitioners) definitely see it as a moral issue and they feel that they're conscientious objectors and they can complain about it or present barriers to people"-M, healthcare.

Furthermore, many noted that the absence of pro-choice policy and lack of funding for abortion services across the province, also impedes a patient's access to quality abortion care. Fiscal restraints related to the funding of abortion services also impacts the quality of care that is available within the province:

"We would like to bring our clinic to national standard. I've been told that you can't. And again I am not a health economist and I'm not you know... I'm just on this level of frontline care. So I do

understand from my managers and stuff that they have their own pressures and finances.... But it is a bit frustrating"-L, healthcare.

Many participants also noted that although the presence of social conservative views present within the healthcare system remains an issue, it is not a limiting factor. Some noted that one of the reasons why abortion policy in the province hasn't progressed is the lack of public pressure and awareness of abortion inaccessibility within the NSHA and among healthcare practioners:

"So I don't see it as a priority in administration because I don't think they're aware that it's an issue...I don't think the NSHA as an organization is opposed to working towards that (increasing access) for abortion...you have to remember that the NSHA receives their funding from a politician… I just don't think it's (abortion) currently recognized as a high priority issue." -R, service provider.

2.1d Communication:

Poor communication practices were noted as creating a wide range of barriers to abortion. Several informants noted that many healthcare providers are simply unaware of the need for abortion services in Nova Scotia and that if informed, many would be more inclined to offer the service:

"...I think providers would be more impassioned if they realized how much of an issue access is."- R, service provider.

Others noted that the lack of awareness is partially due to stigma surrounding abortion services and challenges advertising the service. Such challenges make it difficult for providers to communicate with others within their professional network and provide their patients with options regarding abortion services close to home.

"Well you know it's hard with abortion to advertise...If you live just one community away from Sydney, you don't know any of the doctors in Sydney, let alone which ones prescribe Mifegymiso... If you're a doctor in Sydney, you're so busy and you don't have the time or security wise you don't advertise "Hey! I prescribe Mifegymiso, and if you have an unplanned pregnancy come in."- L, service provider.

Many emphasized the importance of the centralized phoneline as helping to mitigate issues of poor communication between providers and to better inform those seeking abortion services of their options closer to home. The centralized line also helps to protect the security of physicians working in areas where abortion may be heavily stigmatized. The majority of participants recognized the importance of the centralized line in eradicating access barriers associated with poor communication and low awareness. However, many noted that many healthcare providers and prospective abortion patients remain unaware of the existence of the centralized line. Furthermore, phone-based communication was also identified as barrier, as it may interfere with a patient's confidentiality, as they may not be able to safely make the phone call during the day or communicate privately with their abortion provider over the phone. Such communication practices can cause unnecessary delays which are especially problematic for those seeking abortion services, as it is constrained within a short window of opportunity.

"I think it's bad that we have to play telephone tag with patients...What we need to be doing is texting or emailing patients"- P, healthcare.

2.2 Social Barriers

Participants identified serveral barriers impeding abortion access that were directly related to the presence of abortion stigma and factors of a prospective patient's identity. Income, sexual orientation and gender identity, and social conservatism were noted by participants as being the most prominent social barriers related to abortion access.

Figure 6

Social Barriers Impeding Abortion Access in Nova Scotia
Demographic: age, income, mental health status, homeslessness, sexual orientation, gender identity, citizenship status, province of origin
Stigma: social conservatism, discrimination based on health status (pregnancy), stigmatized populations (homeless, gender & sexual minorties)

"Oftentimes it's the people who have difficulty accessing healthcare that are the ones that don't have somebody fighting for them"- R, healthcare

Stigma and fear of ostracization from loved ones or community members create access barriers both for those needing the healthcare service and for those providing services.. Informants noted the vulnerable position patients are put in when attempting to access abortion services, and the importance of ensuring patients have access to abortion services within a safe environment. Gender minorities, in particular, were noted to face significant challenges accessing culturally competent abortion services. Several informants spoke of the presence of anti-choice activism occurring across the province and how it shames individuals for exerting their reproductive rights, and in turn impedes abortion access:

"You will see people protesting against abortion and that creates a situation where it's very stigmatized and makes them think that they can't access".-M, healthcare.

However, the perception of stigma, many noted is stronger that the actual presence of anti-abortion advocates across the province. Though informants acknowledged the presence of anti abortion stigma, they also recognized that the anti-choice movement in Nova Scotia isn't particularly strong, even in rural areas, and that many community based organizations across the province exist to help support those seeking abortion services. The perception of abortion stigma impacting the career and wellbeing of physicians that include abortion in their practice, was also

seen as being more prominent than threats that actually occur. Several noted that the perception of abortion stigma creates more of a barrier than abortion stigma itself.

Participants noted that many social barriers intersect with systemic barriers. For example, procedural barriers such as 'fee for service' policies and lack of coverage for patients without citizenship status or from out of province, actively discriminate against those who are financially marginalized. System navigation was also noted by participants as additionally challenging for those who speak limited English or who suffer from mental illness. Gender and sexual minorities also face added difficulties accessing culturally competent care. Participants also indicated that anti-choice views among healthcare practitioners were especially an issue within regional hospitals as they are not specialized in abortion services as an abortion clinic or private practice may be, and are therefore not a guranteed safe space for patients seeking abortion services. However, others noted that these perceptions are often overstated and are not a common occurrence.

Canada Health Act & NS DHW Framework for a High Performing Health & Wellness System

Definitions of accessibility within both the CHA and the NS DHW's Framework were seen as being ineffective in ensuring and operationationalizing abortion care in Nova Scotia. Participants noted significant limitations surrounding the accessibility criteria of the CHA and the use of the phrase 'where and as available'. Informants noted the vague language employed through the CHA, and how it is challenging to decipher exactly what the Act is stating. Many noted that the vagueness of the language makes it difficult for the public to hold the government accountable for anything specific. Others noted that the clause "where and as available", questions the implementation of the 'accessibility criteria'. Though the CHA has been used to ensure healthcare rights of individuals in the past, Constitutional Law is seen as a more effective tool in holding the government accountable for providing healthcare services that are accessible. For example the division of powers between the provincial and federal government and the Charter of Rights and Freedoms have both been used as legal tools in court proceedings in both New Brunswick and Prince Edward Island. Several

participants noted that the fight for abortion services in both provinces directly impact the legal climate surrounding abortion provision and reproductive rights in Nova Scotia.

'They mean that if it's not really accessible in your areas, then it is 'equitable unaccessible' - M healthcare.

"The policy is strong from a bureaucratic standpoint, but that doesn't mean it's strong for us (the community)... for the patient. It's government policy, it's vague and it's safe from a bureaucratic perspective... it's hard to poke holes into"-R, support services.

""If "where and as available" is kind of the general rule, it's not a very high standard to live up to", -J, support services

The NS DHW Framework was seen by participants by providing a good standard to strive towards in terms of accessible abortion services, however as it has no authoritiative or legal power, it is ineffective in actually ensuring a quality standard of abortion access across Nova Scotia. Some participants spoke of how the framework can be used to guide a private practice, but noted that it is not being implemented within public healthcare services.

"I think as an individual practitioner in this framework, you could probably finesse your practice to some degree but on a systems level this is not health authority policy."- M, healthcare.

"You know it's a great policy on paper but not something that is translating into action on the frontlines of health care delivery." -R, support services.

Abortion access in urban Halifax was noted by participants as being relatively good while abortion access in many parts of the province remain poor. Such access disparities led many to critique the NS DHW's quality framework, stating that equitable access to abortion services is not being operationalized across the province:

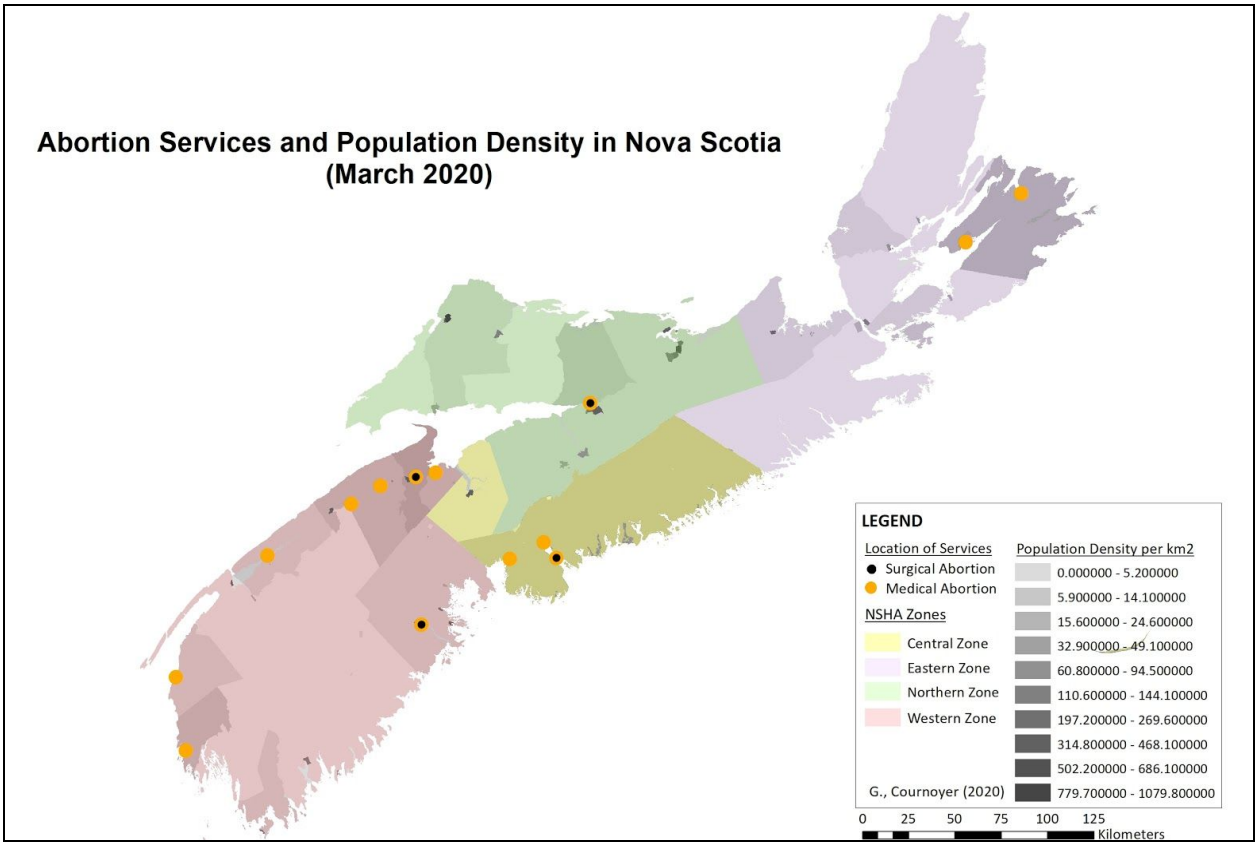
"If you are from a small town in Nova Scotia, you're going to get the same amount of health care as a person living in downtown Halifax? I've yet to see that translate in any part of our work."- R, support services.

"I think the lived experience of people that are just geographically marginalized or financially marginalized is their lived experience... I would not say they have reasonable access." - M, healthcare.

GIS Analysis

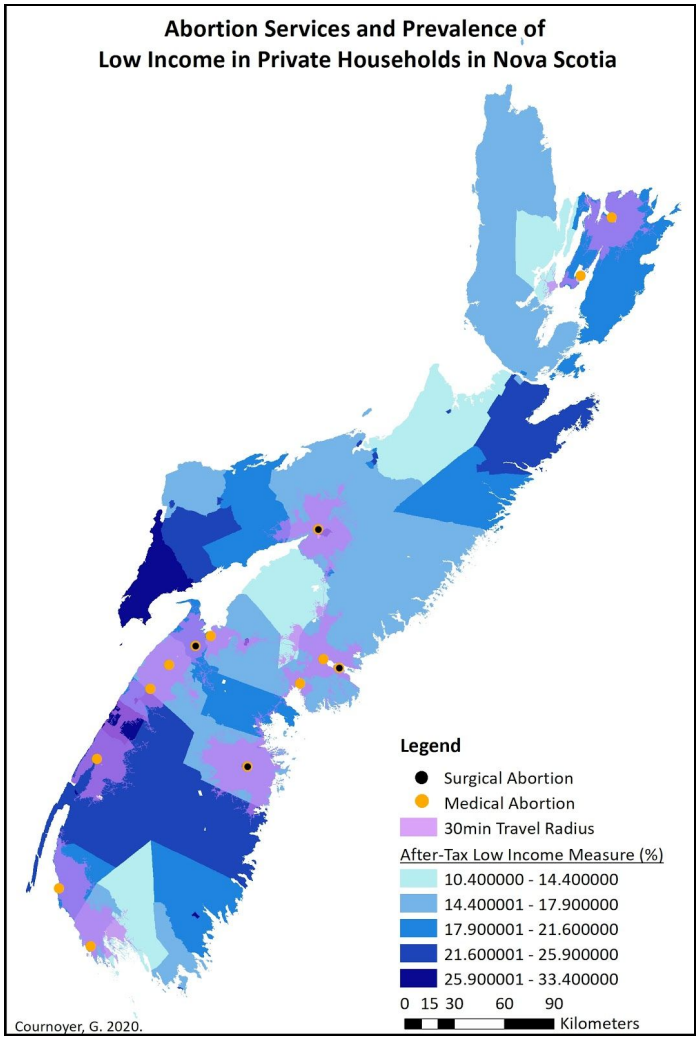
Figure 7

MAP 1



The GIS analysis identifies the presence of significant access disparities in Nova Scotia, where those living outside of regional centres offering surgical abortion services face significant disparities related to abortion access. All surgical abortion is within a 100km radius from Halifax, concentrating the access to surgical abortion services to a central part of the province. Surgical abortion services are predominantly located in more affluent areas of the province (see Figure 7). However, as other affluent areas of the province also remain underserviced, it is difficult to determine a direct correlation between LIM-AT and the absence of abortion services. Abortion remains inaccessible, based on the 30-minute travel radius, to a large portion of the province. Those residing in areas away from larger regional centres, face particularly significant access barriers causing geographic marginalization. There are greater disparities in surgical abortion access as medical abortion is more widely available across the province due to the low ressources it requires and broader network of providers.

Figure 8 ***MAP 2***



The highest standard of abortion access in Nova Scotia is located within urban Halifax. Abortion is quite accessible in urban Halifax as the area is well serviced, with services located along bus routes and in close proximity to those requiring the service. Urban Halifax also contains the highest population density than elsewhere in Nova Scotia, however those living within the wider HRM, do not have the same access to abortion services. Those living along the Eastern Shore of Nova Scotia face significant access barriers as compared to their counterparts living in urban HRM (see Figure 8). Other areas with high population density such as Cape Breton Island and areas surrounding Yarmouth, face significant inaccess to surgical abortion services.

Recommendations

"I want (abortion) to be treated like healthcare... like any other piece of health care…"
-H, support services

Participants gave several recommendations on how to improve abortion access in Nova Scotia. Increasing access to primary care practioners across the province and normalizing abortion within mainstream healthcare services were the most prominent recommendations made by participants. Allowing nurses and pharamacists to prescribe Mifegymiso to those seeking medical abortion was also mentioned by many as a way to improve access to medical abortion. Introducing standardized abortion procedures across the province, which is comprised of a single appointment where patients are able to complete the neccesary pre-abortion tests and obtain an abortion within the same time frame, was seen to reduce many barriers associated with system navigation, travel and time constraints. Increasing staffing ressources to the centralized line and providing more information on the NSHA website would also increase patient access to abortion services. Normalizing abortion services within the healthcare system by ensuring that the healthcare service is available in all regional hospitals and advertising the availability of the service to raise physician and public awareness, would also help reduce the stigma surrounding abortion. Providing universal access to contraceptives such as intrauterine devices (IUDs), and increasing access to quality sex education, was seen to be a preventative measure that could help reduce the demand for abortion services across the province.

Discussion

The findings of this study reveal that there are significant access disparities to abortion services in Nova Scotia which are perceived to be caused by a variety of barriers, the majority of which are products of policies and operations of the public healthcare system. Current legislation and guiding frameworks that address healthcare access are viewed to be ineffective in operationalizing access to abortion services across the province, and stronger policy and legislation are required to ensure that Nova Scotians are provided with equitable abortion access.

As access is defined throughout the literature as 'one's ability to obtain a required healthcare service', (Khan & Bharwaj, 1994), this study has shown that many Nova Scotians face significant barriers accessing abortion services. The state of abortion access in Nova Scotia is inequitable, as those living within 100km of Halifax are better resourced than those living further from the urban centre. Informants identified a variety of both spatial and non spatial barriers contributing to disparity of abortion access across the province, which intersect with one another in an aggravating manner. Those who face more barriers are more likely to be geographically marginalized, living further away from urban Halifax. That being said, many individuals that reside outside of the broader HRM, particularly those along the Eastern Shore, also face access disparities despite their closer proximity to Halifax.

The state of access in Nova Scotia echoes many rural abortion access issues that are mentioned throughout the literature. The prominence of the rural-urban divide, rural poverty, and the lack of primary care providers are all factors frequently mentioned as impeding abortion access in rural Canada (Dressler et al., 2013; Sethna & Doull, 2013). Primary care providers residing in rural areas are often reluctant to add abortion to their practice, due to the limited resources and growing pressure placed upon by a growing demand for a wide range of healthservices (Dressler et al., 2013). The lack of primary care providers across the province was acknowledged by the majority of participants as being detrimental to abortion access in Nova Scotia. However, the shortage of primary care in Nova Scotia was not only recognized as impeding access to abortion, but to all healthservices across the province. Informants emphasized that the current healthcare system is under significant pressure and that due to many other healthcare needs that are prioritized over abortion service, improving abortion access in Nova Scotia is often overlooked. The majority of

barriers mentioned by participants were intersectional. For example, economic barriers are seen as an aggravating factor that mitigate abortion access (Doran & Nancarrow, 2015; Erdman & Cook, 2006; Sabourin & Burnett, 2012; Sethna & Doull, 2013). Poverty was identified by informants as intersecting with transportation needs, rurality, low proximity to available healthcare services. Furthermore, obtaining an abortion in Nova Scotia also requires an individual to make time, often over the course of several days, expanding weeks at a time. This raises significant questions regarding financial ability to take the time off work, pay the cost of travel and accommodation if required, and also potentially paying for childcare is necessary. Those who cannot afford to do so, are not able to obtain access to the required health service. Abortion in Nova Scotia is therefore less accessible to those who are financially and geographically marginalized.

Systemic barriers present within current healthcare operations are also acknowledged as being obstructive to abortion access (Sabourin & Burnett, 2012). Structural barriers present within the current healthcare system were widely acknowledged by informants as creating unnecessary barriers to abortion. The under utilization of mid level healthcare practitioners such as nurses and pharmacists is causing significant barriers to medical abortion. The lack of political action and policy specifically addressing abortion access in Nova Scotia creates systemic barriers, as current legislations and frameworks are ineffective in operationalizing abortion access. Both the CHA and the NS DHW Framework fail fail to impose clear guidelines on how to ensure the accessibility of abortion services across the province. Though the CHA addresses healthcare access and has legal bearing, the use of vague language gives the legislation weak operational impact, as it fails to ensure access to healthcare services on the ground, and rather protects government interests from being held publicly accountable for failing to do so. In the case of New Brunswick, financial sanctions have been applied by the federal government in order to pressure the province to increase abortion access in the province, however these measure have been unsuccessful as abortion access across the province continues to be sparse (Jones, 2020). The use of Constitutional Law such as the Charter of Rights and Freedoms and the division of powers listed under the constitution of 1867 have been significantly more effective in ensuring abortion access across Canada. The decriminalization of abortion in 1989, used section 7 of the Charter, the right to life, liberty and security of the person, to persuade the courts (Mckenna, 2018). In 2016, the fight for abortion on Prince Edward Island

was won, as advocates challenged the province in court for defying section 15 of the Charter that protects an individual's right to equality, stating that provincial policy actively discriminates against women for failing to provide abortion services on the island (Mckenna, 2018).

Though the NS DHW's Framework is seen as a better operational tool to guide health care practices, due to its lack of legal standing, it cannot be used to hold governing bodies accountable for failing to provide accessible healthcare services. Both pieces are therefore impotent in ensuring actual healthcare access as they cannot be utilized by the public to hold governments accountable for failing to do so. Systemic barriers such as the failure to provide abortion services in regional hospitals, ineffective communication practices among service providers, the lack of provider awareness regarding abortion access, the lack of standard abortion procedures, and a lack of funding in ensuring abortion services are indeed accessible across the province, could all be mitigated through stronger healthcare policies and operations that actively addresses abortion access. Failing to do so reflects government neglect in fulfilling the healthcare needs of Nova Scotians. Significant systemic change is required in order to ensure equitable abortion access is established across the province, as current practices are barrier enducing rather than barrier free. Efficient patient-centered healthcare models are advocated for by those actively working to address abortion inaccess across the province. Such approaches to healthcare address the unique healthcare needs of individuals, providing them with equitable access to the healthcare services they need.

LIMITATIONS

Several limitations of this study should be mentioned. There was little representation from North Eastern Nova Scotia, as only a single informant was from the area. As this study only interviewed those working in abortion access, the findings are only indicative of barriers identified by those working within the sector of abortion provision and support services and not those experienced or observed by individuals seeking abortion services. Due to the lack of patient feedback received by those interviewed, many indicated that there may be multiple other barriers that they may not be aware of. None of the participants could comment on access barriers specifically facing racialized populations such as migrants/refugees, Mi'kmaq and other Indigenous peoples, and members of the African Nova Scotian community.

Further study is recommended for identifying abortion access that impact marginalized populations across Nova Scotia, particularly those pertaining to racialized groups and gender-minorties. Furthermore, scholarship on the experiences of those accessing abortion services within thprovince is also recommended.

Conclusion

This study provides an overview of the state of abortion access, identifies significant barriers related to abortion access and evaluates the effectiveness of legislation and frameworks that address healthcare access that are applicable to Nova Scotia. Barriers to abortion access identified throughout the literature parralleled many of the finding of this study. Geographic marginalization, economic status, abortion stigma and systemic barriers present within the current healthcare system create significant barriers facing those seeking to access abortion services within Nova Scotia. Current legislation and frameworks that specifically address the topic of healthcare access have proven to be ineffective in ensuring the operational access of abortion services in the province. As no former studies have been conducted on the state of abortion access within the Nova Scotians, the findings of this study are an important introduction to the state of abortion access in the province. However, further research is required to fully understand the complexity of barriers facing those seeking abortion services and to develop solutions that ensure equitable access to abortion services in Nova Scotia.

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Appendix I

SUST 4900: Interview Guidelines

BACKGROUND:The information gathered as part of this interview will help inform my honours thesis in Environment, Sustainability and Society as part of my Bachelor of Arts. My thesis is focused on abortion access in Nova Scotia in which my primairy research question are as follows:

- *How is the 'accessibility' of healthcare services operationalized through the provision of abortion services in Nova Scotia?*
- *How effective are guiding legislation and frameworks such as the 'Canada Health Act' and the 'Quality Framework for a High Performing Health and Wellness System in Nova Scotia' in ensuring the access of health services such as abortion?*

By examining the ways in which the accessibility of abortion services are being operationalized in Nova Scotia, this study seeks to provide a clear picture depicting the availability of abortion services across the province and the influence of guiding legislation and framework.

****All informants to this research will remain anonymous and the information gathered will be used solely to provide a context for the research project. The details and specifics of the informant's answers will be altered in order to ensure their anonymity. Informants will be asked questions based on their professional opinion/experience. Information regarding personal opinion/experiences will not be utilized in the research as it would violate Dalhousie's Research and Ethics Board Guidelines.*

ETHICS APPROVAL WAS NOT REQUIRED FOR THIS PROJECT AS STATED UNDER SEC 2.5 OF THE TRI-POLICY STATEMENT FOR ETHICAL CONDUCT FOR RESEARCH INVOLVING HUMANS (TCPS2 2018).

Interview Questions:

1. (Interview Profile) Please describe your role in relation to abortion services in Nova Scotia.
   *probes: geographic range, how long in this role.
2. (Opening) What letter grade would you give abortion access in Nova Scotia? Please explain.
3. What do you see as being the greatest challenges to abortion access in Nova Scotia?
4. (If applicable) How would you describe the geographic aspect of abortion services in Nova Scotia?
5. [provide sheet with these written out] Having read selected definitions of guiding legislation and frameworks such as the 'Canada Health Act' and the 'Quality Framework for a High Performing Health and Wellness System in Nova Scotia' , how do abortion services in Nova Scotia meet these definitions?
   *probes: How are they operationalized?
6. How are issues of abortion accessibility currently being addressed within the Nova Scotian context?
7. What would be your vision for making abortion services accessible in NS?

Appendix II (Part 1 of 3)

Nova Scotia Quality Framework for a High Performing Health and Wellness System in Nova Scotia

Serves to guide the quality of the healthcare system

"The Quality Framework for a High Performing Health and Wellness System in Nova Scotia serves as a lens or guide to quality. The framework can provide a common vision and approach for Nova Scotia's health and wellness system. When applying the framework, focus on the quality dimensions most applicable to your situation. You may wish to adopt the framework or adapt it to develop locally relevant tools and strategies."

1. Respectful of Diversity and Equity: Providing services that are fair and respected
2. Accessible: Providing Timely Services

Canada Health Act Criteria

Requirements that provinces/territories must fulfill in order to qualify for the full amount of funding under the CHT.

1. Universality (section 10)
    a. Under the universality criterion, *all insured residents of a province or territory must be entitled to the insured health services provided by the provincial or territorial health care insurance plan on uniform terms and conditions.* Provinces and territories generally require that residents register with the plan to establish entitlement.
2. Accessibility (section 12)

    The intent of the accessibility criterion is to ensure that *insured persons in a province or territory have reasonable access to insured hospital, medical, and surgical-dental services on uniform terms and conditions, unprecluded or unimpeded, either directly or indirectly, by charges (extra-billing or user charges) or other means (e.g., discrimination on the basis of age, health status or financial circumstances).*

    Reasonable access in terms of physical availability of medically necessary services has been interpreted under the Canada Health Act using the "where and as available" rule. Thus, residents of a province or territory are entitled to have access on uniform terms and conditions to insured health services at the setting "where" the services are provided and "as" the services are available in that setting.

APPENDIX II (Part 2 of 3)

Accessible

Providing timely services

What does this look like in practice?

- Continue to develop methods/models to help people get services when they need them.
- Ensure services are available in a suitable setting and when possible in a reasonable time and distance.
- Provide services that are easy for people to get to and use (for example, physically barrier free, well-designed spaces).

What are the desired outcomes for people receiving services?

I can get safe, quality health and wellness services when needed.

Appendix 2 (Part 3 of 3)

Respectful of diversity and equity

Providing services that are fair and respectful to all

What does this look like in practice?

- Promote, value, and respect the healthcare rights of all citizens regardless of age, education, income, race, disability, geography, language, sexual orientation, gender, gender identity, and faith perspectives.
- Work collaboratively to reduce avoidable health disparities and promote health equity for all.
- Use a needs-based focus for the provision of services, so that those with the greater need receive greater access to culturally competent, culturally specific, and culturally safe services.
- Understand and respond to the needs of diverse and marginalized populations.

What are the desired outcomes for people receiving services?

I know my healthcare rights; they are recognized and supported. I am confident that decisions are made to improve the health of all Nova Scotians and reduce avoidable health disparities.