EXPLORING THE EXPERIENCES OF MIDWIFERY-LED MEDICATION ABORTION CARE IN ONTARIO, CANADA: AN INTERPRETIVE DESCRIPTIVE STUDY

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LAY ABSTRACT

Quality abortion care improves the lives, health, and wellness of reproductive-aged people. Abortion is time-sensitive and people face barriers to this care. Reproductive-aged people benefit from healthcare systems that make abortion simple, safe, and effective. Internationally, midwives play a significant role in abortion care by delivering comprehensive services within sexual and reproductive healthcare. In Canada, however, the potential of midwifery in providing abortion care has not been fully realized. As an exception, Ontario's Expanded Midwifery Care Models (EMCMs) - innovative sexual and reproductive healthcare delivery programs - have made it possible for midwives to provide abortion services. Midwifery-led abortion care in EMCMs includes providing early abortion care in ways that make it easier for people who find it difficult to access care. This research explores and compares the personal and professional experiences of medication abortion care delivered by midwives across three regions in Ontario.

ABSTRACT

The World Health Organization, the International Confederation of Midwives, and the Canadian Association of Midwives advocate for the inclusion of comprehensive abortion care within midwifery practice. International evidence shows positive outcomes in terms of efficacy, safety, acceptability, and post-abortion contraception uptake when midwives provide abortion services. In Canada, midwifery services are available across various populations, including urban, rural, remote, and Northern areas, suggesting a potential to enhance access and quality of abortion care, particularly for underserved people. Expanding the role of Canadian midwives to include comprehensive abortion care could improve accessibility, address gaps in service provision, support community needs, ensure professional sustainability, foster interprofessional collaboration, and offer continuity of care. Since 2017, the Ontario Ministry of Health has funded Expanded Midwifery Care Models to support midwifery integration, interprofessional collaboration, and delivery of midwifery-led sexual and reproductive care that is not funded under the current payment model. This research explores the individual and shared experiences of midwifery-led medication abortion delivered through Expanded Midwifery Care Models across three distinct regions in Ontario. The study employs interpretive description methodology to understand how midwifery influences the experiences of medication abortion for midwives, collaborating healthcare professionals, and clients. The methodology focuses on exploring how integrating a midwifery model of abortion care supports medication abortion services and promotes Reproductive Justice within primary care settings. By gathering insights from multiple perspectives, the findings hope to inform clinical practice, interest policymakers, and identify outcomes valued by midwives, clients, and healthcare professionals for future research on midwifery-led abortion care.

ACKNOWLEDGEMENTS

I am grateful to be able to live, work and conduct my research on the traditional and current lands of Indigenous Peoples of the Fort William First Nation, Signatory to the Robinson Superior Treaty of 1850, on land protected by the Dish with One Spoon Wampum agreement created to bind the nations of the Haudenosaunee Confederacy to the Great Law of Peace, and on the traditional territory covered by Treaty 13 signed with the Mississaugas of the Credit on the traditional territory of many nations, including the Anishinabek people, the Chippewa, the Haudenosaunee, and the Wendat peoples and now home to diverse First Nations, Inuit and Métis peoples. In my work and research, I strive to listen deeply to people facing discrimination, oppression, and racism experiencing social and ecological barriers to health to provide better care, advocacy, and allyship.

I want to thank my supervisor, Dr. Liz Darling, RM, Ph.D. (Director/Assistant Dean, Midwifery Education Program, Associate Professor, Department of Obstetrics and Gynecology, Associate Member, Department of Health Research Methods), who supported this research in its design, undertaking, analysis, and synthesis. Thank you to my committee members, Dr. Susan Jack, RN, Ph.D. (Professor, School of Nursing, Associate Member, Department of Health Research Methods), and Dr. Meredith Vanstone, Ph.D. (Associate Professor, Department of Family Medicine), for offering this study a broader perspective within qualitative research design and healthcare research and supporting the development, conduction, rigour, trustworthiness, and completion of my thesis. My committee members' expertise, feedback, and encouragement helped shape the data into practical knowledge and new insights to advance Reproductive Justice and midwifery practice.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF ABBREVIATIONS AND SYMBOLS

ACNM	American College of Nurse-Midwives
βHcG	Beta human chorionic gonadotropin
CAM	Canadian Association of Midwives
CHC	Community Health Centre
CMO	College of Midwives of Ontario
EMCM	Expanded Midwifery Care Model
FHT	Family Health Team
ICM	International Confederation of Midwives
MAB	Medication abortion
RM	Registered Midwife
MD	Medical Doctor
NP	Nurse Practitioner
SRHC	Sexual and reproductive healthcare

LIST OF APPENDICES

DECLARATION OF ACADEMIC ACHIEVEMENT

I, Rebecca Joan Hautala, am the primary author and responsible for all data collected for this study. My thesis committee members, Dr. Liz Darling, Dr. Susan Jack, and Dr. Meredith Vanstone, supported this project's study design, data collection, analysis and synthesis, and manuscript writing.

Chapter 1: Introduction and background

Access to safe abortion is essential to health. Quality abortion care improves the lives, health, and wellness of reproductive-aged people. Even though accessing abortion services is time-sensitive, people who need abortions face barriers to care. Reproductive-aged people benefit from healthcare systems that make abortion simple, safe, and effective. However, many people living in Canada who need an abortion continue to face intersectional discrimination and barriers to care. Internationally, midwives are contributing to safe abortion by providing comprehensive abortion care as professionals in sexual and reproductive healthcare delivery. In Canada, the potential of midwives to provide comprehensive abortion care has not yet been fully realized. Ontario's Expanded Midwifery Care Models - innovative sexual and reproductive healthcare delivery programs - are broadening midwifery services to include abortion care. This consists of the development and delivery of services to reach populations with barriers to accessing quality sexual and reproductive healthcare. This research explores and compares the personal and professional experiences of medication abortion care delivered by midwives across three regions in Ontario while seeking to understand what makes midwifery-led abortion care valuable.

Historical overview of medication abortion in Canada

Canada is one of the few countries where abortion is considered essential and treated as a regular part of reproductive health. In 1998, abortion was decriminalized in Canada and struck from the criminal code as unconstitutional. (1–3) The Canada Health Act indirectly protects abortion rights by mandating funding and accessibility for all essential healthcare "without financial or other barriers." (2–8) Under the International Covenant on Economic, Social, and Cultural Rights, which Canada is a signatory, reproductive people are entitled to accessible

abortion care as a fundamental element for fulfilling the human right to health and well-being. (3,5,6) Canadian law has policies enacted to protect abortion, such as considering clinic abortion services as medically necessary, thereby recognizing abortion as vital to reproductive health and requiring provinces and territories ensure abortion care for residents. (8) Provinces and territories individually govern how abortion care is delivered; all have deemed abortion medically necessary and use a combination of federal and provincial funds to cover the costs of abortion services for residents. (3,9,10) The only law currently in violation of the Canada Health Act restricting abortion access occurs in New Brunswick: despite having only three hospitals that provide procedural abortion care, Regulation 84-20 in the Medical Services Payment Act limits funded procedural abortions to hospitals, thus preventing independent clinics from providing provincially-funded procedural abortions. (11)

Equitable access to abortion is crucial for improving the social, economic, and overall health and well-being of reproductive-aged people. (12–16) The World Health Organization's *Abortion Care Guideline* asserts that abortion must be timely, affordable, geographically reachable, person-centred and of equal quality despite social and economic determinants of health. (17) Access to abortion depends on the availability of enough trained healthcare professionals willing and able to offer the care. (12,18) Barriers to receiving quality abortion care include legal restrictions, lack of social support, delays in seeking care, negative attitudes from healthcare workers, discrimination within healthcare systems, low socio-economic status, and poor quality of services, impacting abortion access, experiences, and outcomes. (13) Disparities in abortion access are intensified by intersecting factors such as stigma, discrimination, racism, ability, gender identity, sexual orientation, and geography. (14,15,19–22) Furthermore, the political and cultural stigma surrounding abortion and a lack of trust in the healthcare system are

significant barriers for underserved populations in many places. (2,12,23–27) To improve equitable access to abortion, healthcare needs to address impeding social-ecological factors, for example, providing transportation and childcare to make attending appointments easier, facilitating interpretive services, extending clinic hours, locating services closer to where people live and work, ensuring a welcoming and culturally safe practice environment, offering care through outreach services, and partnering with community groups and organizations. (25,28)

Access to abortion remains a human rights issue across Canada. (2,14) Geographical location is the most common barrier to accessing an abortion, and increasing the availability and accessibility of abortion services can expand access for all people regardless of where they live. (2,4,29,30) Before the approval of mifepristone and misoprostol for medication abortions in 2015, most abortions across Canada were performed procedurally and only by medical doctors at fewer than 100 facilities primarily located in larger urban centres. (29–31) As of 2012, there were fewer than 300 physicians offering abortion services in Canada. (30) For procedural abortions, many Canadian hospitals have a 12-week gestational duration limit based on the availability of clinicians with the skills required and the availability to manage the potential for complications that may arise with abortions at more advanced gestational durations. (2) Concern for the inadequate and inequitable access to abortion in Canada is expressed in the literature, such as the 2016 report from the *Committee on Elimination of Discrimination Against Women*, the United Nations Human Rights Commissioner calling the government of Canada to improve abortion access and the 2023 submission by Action Canada for Sexual Health & Rights in partnership with stakeholders across Canada to submit recommendations to the Universal Periodic Review at the United Nations Human Rights Council outlining how Canada is failing to provide equal access to abortion. (14,16,32–35)

In July 2015, Health Canada approved the combined prescription of mifepristone and misoprostol for use in medication abortion, with a proven history of success, safety, and satisfaction globally. (17,29,36) Although the prescription for mifepristone and misoprostol became publicly available in Canada in January 2017, initially, there were mandated limitations such as physician-only prescribing and dispensing, registration with the manufacturer, compulsory online training, and requiring obstetric ultrasound to rule out ectopic pregnancy or pregnancy of unknown location. (17,22,29,37–39) These regulations were considered unconstitutional by the physicians required to follow them, the company approved to import and distribute the drug, and allied healthcare workers, activists, and advocates who supported Reproductive Justice and human rights. (3,31,40–43) As such, the manufacturer and distributor of the medication abortion prescription, Celopharma Inc., applied to Health Canada to change the distribution and administration of the medications. By November 2017, the restrictions were removed (44), resulting in a globally unique practice of allowing non-physician medical professionals such as nurse practitioners to prescribe, any pharmacist to dispense, and abortion-seeking people to take the medication abortion prescription autonomously. (4,31,34,45–48) Canada's regulatory approach facilitates self-managed medication abortions with the support of healthcare, where people manage some or all of the following components of care: self-assessment of eligibility, self-administration of the medications, choosing where and when to have the abortion outside of a healthcare centre, and self-assessment of completion. (31,49–51) Access to safe, timely, affordable, and personalized medication abortion is supported by enabling people to organize part of their care. (49,50)

By early 2019, medication abortion prescriptions were funded in every province and territory across Canada, protecting abortion rights for residents and guaranteeing interprovincial

coverage for residents travelling, working, or studying out of their home province but within Canada. (31,52) However, the prescription is not funded for uninsured Canadians and people without valid provincial or territorial health insurance. (14,53)

As the prescription for medication abortion was not widely funded until 2019 and few healthcare professionals were able to provide medication abortion services, most abortions in Canada have been procedurally performed. (4,4,16,34,54,55) People living in urban centres have better access to abortion, in part because of the availability of more primary healthcare professionals offering care, freestanding sexual and reproductive health clinics, and more hospitals providing abortion services, compared to those from northern, rural and remote communities. (29,55–59) Many Canadians needing an abortion have incurred and continue to face substantial financial costs, limiting time delays, and significant social burdens. With the unrestricted approval of mifepristone and misoprostol for medication abortion, access to timely abortion appears to have improved, human rights seem better respected, and experiences of pregnancy termination can be viewed as more person-centred. (3,4,22,60) A study linking population-based administrative health data to create a cohort of reproductive-aged female residents in Ontario who had abortions from January 2012 to March 2020 compared trends in incidence before and after the medication abortion prescription's approval and funding. The research found that the overall abortion rate remained stable despite a rapid rise in the number of medication abortions (from 2.2% to 31.4%), with no increase in complications or adverse outcomes. (4,31)

Medication abortion is chosen by people who want to avoid surgery, who consider the method more natural and private, and for those without reasonable access to procedural abortion services. (61–65) Thus, many first-trimester abortions in Canada are now medical and self-

managed within supportive healthcare systems. (22,30,54,66,67) The call for 'no-touch' or 'low-touch' abortions has increased because of the COVID-19 pandemic, and international professional associations have published guidelines for medication abortion care delivery by telemedicine. (13,68–72) In Canada, the Society of Obstetricians and Gynecologists of Canada released guidelines that waived the need for ultrasound dating and other in-person tests, supported by studies showing telemedicine abortion care is safe, effective, and highly acceptable. (73–77) Primary healthcare professionals across Canada now commonly deliver medication abortion services through a combination of in-person and virtual visits to support taking mifepristone and misoprostol for medication abortion where and when someone chooses, with access to healthcare as wanted or needed. (31,49,63,78) This model of providing self-managed medication abortion has the potential to address inequities in access by expanding the number and location of abortion providers, making the process more convenient, private, and person-centred, and respecting human reproductive rights. (13,31,71,74,75,78)

Despite the established benefits, the general lack of restrictions, and the increase in telemedicine services, equitable access to medication abortion in Canada remains complex. (22,37,79,80) Canadians face obstacles such as varying provincial regulations, healthcare professionals refusal or reluctance, poor availability of services, travel from remote and rural locations, over-medicalization of procedures, and access disparities from intersecting factors such as language, knowledge, race, gender, insurance status, and socioeconomic issues that limit or prevent timely care. (14,16,18,28,29,55,55,81–83) Improving the accessibility and acceptability of abortion needs to include routinely training healthcare professionals and allied healthcare workers in medication abortion, regulating the quality and provision of comprehensive abortion care, improving post-abortion follow-up, and expanding the type of

professionals providing abortion care, e.g., including midwives. (79,84–88) Comprehensive abortion care is an essential health service, and removing barriers protects the lives, health, and human rights of those needing an abortion (17,84,89,90). Having well-trained and willing healthcare professionals and allied healthcare workers within supportive systems that embrace building collaborative healthcare teams, networks, and cultures of safe care can support better abortion experiences, improve outcomes, and protect sexual and reproductive health. (17,86,91)

Glossary of terms and concepts

My thesis uses inclusive language, unless referencing a direct quote, to acknowledge all people, including those who identify as gender nonbinary and transgender, who have abortions. In addition, healthcare professionals use the terms *patient* and *client* to describe the person accessing healthcare, depending on the context in which care is delivered (e.g., hospital/community). As per the midwifery model of care, and for this thesis, I use the term *client* to describe the person receiving healthcare.

Clinician

The term clinician refers to a healthcare professional who practices clinically through a recognized scientific knowledge base by working directly with clients to deliver personal health services. (92) Medical doctors, nurse practitioners, registered nurses, registered midwives, counsellors, and other allied health professionals are considered clinicians in healthcare.

Community Health Centres

Community Health Centres (CHCs) are non-profit organizations that provide primary healthcare and health promotion programs for individuals, families, and communities. They are

established and governed by a community-elected board of directors. CHCs work with individuals, families, and communities to strengthen their capacity and promote individual and community responsibility for health and well-being through education and access to resources from other community agencies, schools, housing developments, and workplaces. In addition, CHCs link healthcare consumers with support and self-help groups, offer peer education and coping support, and work to address conditions that affect health. (93) Two of this study's three expanded midwifery programs are within community health centres. (94,95)

Comprehensive abortion care

Comprehensive abortion care is affordable abortion services integrated within health systems to equitably meet the needs of people seeking an abortion without discrimination, where healthcare professionals offer up-to-date information, medical support, medication management, post-abortion follow-up, treatment of complications, and contraceptive counselling and services within centralized and enabling environments. (17,96) Abortion care is within the midwifery scope of practice, and internationally, midwives are involved in comprehensive abortion care provision to varying degrees. (84,85,97,98) To address the global morbidity associated with barriers to safe abortion, World Health Organization agencies partnered to develop a publicly available database describing laws, policies, health standards, and guidelines for comprehensive abortion care. (17) The objective of the abortion care database is to make information and global comparisons transparent for use by any country considering its positions on abortion-related care. (99)

Expanded Midwifery Care Models

Expanded Midwifery Care Models (EMCMs) refer to a funding mechanism developed by the Association of Ontario Midwives and the Ministry of Health to support midwives working in practice arrangements that the traditional midwifery 'course of care' model does not fund. These arrangements may involve midwives working in expanded roles and providing episodic care. (100,101) All three midwifery practices in this study are funded as EMCMs. (100)

Family Health Teams

Family Health Teams (FHTs) are community-centred primary care organizations that include teams of interprofessional healthcare professionals. Led by a family physician or nurse practitioner, the teams commonly include registered nurses, social workers, dietitians, and other health professionals working together to provide healthcare, programs, and services geared to the population groups they serve. FHTs are set up across Ontario based on local health and community needs, serving rural and northern communities and unique populations of clients and clients with specialized health needs. (102) One of this study's three expanded midwifery programs is within a family health team. (103)

Integrated healthcare

Integrated healthcare refers to a process or strategy aimed at better coordinating health services to meet the needs of clients and healthcare professionals. Integration can mean different things in different contexts and takes many forms. Integrated healthcare is designed to be person-centred, collaborative, and continuous, where healthcare team members understand their roles and the roles of other team members. The goal of integrated healthcare includes continuously caring for clients' complex needs by creating partnerships to improve their health, outcomes, and

experiences. (104–106) Expanded Midwifery Care Models within primary healthcare organizations and hospitals are considered integrated healthcare. (100,101)

Interprofessional collaboration

Interprofessional collaboration occurs when healthcare professionals collaborate with clients, families, carers, and communities to deliver high-quality care. (107) Midwives across Ontario collaborate with other healthcare professionals through consultations and transfers of care to provide comprehensive sexual and reproductive healthcare as needs outside their scope of practice or authority arise. (108–110)

Medication abortion

The use of pharmacological agents to terminate a pregnancy is termed a medication abortion. (17) Mifepristone and misoprostol are on the World Health Organization's list of core medicines for primary healthcare, a category of the most productive, safe, and cost-effective medication that should always be available in healthcare systems. (111) Mifepristone is included in the essential medication lists of at least 16 countries. (45,111–113) Midwives in Canada do not yet have the authority in most jurisdictions to prescribe medications for abortions in Canada. (108,114) However, with recently approved changes to the regulations in Quebec, midwives in that province will soon be able to prescribe mifepristone and misoprostol for medication abortion. (115)

Mifegymiso

The combination of mifepristone and misoprostol (one mifepristone 200 mg tablet and four misoprostol 200 µg) commonly used for first-trimester termination of pregnancy is marketed in Canada under the trade name *Mifegymiso* for the indication of early medication

abortion. (29,116) Mifepristone, one of the World Health Organization's list of essential medicines, is considered exceptionally safe, effective, and highly acceptable, as proven by the administration of this medication to millions of people needing an early abortion. (4,17,37,79,117)

Medical directive

Medical directives are written orders by primary health clinicians to be implemented by other healthcare professionals, and they specify which clients and what delegated acts are included. Medical directives provide the authority to carry out the treatments, procedures, or other interventions specified in the directive under certain conditions and circumstances. Primary healthcare professionals can delegate controlled acts only when having a medical directive is in the client's best interest. Only acts that can be performed safely, effectively, and ethically may be delegated. Delegation promotes safety, facilitates access to care where needed, promotes timely or efficient healthcare delivery, and contributes to the optimal use of resources. (118) As the combined prescription of mifepristone and misoprostol for medication abortion is not currently included in the list of designated drugs midwives can prescribe, midwives providing comprehensive medication abortion care must work under a medical directive signed by a healthcare clinician like a medical doctor or a nurse practitioner for prescription support. (100,114,119)

Midwifery model of care

The midwifery model of care promotes reproductive health, wellness, and rights by supporting and protecting pregnancy, birth, and postpartum experiences and well-baby health through person-centredness, continuity of care, and informed choice. (120,121) The midwives

involved in this study are applying the midwifery model of care to comprehensive abortion services within their expanded care practices. (94,95,103)

Midwifery course of care

In Ontario, the traditional midwifery course of care funding model through the Ministry of Health's Midwifery Program entails bundles payment for a midwifery client's 'course' of perinatal and newborn services encompassing pregnancy, birth, and up to six weeks postpartum. (122) In contrast, midwives working in salaried models as employees funded by the Ministry of Health Midwifery Program are paid as employees or independent contractors by the healthcare organizations where they work. (100,101)

Post-abortion care

Post-abortion care includes the provision of services after an abortion, such as the management of complications, reproductive health planning, contraceptive care, and counselling. (17) Midwifery-led abortion care includes comprehensive post-abortion follow-up. (120)

Primary healthcare

Primary healthcare is the first point of contact between a client and the healthcare system and includes illness prevention, health promotion, diagnosis, treatment, rehabilitation and counselling. Primary healthcare aims to consider the equitable distribution, coordination, and best possible location of resources in the healthcare system that contribute to the determinants, treatment, and promotion of individual and community health and wellness. In addition, primary healthcare responds to community needs through the provision and coordination of first-contact services and by ensuring continuity and ease of movement across the system. (123,124) Midwives across Canada are considered primary healthcare professionals, practicing

autonomously to provide sexual and reproductive healthcare within their scope of practice and authority to pregnant and postpartum people. (125,126) A pregnant person can self-refer for midwifery care and is not required to see another healthcare professional during their midwifery care. (127) Midwifery clients and their newborns see their midwives for pregnancy, labour, birth, and up to 6 weeks postpartum. (108,121,126) Midwives can consult directly with other primary healthcare professionals when needs extend beyond the midwifery scope of practice. (125,126)

Primary healthcare in Ontario has evolved from a primarily fee-for-service system of individual physicians providing care to include other payment models and integrated team-based care with various interprofessional healthcare professionals working in group-based practices. (128) Different governance and funding models exist as the range and organization of primary healthcare services vary between communities. Community health centres are examples of integrated primary healthcare teams where professionals are salaried employees working in collaboration with other employee professionals to deliver connected care for individuals and communities. (93) Community-sponsored Family Health Teams are a blended salary model where the majority of income for healthcare professionals comes from being salaried employees of the Family Health Team. (129)

Ontario midwifery practice groups, Indigenous midwifery practices, and expanded midwifery care models are all examples of how midwives work as primary healthcare professionals. Midwives working in these models may be based in independent midwifery clinics, hospitals, community health centres, or family health teams. (100,119,121,130,131)

Quality healthcare

The World Health Organization identifies six areas that are required for quality healthcare: *effectiveness* is evidence-based care that results in improved health outcomes for individuals and communities based on need; *efficiency* is care that optimizes resource use and avoids waste; *accessibility*, care that is timely, geographically appropriate, and provided in settings where skills and resources are relevant to need; *acceptability/person-centredness*, care that considers the preferences and goals of consumers and the cultures of their communities; *equitability*, care that does not vary in quality because of individual characteristics such as gender, race, ethnicity, geographical location or socioeconomic status; and, *safety*, care that minimizes risks and harm to service users (132,133) The midwifery philosophy is centred around high-quality, person-centred healthcare. (120)

Reproductive Justice

Reproductive Justice is a term coined in 1994 by Women of African Descent for Reproductive Justice, now *SisterSong*, that describes a movement founded through the advocacy of people of colour by grassroots health organizations in the United States to illustrate links between human rights, sexual and reproductive healthcare, and social justice. Reproductive Justice in healthcare includes recognizing and addressing the intersecting, collective, and often insurmountable political, social, and ecological barriers that equity-deserving people face to realizing their freedom and human right to have a child, not to have a child, live in a safe and supportive environment, and to enjoy sexual and reproductive health and care that is free from discrimination and stigma. (19,134,135) See Chapter 3, *Theoretical scaffolding*, for a more detailed explanation of how midwifery and Reproductive Justice overlap as part of my theoretical scaffolding of midwifery-led abortion care.

Scope of practice

Individual healthcare professionals' activities, including controlled acts, that they have the authority to perform within their profession are regulated and standardized according to their scope of practice and determined by education and law. The context within which a healthcare professional practices, including the community's needs and the health service's policy requirements, influences individual professionals' scope, confidence, and practice competence. (96) The midwifery scope of practice in Ontario is defined and regulated by the Midwifery Act and the College of Midwives of Ontario. (108,136)

Self-managed abortion

In this study, *self-managed* abortion refers to the promotion of person-centred management of some or the entire process of medication abortion, including self-assessment of eligibility, administration of medicines, and assessment of completed abortion. (38,116) The midwifery practices featured in this research provide both virtual and in-person medication abortion care tailored to client needs for those that are appropriate for self-managed medication abortion. (50,137)

Task-shifting

Task-shifting is the redistribution of appropriate tasks from one health professional to another health professional to increase productivity within healthcare systems. (86,91,138) Midwives providing comprehensive abortion services within primary care settings under medical directives is an example of task-shifting within primary healthcare. (86)

Study aim

The World Health Organization states that abortion is an essential healthcare service. (13) Canadian experts, including the Canadian Association of Midwives and the Society of Obstetricians and Gynecologists of Canada, support increasing midwifery care to include a broader range of sexual and reproductive health services. (84–86,89) In Ontario, where this study is situated, midwifery stakeholders such as the Canadian Association of Midwives, the Association of Ontario Midwives, and the Midwifery Education Program support an expansion of midwifery roles to include comprehensive abortion care. (84,98,139,140) In 2017, the Ontario Ministry of Health announced funding for expanded midwifery care models through the Ontario Midwifery Program, allowing midwives to offer broader sexual and reproductive health services in primary care settings. (101,122) Three expanded midwifery programs in different areas of Ontario provide medication abortion services. (94,95,103) This study will explore midwives, clients, and other healthcare professionals' experiences of midwifery-led medication abortion care within these three programs. My research asked midwives, clients, and other healthcare clinicians to share their experiences and opinions of midwifery-led medication abortion care. The findings describe the participants' experiences in their own words and create an understanding of how midwifery-led care is provided and how midwives are supporting access to quality, safe, and personalized medication abortion care.

Research question

What are the individual and shared experiences of midwives, collaborating healthcare professionals, and clients of medication abortion when provided through Ontario's Expanded Midwifery Care Models?

Research context

The data collection for my thesis was embedded within a larger multiple-case study exploring how Ontario's expanded midwifery care models impact midwifery integration into primary care settings. The larger multiple-case study involved participant interviews, focus groups, and relevant document analysis. For my thesis, interview questions specific to midwifery-led medication abortion services were created, and data were collected, coded, and analyzed separately within the context of my thesis research. Details about the study's methods are provided in Chapter 3.

Research settings

Integrated healthcare teams such as community health centres and family health teams promote interprofessional collaboration and continuity of care, working to improve the quality, accessibility, and promotion of health-related services and community-based wellness programs. (141) This study focuses on two expanded midwifery care models embedded in community health centres (Northern and Southern Ontario) and one expanded midwifery care model working collaboratively with a family health team (Southern Ontario) to provide medication abortion services to Northern, rural, remote, urban, and underserviced people across Ontario. (94,95,103) These expanded midwifery practices consist of small groups of midwives collaborating with other healthcare professionals, including medical doctors and nurse practitioners, to offer low-barrier abortion care. This report does not include location-specific information to protect and respect the organizations' and study participants' privacy. All location-specific information below has been researched, but references will not include identifiable sources.

The Northern community

The Northern location is the healthcare hub for surrounding rural and remote communities. The estimated population of this district is approximately 150,000, according to the 2021 census (142). Primary healthcare is not available to all residents of this area due to a shortage of clinicians like a nurse practitioner or medical doctors, creating significant gaps in essential healthcare such as sexual and reproductive planning, contraceptive care, and abortion. (57,143,144)

In Northern Ontario, abortion services, including procedural termination of pregnancy, can be accessed up to 14 weeks gestation. People needing an abortion after 14 weeks gestation duration must travel to a larger centre, most commonly Toronto, Ontario or Winnipeg, Manitoba. Although the Northern Travel Grant reimburses the costs of receiving healthcare services unavailable in the region, the up-front cost and time involved in travelling to urban centers are significant, and many people cannot afford the cost, time, childcare, travel, or accommodation to go. (29,56,59,59,145,146) Research shows that increasing medication abortion services can improve access to abortion in rural and remote areas. (16,50,55,56,147,148) Publicly available medication abortion has been provided in the Northern location through the community health centre featured in this study in three regional locations and via the hospital's termination of pregnancy referral pathway.

The Northern expanded midwifery care program

The Northern expanded midwifery care model is embedded within a large community health centre with sites situated across Northern Ontario. The Northern location offers primary

healthcare and health promotion programs in the city and surrounding communities, focusing on supporting people who experience barriers to healthcare and wellness.

The Northern location's expanded midwifery care practice was funded in 2018 and began seeing pregnant clients immediately. The organization where the midwifery practice is situated employs three registered midwives who are trained in expanded midwifery services such as extended well-baby care, comprehensive abortion care including medication abortion, long-acting reversible contraception counselling, insertions, and removals, and sexual and reproductive healthcare like screening and treatment for sexually transmitted infections, cervical screening (PAPs), and family planning. The midwives provide integrated care through internal and external consultation and referrals with nurse practitioners, medical doctors, obstetricians and gynecologists, social workers, Indigenous health workers, mental health workers, community health workers, dietitians, harm reduction workers, Fetal Alcohol Syndrome Disorder Program, outreach workers, ultrasound facilities, staff at the main clinic and satellite clinics in surrounding rural communities, and through outreach. The midwifery practice also collaborates with two local midwifery practice groups and an Indigenous midwifery practice. (131)

The Southern 1 community

The Southern 1 community is situated in a large urban region with an estimated population greater than 500,000, according to the 2021 census profile. Primary healthcare is available through most organizations. The main hospital has a termination of pregnancy program that provides procedural abortion up to 16 weeks and six days gestation without the need for referral. Medication abortion services are publicly available at the Southern 1 location's family health centre and two free-standing sexual health clinics.

The Southern 1 expanded midwifery care program

The Southern 1 location's expanded midwifery model is within an interprofessional family health team that works to build a healthier community for people living nearby with barriers to healthcare access. Four midwives from a local midwifery practice group collaborate with the Southern 1 location to offer expanded midwifery services to the surrounding community. As part of a large Family Health Team, the expanded midwifery program aims to provide low-barrier access to sexual and reproductive healthcare.

As one of the first expanded midwifery care models funded in 2018, midwifery services include prenatal and postpartum midwifery care, comprehensive abortion care including medication abortion, long-acting reversible contraception services, sexually transmitted infection screening and treatment, PAPs, and reproductive health counselling. The goal of the Southern 1 location is to improve access to midwifery care for people with low socioeconomic status within high-priority communities and vulnerable populations in the family health centre's neighbourhood. The expanded midwifery care model works collaboratively with on-site medical doctors, dietitians, registered nurses, pharmacists, mental health counsellors, administrative staff, and other local midwifery practice group midwives, obstetricians, and gynecologists at several public healthcare centres.

The Southern 2 community

The Southern 2 community is located in a major city region with an estimated population of more than 2,000,000. Primary healthcare services are located in many areas of the city. Within this large region, several hospitals and healthcare organizations offer medication and procedural abortion services up to 24 weeks gestation.

The Southern 2 expanded midwifery care program

The Southern 2's expanded midwifery model works within a multi-service community health centre with social and community outreach services and an emphasis on health promotion and disease prevention to improve access to healthcare for people who face barriers to physical, mental, spiritual, and social well-being. As a leader in health equity and social justice, the Southern 2 location offers primary healthcare, health promotion, harm reduction, environmental health, community food centres, and population-based community programs for marginalized peoples.

The Southern 2 location's midwifery model was funded in 2018 and offers well-gynecological and pregnancy care services. The midwifery team includes six full-time Registered Midwives and one social worker. The program provides comprehensive abortion care, including medication abortion services, abortion navigation at any gestational duration, and social services support for case management, housing needs, crisis intervention, one-on-one counselling, resource navigation, and assistance acquiring necessary supplies related to pregnancy for all people living in the area. The Southern 2 location's midwives collaborate with in-house healthcare professionals such as physicians, nurse practitioners, social workers, community midwifery practice groups, obstetricians and gynecologists, and community and hospital-based sexual healthcare programs.

Summary

My research question seeks to generate co-constructed and meaningful knowledge from experiences, opinions, and beliefs about midwives providing comprehensive abortion care. As a skilled midwife practicing in an expanded midwifery care model that offers abortion services, I

have a uniquely informed perspective on midwives leading abortion care. I have experienced how the midwifery philosophy and model promote the quality of abortion care advocated for by the World Health Organization. (17,84) I recognize the professional limitations imposed by outdated legislation related to my scope of practice as a registered midwife in Ontario and understand how these limitations impact interprofessional relationships and, ultimately, the access and experiences of medication abortion care for clients.

In Chapter 2, I review what is known in the literature about midwives as abortion providers, internationally and within Canada. Chapter 3 provides an overview of my study's methodology and methods, including a summary of the conceptual framework I have developed from my exploration, values, and understanding of midwives as abortion providers and how these aspects of my personal and professional knowledge apply to Reproductive Justice and translate into providing comprehensive abortion care. In Chapter 4, I summarize and present findings from the interview data I have collected, analyzed, and synthesized, including the themes that emerged from exploring the participant experiences of midwifery-led medication abortion care. Chapter 5 discusses my findings within broader categories, including gaps, strengths, barriers, and enablers of midwifery-led medication abortion in Ontario and Canada. This chapter concludes by examining what is missing from my data, its implications for midwifery practice, and future research needs. Finally, chapter 6 summarizes my thesis and highlights the essential aspects of the newly constructed knowledge.

Chapter 2: Review of relevant literature

To situate my study within what is known and discover what is missing, I conducted an in-depth review of the literature relating to the role of midwives in abortion, focusing on midwifery-led medication abortion. Finally, I searched for literature from Canada related to midwives' role in abortion and peoples' experiences of medication abortion in general, as there is no research related to midwifery-led medication abortion in Canada. Searches in McMaster University Health Sciences databases, CINAHL, PubMed and OVID, as well as Google Scholar, used the following keywords:

> *midwife, midwifery model of care, midwifery-led abortion, medical abortion, medication abortion, therapeutic abortion, experiences, reproductive justice, expanded midwifery care, scope of practice, abortion, Canada, Ontario midwifery, human rights, access*

I reviewed titles and abstracts and selected relevant studies and information. I scanned reference lists of articles for additional research to inform my understanding of midwives in medication abortion care. Grey literature, websites, media and news articles were explored through internet searches, attended conferences, and networking within the Ontario midwifery community. Relevant resources that informed my understanding of midwifery-led medication abortion in Canada were included. I continued to review the literature during my design, data analysis, and description and interpretation of this study's findings.

This chapter begins with the international role midwives play in abortion and what is known globally about the experiences of midwifery-led medication abortion. As there is little known about the role of Canadian midwives in abortion, I provide an overview of the literature about medication abortion in Canada that may be relevant to midwifery, including what is appropriate and transferable to understanding the experiences of midwifery-led abortion in

Ontario. Finally, I review the literature about experiences of medication abortion in Canada and end the chapter by describing my study's significance.

The international role of midwives in abortion care

The World Health Organization encourages midwives to provide abortion services to increase access to care. (17,89) The skills needed for first-trimester medication abortion provision fall entirely within the scope of practice of midwives as reproductive healthcare professionals. (147) Midwives are highly skilled in sexual and reproductive services, including the full spectrum of abortion care such as pregnancy confirmation and gestational dating, evidence-based informed choice discussions, reproductive life counselling, pregnancy prevention, contraceptive counselling, interprofessional referrals, administration of medications, management of complications and obstetric emergencies, and post-pregnancy care and support. (66,96,147,149)

In addition to providing routine perinatal care, midwives commonly manage perinatal care, births, and obstetric complications with the ability to diagnose and address complex, critical, emergent conditions such as ectopic pregnancy, bleeding and hemorrhage, pain management, and infection. (66,90,149) In many settings, it is within the midwifery scope of practice to insert and remove intrauterine devices and contraceptive implants. (150–153) Compared to providing low and moderate-risk perinatal care, the provision of comprehensive medication abortion care requires similar knowledge, skills, and judgment. (96,147) As such, the role of midwives in abortion care is growing to address the global demand for health human resources and reduce the costs of healthcare delivery. (66,96,137,154–157)

In 2008, the International Confederation of Midwives (ICM), representing midwifery associations in 113 countries, released a position statement, *Midwives' Provision of Abortion-Related Services*, to address the rising mortality rates due to unsafe abortion. (85) In 2011, the ICM updated their *Essential Competencies for Basic Midwifery Practice* to include abortion care services. (66,85,99,120) The ICM encourages midwives to acquire the knowledge and skills to deliver additional procedures across the reproductive healthcare continuum to meet the needs of the communities in which they practice. (99) Berer's 2009 comparative study of non-physician mid-level abortion providers, including midwives managing medication or procedural abortion care, demonstrated the benefits of non-physician abortion provider policies. (99,147,154) The way abortion is provided internationally has broadened from physician-dominated services to being led by midwives and other non-physician providers. In countries such as Great Britain, France, Denmark, and the United States of America (USA), midwives commonly deliver comprehensive abortion care. (66,99,147,154) In Vietnam, midwives manage medication abortion under physician supervision, and South Africa permits trained midwives to provide all aspects of medication abortion care. In Tunisia, most medication abortion procedures are carried out by midwives independently (147). In Cambodia, abortion law protects the right to first-trimester abortion on any grounds and permits qualified midwives to perform abortion procedures at public or private health facilities. (154) In Kenya, nurse-midwives carry out post-abortion care for complications of incomplete abortion using manual vacuum aspiration. (154) In Myanmar, midwives are involved in abortion care and link contraceptive care with post-abortion follow-up, including home visits for post-abortion complications and the provision of contraception. (4)

In 2018, Fullerton et al. published a literature review about the appropriateness of midwives providing three essential abortion services: referral for abortion and provision of post-abortion care, medication abortion, and vacuum aspiration abortion. (99) In terms of safety and quality of care, the research found high agreement that abortion should be an essential midwifery knowledge and skill, supporting midwives who choose to provide abortion services. (99) In many countries, midwives are providing abortion services safely and effectively, although specific practices vary. (99,154) Most midwifery-led abortion care involves early abortion with medication. (96,99,154,156) In some settings, physicians supervise midwives, while in others, midwives provide abortion services autonomously with access to physician involvement when needed. (82,96,99,147,154,158) Midwives face obstacles in delivering safe care when restrictions on their training and authorization to perform abortions exist and when the provision of abortion is limited. (99,154,155)

A series of studies conducted in Nepal from 2011 through 2018 demonstrated the safety and efficacy of medication abortion led by trained nurse-midwives in under-resourced areas. (159,160) In addition, a 2011 randomized equivalence trial from Sweden, a country where midwives routinely deliver contraception, family planning, abortion and sexual and reproductive health education services, compared midwifery-led and physician-led medication abortion with midwives trained to provide medication abortions using ultrasound for low-risk abortions at less than 63 days gestation. The findings demonstrated that midwifery-led medication abortions were more cost-saving, equally effective, and highly acceptable compared to the medication abortions provided by physicians. (61,80) Participants in the midwife-led medication abortion group also had a much higher uptake of contraceptives post-abortion. (61,80) In 2016, the Ipas Impact Network, a global nonprofit organization working with governments across five continents to

train healthcare professionals in abortion care, reported results from abortion provision by midlevel healthcare professionals, including midwives, across Asia, Africa, Ethiopia, and Bangladesh. (161) The Ipas evaluation found that the midwives offered high-quality, safe abortion and follow-up care, increased sustainable coverage in healthcare facilities, expanded access to safe abortion and postabortion care for underserved people, improved services for people in remote and rural areas, and brought accessible reproductive healthcare to at-risk populations. (161)

Alonso's 2020 article, *Integrating the midwifery model of care into abortion services*, described how some midwives in Mexico integrate the midwifery model of care into abortion services in a location where protocols and regulations do not include midwives as abortion providers. (162) Within the midwifery model of care, a group of midwives working in Mexico City autonomously provide comprehensive abortion services, including counselling, medication and procedural abortion, and contraception outside of the public system without regulation by their profession. The midwives described optimizing choice by offering all methods of early termination and ensuring the method used "best matches the pregnant person's lifestyle and choices and [optimizes] their capacity to care." (162). The article described continuity of care, especially for clients who have had previous pregnancy experiences with the same midwives, for new clients who are referred by family and friends familiar with the midwives, and by the same midwives offering comprehensive abortion services, including testing, counselling, procedures, referrals to specialists, and post-abortion care and contraception. The midwives supported culturally sensitive care by engaging in ceremonies to honour abortion through person-centred cultural and spiritual values and wishes. The midwives have developed relationships with other specialists to order additional services such as testing, ultrasounds, antibiotics, and medications

that support the midwives in providing abortion services more autonomously. Other healthcare professionals are reported to refer clients to midwives for abortion care. Midwives are not overseen by physicians but instead rely on support from national and regional networks such as Ipas, an international, non-governmental abortion advocacy organization, for abortion-related training, supplies, and education and have adopted protocols according to international guidelines for abortion care. (161) Notably, midwives continued to deliver early abortion services during the COVID-19 pandemic, including medication and procedural options, with a dramatic increase in the number of midwifery-led abortions performed from 2019 to 2020, to fill the significant gap in public services created by complexities and restrictions in delivering hospital-based abortion services created by COVID-19 pandemic. (162)

A 2020 scoping review of the role of nurses and midwives as abortion providers demonstrated that midwifery-led services are essential to abortion provision in many countries. (96) This review concluded that midwives working in abortion care have been over-regulated and that the risk profile of abortion is lower than that of advanced-practice midwifery, including intrapartum care. The authors found that expanding midwives' scope of practice encouraged high-quality abortion care away from the hospital. (96) Client-managed medication abortions were shown to be acceptable, and the findings suggest that the risk profile of abortion medication in many countries needs review to make it more available in the midwifery scope of practice. (17,96) The barriers to midwifery-led models of abortion included lack of training, varying support from general practitioners and other stakeholders such as local health professionals, restrictive funding models, persistent abortion stigma, and uneven distribution of work between physicians and other healthcare professionals. (96) This review highlighted that little is known about the education and training midwives receive before providing abortion services, and what

is taught in midwifery curricula needs reviewing. (96) This scoping review called for more research to inform the scope of midwives in abortion care frameworks and to increase the availability, accessibility, and affordability of midwifery-led abortion. (96)

In the United States, abortion has been part of the midwifery scope of practice since 1979. (163) In 2017, the US Food and Drug Administration changed the regulations, changing who can prescribe mifepristone from physician to healthcare provider, permitting midwives, advanced practice nurses, and physician assistants to prescribe and manage medication abortion. (164) In addition, the gestational duration for medication abortion was expanded to 70 days, decreasing the number and location of visits, reducing the dosage of mifepristone and, thus, the overall cost, and updating the timing, dose, and route of administration for the second drug, misoprostol, to reflect research evidence. (164,165) These changes aligned with the increasing role of midwives as autonomous providers in medication abortion care, making midwifery-led medication abortion more accessible. (97,164–166) In 2020, the American College of Nurse-Midwives recognized medication abortion as a core competency of midwifery practice and an advanced practice midwifery skill by state scopes of practice and licensing statutes. (97,155,165) To meet core competencies in abortion care, midwifery education programs across the United States are updating curricula to include abortion management. (155)

On June 24, 2022, the *Dobbs v. Jackson Women's Health Organization* decision by the US Supreme Court removed federal abortion protection, resulting in new state laws. (26,27,167) In states where laws banned or restricted abortion access, midwives faced additional challenges to supporting reproductive rights. They were forced to manage more complex abortions, especially for people who historically experienced disproportionate disparities in accessing sexual and reproductive healthcare. (137,155) Midwives working near states with restrictions

experienced an influx of people seeking abortion and have needed to alter their practice to ensure access. (155) For example, midwives in Springfield, Massachusetts, started offering medication abortion services for people seeking care from out of the state in addition to those connected with their facility, providing continuity for established midwifery clients, improving access for urban and rural patients, and increasing regional capacity for people travelling from out of state seeking abortion services. (156) US midwives are seeing an increase in self-managed abortions outside of clinical settings: they are working to provide supportive care, counsel people on what to expect, and increase access to accurate, non-judgemental information to promote harm reduction and protect reproductive rights for those facing legal restrictions to abortion. (137)

My review of the role midwives play globally in abortion care revealed how and why midwives are essential in many countries as providers of medication abortion. However, the way midwifery policy and practices are situated poses challenges to decentralizing abortion services and incorporating high-quality, comprehensive medication abortion care into midwifery practice. Further research is required to support and expand the role of midwives in abortion globally. (96,161)

Global experiences of midwifery-led abortion care

There is little research exploring the experiences of midwives who provide comprehensive medication abortion care. It has been established that integrating the midwifery model and philosophy of care increases the quality of abortion services through person-centredness, relationship-building, informed choice, and continuity of care. (18,84,85,90,97,99,137,155,156,162,168) As autonomous primary healthcare professionals, midwives will have different personal and professional opinions and values about participating in abortion care, which can create challenges in separating the global call for midwives to offer

abortion services from personal views, contexts, values, and beliefs. Some countries such as Iceland, Finland, and Sweden disallow conscientious objection to abortion provision in practice if it is within the healthcare professional's professional duties. Some research supports that disallowing healthcare professionals to object is associated with improved access, reduced barriers and delays to care, and has no negative impacts on healthcare professionals who choose to find work in another branch of medicine. (169,170) Clarifying the values, attitudes, and duties of the midwifery profession while exploring midwives' wishes and responsibilities is fundamental to the expansion of midwifery-led abortion care. (62,99,162) Conflicts between professional expectations, human rights, and conscientious objectification have been examined, and research shows this tension can prevent or hinder midwives from expanding into comprehensive abortion care, potentially affecting the health and rights of the pregnant people they serve. (171)

Abortion is highly stigmatized and arouses religious, moral, ethical, sociocultural, and medical fears when considering the provision of abortion services. (62,172) A systematic review published in 2018 explored the reasons midwives object to providing abortion care and found no evidence supporting or contradicting conscientious objection, in part because little was written on the subject at the time and midwives were not “visible” in the debate. (173) The authors called for more theoretical and practical research exploring changing abortion practices and how they affect the roles and responsibilities of midwives. (173)

A more recent study from the United Kingdom in 2022 found that some midwives objected to providing abortion services. (174) Although most participants believed that pregnant people have the right to have an abortion, some struggled to find a balance that allowed them to opt out of providing abortion care while maintaining their clients’ reproductive rights. This

hierarchy of rights was argued from both the client's and the midwife's perspectives, where participants expressed difficulties in determining what constitutes *providing* abortion care. Overall, the right to object was seen as complex, particularly with the growing role in the United Kingdom of midwives in abortion, along with an overall sense that the profession considers the care of the client as the priority and an obligation, which seemed in direct competition with the midwife's rights. The authors recommended further research to explore how midwives who object find balance in abortion care. (174)

In Canada and the US, professional associations have strongly advocated for midwives to improve access to comprehensive sexual and reproductive healthcare and deliver abortion services, as evident in the American College of Nurse-Midwives (ACNM) and the Canadian Association of Midwives (CAM) position statements. (84,97) The ACNM recognizes the potential for moral distress for some midwives and states, "[midwives] who exercise conscientious objection must consider the added cost and risk of delaying care, which are unintended consequences that the individual seeking care must shoulder" and ultimately negatively impact the human right to timely abortion. (175) The CAM's position statement makes no mention of midwives who may object to abortion care but rather "calls on midwives and all reproductive healthcare professionals to work to ensure access to abortion care in Canada." (84)

Despite the debate over conscientious objection, studies that have explored midwives' opinions and experiences as implementers and service providers of medication abortion show support for expanding the role of midwives to include abortion care. (18,18,90,90,176) In Sweden, where abortion for any reason is legal up to 18 weeks gestation, the provision of abortion is commonly practiced by midwives in primary care, educational institutions, youth

centres, and specialist gynecology settings. (169,177–180) Lindstrom et al.'s study from 2007 explored the clinical and emotional experiences of Swedish midwives working in abortion and found the majority felt abortion should be part of their midwifery work and agreed with the shift from procedural to medication abortions managed within primary healthcare. Even though Swedish law allows healthcare professionals to object to providing abortion care, more than 50% of participants in this study expressed a belief that healthcare professionals who can provide abortion services should not have the ability to opt-out. (177) Among the midwives in the survey who offer abortion care, two-thirds expressed positive experiences with their work. (177) Four years later, some of the same researchers conducted focus groups with gynecologists, midwives, and nurses involved in abortion care from three different cities in Sweden. (180) When asked about medication and home abortions, gynecologists said most of the care was delivered by midwives and nurses and expressed some concerns about losing their abortion-related skills. (180) Midwives in the study described working from a client-centred approach and thought abortion care was more ideal when they knew the person. No healthcare professionals expressed hesitation in working to support people through abortions, and the participants wished for ongoing guidance and professional development in abortion care. (180)

A 2017 qualitative study surveyed the experiences of Italian nurses and midwives involved in the termination of pregnancy, including medication abortion care. (181) Italy is a country where, although voluntary abortion is legal until 90 days of gestation, early abortions are reported as rare. (181) Of note, in this study, medication abortions were only conducted in health centres. The midwife participants linked the number of years of working in abortion care to their growing skills, acceptance of the process, and increased non-discrimination. Participants valued

their multidisciplinary team setting and called for more continuous training to improve the quality of care. (181)

A 2018 qualitative descriptive study conducted in New England, USA, explored the experiences of nurse practitioners and certified nurse-midwives providing community-based early abortion care, where the midwife and nurse practitioner participants had the legal and regulatory authority to prescribe and manage medication abortions and attitudes and laws around abortion were more favourable. (182) The primary investigator was a nurse practitioner with 25 years of clinical experience in sexual and reproductive health and abortion. The study found that providing comprehensive early medication abortion care in a primary healthcare setting was seen as an overwhelmingly positive experience for the nurse-midwife participants. (182) The midwives and nurse practitioners delivering abortion care expressed satisfaction with their work, appreciation for a person-centred approach, strong support for their role as abortion providers within their personal and professional lives, and minimal to no concerns about their safety. (182) In contrast to other studies that have focused on the potential moral distress (62,177,183), participants in these supportive settings expressed feeling energized from abortion work and a robust moral conviction in alignment with their professional and personal beliefs. (182) The midwives and nurses reported *conscientiously choosing* to offer dignified and safe abortion care and expressed that the provision of abortion can be a deliberate choice for healthcare workers. (182) The reasons given for providing abortions were reported as exposure to social movements, family values and beliefs, mentors and role models, introduction to abortion during their education, and prior personal or professional abortion experiences, like helping others or having an abortion themselves. (182) Professional enablers involved supportive laws, regulations, and relationships that sustained participants' subjective and practical experiences of providing

abortions, including backing from colleagues, friends, and family and the organizations where they practiced. (182) Finally, participants identified a need for more professional support for midwives providing abortion services, especially when working with communities that have increased demands for services and complex social needs. (182)

A 2022 systematic Integrative review explored thirty-one studies published between 2000 and 2020 from five continents on the experiences of midwives and nurses implementing abortion policies. (62) Most countries where the research was conducted were classified as upper-middle or high-income, and not all countries allowed early abortion upon request. In terms of delivering client-managed first-trimester medication abortions, studies with midwives and nurses providing the care from Sweden, Canada, South Africa, Uganda, and the USA found the providers were overall satisfied with abortion work and expressed feeling positive, satisfaction, pride, and reward when describing how they provided care that meets the person's needs. (62,169) Some of the studies reported participants' feelings negatively towards repeat abortions and teens not using contraception, with the perception that some were using abortion as a convenient option as opposed to a human right. (62) In many studies, midwives and nurses identified the importance of non-coercive counselling and decision-making in abortion care. They expressed concern that non-midwife providers may not take the necessary time to explain and support the abortion process. (182) There were a few studies where midwives admitted to not wanting to offer choice, referring to another professional, judging people seeking abortions and expressing efforts to conceal their emotions in response to their professional responsibility and human rights. The studies that found conflicting feelings from midwives and nurses about providing abortion care also reported more significant degrees of work stress and dissatisfaction. (62) Finally, many studies found that supportive relationships with colleagues related to midwives providing

abortion improved participants' knowledge and feelings of belonging. However, midwives and nurse participants in some settings reported being cautious about telling people outside of their professional circle about offering abortion care due to stigma. Other factors that negatively impact midwives' experiences of abortion care include insufficient funding and resources, lack of support from healthcare systems, and discrimination. (62) Finally, this systematic review identified significant gaps in midwifery training and education regarding ethical decision-making in abortion care and suggested improvements to the practical and ethical competencies required for midwives to provide high-quality abortion care. (62)

A study from 2024 investigated Chilean midwives' experiences of abortion care, where abortion remains strictly regulated, with high levels of conscientious objection among healthcare professionals. (183) Midwives in Chile provide only hospital-based abortion care for three specific legal reasons where abortion is allowed (pregnancy threatening a person's life, fetal anomalies incompatible with extrauterine life, and pregnancy resulting from rape up to 12 weeks for people aged 14 or older or until 14 weeks for people aged 13 and under). (183) The findings suggested midwives involved in restricted hospital-based abortion found their work professionally, ethically, and emotionally challenging. Participants described the concept of traditional midwifery as accompanying people in their sexual and reproductive lives through childbearing and expressed a high value in treating life with respect. For these midwives, the idea of working with "expected and scheduled death" in this highly regulated way was very emotionally challenging. (183) Participants had conflicting thoughts about being required to provide abortions under these circumstances, where some saw abortion as a human right supporting free choice, and others felt abortion was their professional obligation only under lawful circumstances. Despite the different opinions, the midwives unanimously agreed that

abortion was within the midwifery scope of practice. (183) Some expressed their views on abortion had changed as they became more comfortable and accepting due to their increased training and day-to-day experiences, which shifted personal beliefs towards abortion being part of everyday life and acceptable midwifery practice. (183) Although the participants identified conscientious objection as being the most significant barrier to quality abortion services in their healthcare system, many believed that requiring a healthcare professional to deliver abortion against their beliefs was detrimental to the objector and would ultimately affect the quality of care. (183) This study concluded that midwives providing abortion care in Chile would benefit from increased support and training to promote emotionally safe, high-quality care and develop a greater understanding of the differences and responsibilities of midwives as autonomous healthcare professionals and the profession as a whole. (183)

The Reproductive Health Access Project promotes access to sexual and reproductive information in the USA and beyond. (184) As a midwife, I find the information accessible, research-based, up-to-date, and relevant to Reproductive Justice and I frequently refer clients to their website and resources. When searching for literature about midwives' experiences as medication abortion providers, I came across an article on the website from July 5, 2018, titled "Midwives: Reclaiming Abortion." (185) In this article, the author, a midwife who works as an abortion provider in New York, expressed her dedication and calling to abortion care and her respect and appreciation for the advocacy and support from the American College of Nurse-Midwives. (185) This commentary speaks to the lived experiences of midwives who choose to work to their fullest scope as a model of Reproductive Justice within healthcare systems where access to abortion is complex.

Midwifery and abortion in Canada

International studies have explored experiences of midwifery-led abortion and report overall satisfaction with the care and acceptance of midwives in this role. (61,74,80,154,186) No research has examined the experiences of midwifery-led abortion in Canada, as the potential for midwives to provide comprehensive abortion care has not been widely realized due to legislation, policies and regulation restrictions limiting the ways that midwifery care is delivered. (18,90)

Canada does not have laws that restrict abortion care to physicians. (2) Within the construct of *normal pregnancy* in the first trimester, the World Health Organization, the International Confederation of Midwives, the Canadian Association of Midwives, and the Association of Ontario Midwives endorse midwives in Canada as medication abortion providers. (82,84–86,187,188) Qualitative studies from two Canadian provinces, Ontario and British Columbia, explored the opinions of midwives about abortion within the midwifery scope of practice and philosophy of care. (18,90) In 2016, attitudes and opinions among registered midwives from Ontario about abortion and their readiness to offer abortion services were explored. (90) Of the 523 practicing registered midwives, 359 participated in the survey, representing most of Ontario's midwifery workforce. (90) Most participants were educated in the Ontario Midwifery Education Program (188), and some had international education in midwifery. Most of the participants recalled receiving some education on abortion counselling, some had instruction on the different techniques, few had been involved in abortion in a professional setting, and 14% said they had no education or training related to abortion. Most respondents supported abortion, and 83% of participants agreed with first-trimester abortion with decreasing acceptability for abortion for any reason. In response to the statement "[abortion]

should be included in the scope of practice of Ontario Midwives," midwives were evenly divided; however, many responded in favour of abortion, which was consistent with the philosophy of midwifery care (90). The majority of midwives were willing to provide abortion services to meet community needs. Concerns with midwives in abortion care included potential threats to personal safety or the safety of family and community, opposition from other clients, and concern for clients' safety and comfort. (90) Participants also expressed concerns with incorporating abortion care into the current midwifery model, such as the ongoing challenges of integration, practicing to the fullest scope, the funding model, and the demands of the profession. (90) Finally, midwives had concerns about how built environments would accommodate abortion along with child-bearing practices and had concerns for clients' safety and privacy. (90) There was a willingness to provide first-trimester medication abortion with an expansion of the midwifery pharmacopeia, and many midwives felt the administration of drugs for abortion was within their current skill set. (90) However, openness to provide abortion beyond the first trimester decreased as skills for later abortion were perceived as more complex and needed further training and compensation. Seventeen percent of participants identified as objectors to abortion under any circumstance; some voiced concerns about the inclusion of abortion into the midwifery scope of practice for all midwives, while six percent stated that they would not refer clients to abortion care. (90)

A 2019 study with midwives from British Columbia exploring thoughts about providing abortion found the participants unanimously in favour of integrating medication abortion into their practice, expressing the belief that the midwifery model of informed, continuous, client-centred autonomous choice aligned well with high-quality abortion care. (18) All practicing midwives were invited to participate, and 15 of the 274 registered and practicing midwives in

British Columbia were interviewed to achieve thematic saturation. (18) Participants were from urban and rural settings and, on average, had practiced for 5.8 years. The participants felt their knowledge, skills, and judgement would transfer to abortion and that midwifery-led medication abortion would help address access issues across the province, such as privacy concerns and the need for care closer to home for people living far from larger centres. In addition, participants thought increasing the number of abortion providers and improving the quality of care would benefit people living in vulnerable circumstances and decrease barriers to abortion. (18) The interviewees identified a need for shifting the midwifery paradigm to promote midwifery-led abortion, as abortion may be seen as "discordant" with current midwifery care. (18) Furthermore, the midwives felt that leading abortion care would increase their professional autonomy and ability to have a more significant role in healthcare systems, provide new ways to work, and support sustainability. (18) Like the Ontario study, concerns about the practicalities of expanding the midwifery scope to abortion were found, namely, barriers to incorporating abortion services into the built environments of independent midwifery practices, remuneration mechanisms, conscientious objection, and balancing the current demands of the profession. (18,90)

The idea of midwifery-led medication abortion in Canada has received a lot of attention in the media, within sexual and reproductive healthcare publications, and from professional organizations' communications: many stakeholders believe the midwifery model has a unique place in high-quality abortion care, including the ability to support care in a variety of settings, provide continuity across multiple pregnancy experiences, bring abortion services to places where there are no abortion providers, offer support through on-call availability to address urgent needs more efficiently and give personalized support when needed for youth, uninsured people, or those living in precarious situations. (82,168,176,189–194) In 2022, Quebec was announced

as the first province to enable midwives to prescribe mifepristone and misoprostol for medication abortion legally; however, the profession is still negotiating how to implement medication abortion into midwifery practice. (195–197) News articles have called for an expansion of midwifery services to include comprehensive contraception and abortion care, and abortion advocacy organizations such as the Abortion Rights Coalition of Canada and Action Canada for Sexual Health and Rights, the National Abortion Federation of Canada, and the Abortion Rights Coalition of Canada promote midwives doing more for Reproductive Justice through news articles, webpages, social media campaigns, and publicly available policy briefs. (35,59,189,190,198–201)

The University of British Columbia's Contraception and Abortion Research Team (CART) received over $4.2 million in funding from the Federal Sexual and Reproductive Health Fund through the 2021 budget. (202,203) With the help of investigators and partner organizations across Canada, CART has developed a research strategy called *Canada's Midwifery Abortion Implementation Study* to support the inclusion of abortion in the role of midwives across Canada to remove barriers and promote high-quality abortion care. (82) In April 2019, stakeholders from across the country, including the Association of Ontario Midwives, the College of Midwives of Ontario, the Women's Health Research Institute, the Canadian Institute for Health Research, midwifery regulators, association representatives, researchers, healthcare workers, students, health authority leaders, and community organizations, met to identify and plan research priorities. (82) The "take-home" messages from this research planning meeting included recognizing midwives as experts in sexual health across the globe, highlighting the inequitable access to abortion across Canada, particularly in rural, remote and underserved communities, and supporting midwifery as well-situated to improve abortion services. (82)

Action Canada for Sexual Health and Rights actively advocates for midwives to provide abortion care in Canada. (204) The organization received $428,236 in funding from the Canadian Government to expand its access phone line and sexual health information hub programs and to support financial assistance to cover travel and accommodations for those needing to relocate for services. (202) In 2023, Action Canada released a policy brief, *Increasing Abortion Access In Canada Through Midwife-led Care,* and, along with other Canadian stakeholders, produced a submission for the United Nations Universal Periodic Review with recommendations about how Canada can improve access to abortion for everyone. (14,35,204)

Midwifery-led abortion in Ontario

Ontario midwifery's model of care is based on five principles: professional knowledge and practice, person-centred care, leadership and collaboration, integrity, and commitment to self-regulation. (110,120) In 1991, midwifery became a regulated profession in Ontario, protecting the title of *Registered Midwife* with the exception of *Indigenous Midwife,* allowing only individuals registered with the College of Midwives of Ontario (CMO) or Indigenous Midwives providing traditional midwifery services to Indigenous people or members of an Indigenous community to practice legally. (114) With the regulation of midwifery in Ontario, the scope of practice was set in the profession-specific *Midwifery Act* of 1991. (108,136) The scope for Ontario midwives includes "the assessment and monitoring of women during pregnancy, labour and the postpartum period and of their newborn babies, the provision of care during normal pregnancy, labour and the postpartum period and the conducting of spontaneous normal vaginal deliveries." (114,136) To interpret the scope of practice, the CMO defines the terms *normal* and *spontaneous,* where normal refers to an overall clinical picture that is uncomplicated, and spontaneous is a birth that occurs with the pregnant person's effort only and is not assisted.

(108) In addition, acts included in the midwifery scope include pregnancy diagnostic ultrasounds to identify and date pregnancy and assess for retained products of conception, insertion of intrauterine devices/systems and contraceptive implants, and prescription and administration of substances designated in the regulations. (108,121,136)

The ability of midwives to work to their fullest scope is determined by intrinsic and extrinsic factors such as personal experience, opportunities, interprofessional relationships and collaborations, practice settings and context, and client population needs. (205–207) Midwives practicing in Ontario typically provide all aspects of care for labour, birth, postpartum, and newborn wellness, including some or all of the authorized acts. (108) The CMO states that healthcare systems should enable midwives to practise to the fullest extent of their scope so midwives can optimally contribute and offer "high-quality patient-centred care without compromising patient safety." (108) Midwives practicing to their full scope require the knowledge, skills and experience to do so. They are encouraged to gain new competencies that align with professional standards when providing care based on unique client and community needs that may not be typically offered in other settings. (108,110)

In 2008, the CMO advocated for an extended scope of practice to fill gaps in sexual and reproductive health services outside of the perinatal period for communities facing health human resource shortages. (57) In response, the Regulated Health Professions Statute Law Amendment Act (2009) allowed some amendments to the Midwifery Act of 1991. Still, these amendments did not result in midwives expanding their scope to include care outside the perinatal period. (136,191) Despite this, Ontario midwives routinely provide preconception counselling, pregnancy planning, perinatal and gynecological services, and reproductive health planning, in addition to postpartum and newborn care. (100,108,121,187)

Midwives across Ontario have created innovative ways to provide comprehensive medication abortion services within their current governing regulations. Ontario midwifery services are publicly funded through the Ontario Midwifery Program. (122) Three expanded midwifery care models situated in team-based primary care settings provide services through interprofessional collaboration and offer comprehensive sexual and reproductive healthcare, including abortion and contraception. (94,95,103) The Connected Care Act of 2019 was enacted in Ontario to "empower providers to work directly with one another to offer the highest quality, coordinated care, protecting patients from disruptive transitions through the system." (141) Barriers to interprofessional collaboration exist due to low awareness about the skills and qualifications of other health professionals, fear of liability risk, and incompatible funding mechanisms. (107,109,208,209) Team-based care provides better integration, such as that offered through the three expanded midwifery care models based in the community health centres and family health teams featured in this research. (57,105,205,208,210,211)

Ontario midwives delivering comprehensive medication abortion services through expanded midwifery care models work under medical directives with nurse practitioners and physicians to provide prescriptions for abortion-related care not included in their designated drug list. The Midwifery Act, 1991, Ontario Regulation 884/93's designated drugs list includes misoprostol, one of the medications that can be used for medication abortion, listed in section 4 of the act as a drug that a midwife may prescribe on their responsibility, but only for postpartum hemorrhage. (114) Thus, midwives who offer abortion services through expanded midwifery care models must collaborate with other primary healthcare professionals who do not have restrictive drug classes for prescription support. According to the CMO's professional standards, midwives offering medication abortion services need to have the knowledge, practice principles,

skills, and professional judgment to provide abortion care and participate in leadership and collaboration. (84,100,108,110) In addition, midwives who provide medication abortion must offer care based on current evidence and up-to-date resources on abortion in Canada. (84,108,110,212) It is essential that midwives provide personalized, non-judgemental care and informed choices to clients presenting with unwanted pregnancies. (120,121,149) Providing time for decision-making supports the client's right to choose, gives access to information throughout their abortion process, and ensures personalized follow-up, reducing reliance on hospital or emergency department visits for non-urgent questions or concerns. (110,213) Successfully integrating midwives into interprofessional primary healthcare settings through expanded midwifery care models depends on qualified midwives working alongside supportive healthcare professionals who embrace collaboration by developing new roles and task-shifting to meet community needs and improve access, quality, and efficiency. (57,86,169,205,214,215) Midwives working under medical directives need strong relationships, leadership, and collaboration skills to work autonomously with other midwives and in collaboration with other healthcare professionals when some aspects of abortion care lie outside the midwives' current pharmacopeia. (110,114,216)

From my professional networks, abortion-related peer reviews, and the National Abortion Federation of Canada conference I attended in the fall of 2023, I know that midwives across Ontario are providing abortion care within midwifery practice groups, under additional funding mechanisms, and within hospital-based programs through early pregnancy clinics. However, there is no documentation about the systems developed to provide midwifery-led abortion care in these settings.

Experiences of medication abortion in Canada

Globally, the experiences of people having medication abortions have been well documented and shown to be highly acceptable, especially when provided within healthcare systems that offer high-quality services and support autonomy, access, privacy, and convenience. (61,64,65,80,217) In Canada, access to medication abortion has improved with the approval and funding for mifepristone and misoprostol prescriptions for residents of all provinces and territories, with fewer restrictions and requirements for routine care, and since the introduction of telemedicine abortion. (36,44,48,53,60,76–78,218–220) Since the availability of mifepristone and misoprostol for medication abortion in Canada, a few studies have documented the experiences of people living in Canada having medication abortions. (64) Research published in 2020 by LaRoche and Foster interviewed 64 Canadians between 2017 and 2019 about their abortion experiences. The participants were aged 17 to 41, lived in seven provinces, and mostly identified as white, with some identifying as racialized, Indigenous, Inuit, or Metis. Their pregnancies ranged from 28 to 62 days gestation. Participants who chose medication abortions reported positive experiences and successfully self-managed their medications, symptoms, and decisions about when to seek care for follow-up. (64) The biggest drawback participants identified was the length of time needed to complete the abortion, especially for those required to interact with multiple healthcare professionals in different locations for tests, ultrasounds, and prescriptions. (64) The study identified several ways medication abortion could improve, including better information on what to expect, pain management, the products of conception, different bleeding patterns, and more up-to-date knowledge from clinicians and pharmacists. In addition, participants commented on how publicly available medication abortion information on

healthcare websites was beneficial and expressed a desire for real stories from people who experienced medication abortion to gain a better understanding of the process. (64)

Virtual abortion care is more widely available since the COVID-19 pandemic, with good evidence to support the safety, efficacy, and acceptability of delivering abortion services through telemedicine. (71,74,75,77,219,221) In Canada, medication abortion care is commonly provided through telemedicine in the absence of contraindications or risk factors. (116,219) Telemedicine abortion services improve experiences for rural and remote residents, increase access to abortion in underserved areas, and protect the privacy and convenience of everyone involved. (73,77,78,219,222,223) A recent study explored peoples' experiences of early pregnancy termination, including medication and procedural abortions, across five provinces in Canada during the COVID-19 pandemic and found those who had medication abortions expressed the value and acceptability of virtual care to increase access to services. (222) The obstacles participants navigated to secure timely abortions included multiple in-person encounters without a support person present, incorrect information about insurance coverage, inability to access services in their preferred language, and experiences of judgment and discrimination. (222) The authors called for policymakers and clinicians to consider peoples' experiences of early abortion and for a move towards de-medicalizing and centralizing abortion services through person-centred options like telemedicine. (222)

Significant barriers exist for people living in Canada who want a medication abortion. (14,16,55,116,223) No research has explored how people facing marginalization due to systemic discrimination experience medication abortion. Vast geographical areas without services, uninsured status, systemic discrimination and inequitable access to health care, low socioeconomic status with barriers to accessing and receiving services, and poor healthcare

professional knowledge, understanding, or willingness to provide abortion prevent many Canadians from getting timely care. (2,16,22,28,35,59,82,117,219) In 2023, Action Canada for Sexual Health & Rights partnered with stakeholders to submit recommendations to the Universal Periodic Review (UPR) at the United Nations Human Rights Council about how Canada must improve access to abortion, highlighting issues such as homelessness, migration status, geography, non-medical expenses, transportation, stigma, and systemic exclusion, judgement, and discrimination within the public healthcare system due to intersecting factors such as racism, xenophobia, ableism, and criminalization as significant issues for equitable abortion access. (14,35)

In Canada, there is little known about medication abortion experiences, and no research has explored experiences of midwifery-led abortion. This research addresses a gap in knowledge by exploring midwifery-led medication abortion across Ontario, one of the first provinces to fund and initiate innovative programs of midwifery-led comprehensive abortion care through expanded midwifery care models. (82,116,204) Through qualitative interviews with midwives, collaborating clinicians, and clients with experiences delivering, supporting, and accessing midwifery-led abortion care, clinically relevant and valuable knowledge will be produced.

Reproductive Justice through midwifery-led abortion research

The World Health Organization recommends centring abortion in primary care to improve universal coverage and access. (17,86,188) In their research on the expansion of mid-level abortion providers, such as midwives offering first-trimester abortion care, Berer states, “change needs to begin… with different cadres of health professionals working side-by-side to ensure accessibility and availability of abortion.” (154) As experts in normal pregnancy, midwives have the skills, knowledge, and judgement to offer the full spectrum of sexual and

reproductive services in appropriate settings. In addition, midwives across Canada have expressed interest in providing comprehensive abortion services, and some are already providing abortion care within midwifery practices. (82,84,90,168,176) As abortion access is limited across Canada due to structural, political, and social barriers caused by intersection discrimination, understanding the barriers and facilitators to comprehensive abortion care is essential to optimizing midwifery's role in improving access to safe, equitable, high-quality abortion services.

Summary

The professional practice of midwifery in Canada is dedicated to self-regulation and committed to upholding the profession's standards while promoting the best interests of clients and the public. (110) Access to abortion is limited in Canada, particularly in rural and remote communities and for underserved populations. (2,59,82,204,219) Expanding the role of midwives in Canada to include broader sexual and reproductive services, including medication abortion services, is a crucial step to facilitate equitable access to abortion. (82,84,204) Midwives can provide comprehensive sexual and reproductive healthcare that extends beyond the perinatal period, with the potential to improve access to high-quality medication abortion care in settings where access is limited or does not exist. (16,82,84,116) Midwives providing abortion services can improve postpartum and post-abortion care, including reproductive life and family planning, through continuity of care and established relationships. (18,57,82,90,137,155,162,206) This study will generate new knowledge about how midwifery-led medication abortion is experienced from multiple perspectives to inform clinical practice, engage policymakers, and identify outcomes that clients and healthcare professionals value to apply to future studies about midwife-led medication abortion. (210,224) Finally, disseminating

knowledge among provincial and national midwifery stakeholders will inform how midwives affect, influence, facilitate, support, and deliver medication abortion care and demonstrate how medication abortion provided through the midwifery model helps normalize abortion. (28,81,82,96,99)

Chapter 3: Methodology, study design, and methods

To answer my research question, I chose a qualitative research design that allows for the description, exploration, and explanation of people's perceptions, values, beliefs and experiences of midwifery-led medication abortion to better understand how structures and social contexts influence reproductive rights. Qualitative methodology compares different perspectives through an iterative process of analysis, critique, reiteration, reanalysis, and synthesis. (225–228) Qualitative research findings are built and described from the inquiry process, where the researcher is acknowledged as part of the reality being studied, co-constructing new knowledge from textual data. (227,229–231) A qualitative scholar will use theoretical foregrounding to argue why their research is needed, to guide their process, and to justify how their approach will contribute to their chosen field in a valuable way. (225,226,229,232,233) Qualitative researchers must also identify their positionality within a project's background and design stages by defining who they are, what they represent, and what they are trying to accomplish through theoretical scaffolding and reflexive research practice. (225,228,234,235)

Study purpose and goals

To safeguard every person's right to body autonomy, the World Health Organization, the International Confederation of Midwives, and the Canadian Association of Midwives advocate for midwifery to include comprehensive abortion care. (66,84,85,89,90,236) International midwives provide abortion services and demonstrate good outcomes related to efficacy, safety, acceptability, and post-abortion contraception uptake. (80,99,154,236,237) In Canada, midwifery services are situated among urban, rural, remote, and underserved populations with the potential to improve access to quality abortion care. (18,82,85,90,115) By expanding Canadian midwives' role and reach to include comprehensive abortion care, we may expand accessibility, bridge

gaps, support community needs, improve professional sustainability, encourage interprofessional collaboration and integrated healthcare, and offer continuity of care for people needing an abortion closer to where they live. (82)

Since 2017, the Ontario Ministry of Health has funded expanded midwifery care models to support integration, interprofessional collaboration, and delivery of midwifery-led care that the traditional 'course of care' model does not fund. (100) No research has examined the impact of the midwifery philosophy and model of care on abortion experiences in Canada.

My research question asked, "What are the individual and shared experiences of midwives, collaborating healthcare professionals, and clients of medication abortion when provided through Ontario's Expanded Midwifery Care Models?". This study explores midwifery-led medication abortion care within three expanded midwifery care models based in primary healthcare organizations across Ontario through interpretive description methodology to generate an account and an understanding of how midwifery-led abortion services influence the experiences of medication abortion. I aimed to create knowledge from multiple perspectives to inform clinical practice, interest healthcare policymakers, and identify client- and healthcare professional-valued outcomes to apply to future research on midwifery-led abortion care. (210,224,225)

Methodology

My research uses interpretive description methodology to explore how the midwifery model of care supports expanded midwifery care models based within primary care settings across Ontario to provide medication abortion services and promote Reproductive Justice.

Interpretive description

Interpretive description research generates applied knowledge from the real-world study of clinical phenomena. The researcher applies a disciplinary lens to their work to deeply understand what is known and how it is known and to provide the judgment and authority to lead the inquiry, describe and interpret the data, and construct meaningful and practically relevant information. (225,238) Within interpretive description, various methods such as interviewing, observation, and documentary or collateral data review may be used, and triangulation of multiple data sources (i.e., comparing and contrasting clinician versus client observations and experiences) can ensure robust findings. (225)

Foremost, interpretive description methodology involves a comprehensive literature review, as covered in Chapter 2, that concludes something of clinical interest related to experiences, behaviours, or consciousness that has not been adequately documented, described, or interpreted. Identifying a knowledge gap supports the reason for choosing interpretive description to allow for a better understanding of the phenomenon in practice. In Interpretive Descriptive studies, the clinician researcher's theoretical and disciplinary beliefs must be identified and positioned to recognize how their thoughts, perspectives, experiences, and personal relationship to the phenomenon in question have shaped the study. (225) As a registered midwife working within an expanded midwifery care model, I selected interpretive description as most appropriate to explore how midwifery care impacts medication abortion experiences, to examine the unique and shared relationships within and across different contexts, and to construct practical, helpful knowledge for future practice. (225,239–242) Interpretive description methodology allowed me to critically examine how midwifery's philosophy and model of care promote high-quality abortion services. (225,238,242,243) I centred the voices of

participants to produce an understanding of how midwifery supports personalized abortion experiences and Reproductive Justice. (19,244–246) By encouraging ethically based, reliable, and strategically collected data, interpretive description facilitated my exploration and understanding of the different contextual factors influencing midwifery-led medication abortion experiences. (238,242,244,247)

Reflexivity statement and my positionality

Reflexivity is critical to understanding my role in data collection and knowledge construction and comes from tracking reflections made during engagement with the study. (225,228) Reflexivity happens when researchers engage in open self-awareness to explore how their background, gender, social class, ethnicity, values, and beliefs affect the construction of new truths. (234,248) Researchers relate to their data in many ways, and it is their responsibility to choose and justify what interwoven pieces are relevant to their study to manage their role in data collection and analysis. (225,234,235) Power relations occur during all stages of research, including the initial recruitment, data collection, analysis, report production, and writing of additional publications. Disclosing how the researcher is intertwined in the process protects participants' experiences, strengthens the study's integrity, and enhances the authenticity of how the knowledge was produced. (225,228,235)

I position myself within this research as a white person of European settler ancestry fortunate enough to be educated, financially stable, in good mental health, and to have a healthy family because I have been given opportunities unavailable to others through my inherited privilege. In my work and research, I prioritize listening deeply to people facing discrimination, disadvantage, and racism and who experience social and economic disadvantage so that I can provide better care, advocacy, and allyship. (249–252) Professionally, I have worked as a

registered midwife since graduating from the Ontario Midwifery Education Programme in 2007. I provide expanded midwifery care in urban, rural, northern, and remote communities across Northern Ontario. Through my professional and personal standards, values, and philosophy, I strive to provide high-quality, person-centred, culturally safe reproductive healthcare for everyone, specifically for equity-deserving people who are underserved within healthcare systems. I hope my research informs and expands the ability of midwives to lead high-quality and accessible sexual and reproductive healthcare to advance Reproductive Justice.

As the primary investigator, I continue to reflect on the potential differences between my privileges and the participants' social positions. I have influenced and actively co-constructed the data collection, selection, and interpretation. My professional role as a midwife in Ontario practicing in an expanded midwifery care model that provides medication abortion services may have elicited or constrained participants' responses, particularly for those in my community of practice. In addition, my interests, relationships, and conceptual lens impacted the knowledge I have produced. (4,73,74) Throughout this research, I have adopted a reflexive approach by keeping a journal to record thoughts, decisions, and reflections on what is happening in terms of my values, beliefs, and interests. I acknowledge that this study contains my values as a midwife and speaks to what interests me. Through my clinical experience and expertise, I approached this work to accurately describe the participants' responses and interpret the subjective meanings, differences, and similarities of the experiences shared with the intention for the newly generated knowledge to be applied to clinical practice.

Theoretical scaffolding

According to Thorne, scholarly foregrounding and scaffolding are foundational to interpretive description research design. (225,247) Foremost, reviewing the relevant literature

covered in Chapter 2 helped to scaffold my study by grounding the inquiry within existing knowledge, discovering what is known and not known, and identifying gaps. (225) The next step in my scaffolding was locating myself fundamentally, theoretically, and within my field of work. (225,247) Thus, scaffolding has strengthened this research by identifying my logic for choosing interpretive description, clarifying my epistemological disposition and theoretical forestructure, and helping to guide the study. (225,247,254) In this chapter, I will describe how I locate the midwifery profession within my research, my theoretical allegiances, and my values as a sexual and reproductive healthcare professional and advocate.

As an expanded care midwife, my research considered how expanded midwifery care models within primary care settings influence medication abortion experiences. (18,19,94,100,255–257) The salutogenic nature of midwifery, which includes the principles of relationship-building, person-centredness and individual choice, is considered throughout the study. (121,258,259) I draw on the philosophical underpinnings of Reproductive Justice, a human rights theory developed by SisterSong, to explore how expanded midwifery care models impact access to reproductive rights (19,86,255–257,260). See Appendix A: Theoretical Scaffolding, a visual representation of my study's foregrounding.

The midwifery model of care

My knowledge and experience of the midwifery profession's philosophy and model of care have shaped this study. (225) In 1994, Ontario became the first province to regulate midwifery and currently has the most practicing midwives in Canada. (126,205) As regulated by the College of Midwives of Ontario, midwifery care focuses on individualized services that promote health and wellness through informed choice in decision-making, continuity, and choice of birthplace and services (clinic, home, hospital, and community) throughout pregnancy, labour,

and birth, and postpartum. (110,121) The holistic nature of midwifery is grounded in understanding intersecting social, emotional, cultural, spiritual, psychological, and physical factors that shape experiences and worldviews, recognizing the human right to self-determination. (110,120,121,261)

Relationship building

Midwives can offer person-centred encounters by listening to, informing, respecting, and involving clients in decision-making while honouring their wishes and authority over their bodies and lives. (148,262,263) In midwifery care, individuals are called *clients*, not patients, to respect that pregnancy is not a disease but rather a normal part of sexual and reproductive life and that people understand their bodies and are ultimately responsible for their clinical choices. Supportive relationships are built by focusing on the client's needs, values, and preferences in individualized healthcare encounters. (110) Person-centred care is oriented towards mutual understanding, cultural responsiveness, and respect for unique social worlds; positioning the client at the centre of care respects their values, beliefs, knowledge, feelings, experiences, and lifestyle and empowers them to make personalized choices about their health. (24,110,121,213)

Informed choice

Informed choice is fundamental in the midwifery model of care. Midwives engage in informed choice discussions with their clients designed to allow time for individualized decision-making to ensure care is provided appropriately with informed and voluntary consent, supporting human rights. (110) The professional standards midwives meet to offer informed choice include active listening, communicating in ways the client can understand, and providing information about the nature, benefits, side effects, alternatives, and expected outcomes of having or not

having any proposed treatment while supporting the client as the primary decision-maker. (110,213) Achieving informed choice requires building relationships through verbal and written information sharing on current evidence and up-to-date resources, including counselling on available options, location of services, information on what to expect, and comprehensive follow-up tailored to the client's unique needs and shared in a non-urgent and mutual way. (213) Informed choice discussions encourage clients to consider medical information within their personal experiences, values, and beliefs. (110,212,213) With informed choice discussions, midwives can better understand what motivates a client's choices, provide adequate time for discussion and decision-making, and support the right to accept or decline any aspect of care offered. (110,213)

Continuity of care

Continuity in healthcare refers to the coordination and experience of services over time and can be explained as a series of healthcare events connected and consistent with the person's healthcare needs and individual context. (264) There are three different types of continuity of care - informational, management, and relational - and the emphasis of each type varies depending on the healthcare and setting: informational continuity uses information on past events and personal circumstances to make care more appropriate; management continuity emphasizes a consistent and coherent approach to managing a client's changing needs; relational continuity involves an ongoing relationship between a client and one or more healthcare professional and provides a sense of consistency in primary care. (264) Continuity of care results in a more informed midwife available for future client encounters and improves mutual trust, connection, and mutual responsibility. (264–266) The midwifery model incorporates informational, management, and relational continuity and is highly valued by clients. (266,267) Midwifery care

offers all three types of continuity and emphasizes relational continuity within small teams of midwives to promote client satisfaction, increase uptake of preventative services, and improve clinical outcomes while decreasing costs to the healthcare system. (23,110,268)

Within medication abortion services, many people encounter episodic care offered through specialized clinics from healthcare professionals with whom they have no relationship or connection. (143) Although healthcare professionals commonly provide follow-up abortion services, lacking a continuous relationship and navigating fragmented services may impact access to post-abortion care, like the management of complications, preventative care, and contraception counselling and uptake, affecting overall abortion experiences and future sexual and reproductive health. (143) By providing continuity, midwives offer clients access to known healthcare professionals throughout their care encounters and for future sexual and reproductive healthcare needs. (110,120) Internationally, midwifery-led, continuous abortion care has been shown to improve abortion outcomes, increase contraceptive uptake, and promote overall client satisfaction. (137,154,162)

Expanded midwifery care models

This study utilizes my growing expertise in expanded midwifery care and medication abortion services. (94) Expanded midwifery care models are funded midwifery service delivery models originally negotiated in 2017 by the Association of Ontario Midwives and supported by the Ontario Ministry of Health as alternate funding arrangements for midwives working in settings that cannot be funded by the traditional midwifery ‘course of care’ funding model (care throughout pregnancy, birth, and six weeks postpartum for parent and baby). (100) To be funded through the Ontario Ministry of Health, an expanded midwifery care model must meet the following criteria:

- An inability to provide specific pregnancy and newborn services within the existing course of care midwifery models
- Address gaps in service provision and support high-quality and client-centred care
- Support the effective use of healthcare resources
- Maximize midwifery scope of practice
- Support coordination and integration of pregnancy and newborn care with interprofessional primary care and
- Contribute to an efficient and sustainable healthcare system without negatively impacting or duplicating existing pregnancy and newborn services (100)

Midwives working within expanded care can offer services that extend their role beyond the traditional midwifery practice group course of care model to meet the needs of individuals and communities and may provide contraceptive services, sexually transmitted infection treatment, perimenopausal counselling, immunizations, well-baby care up to 18 months of life, and abortion care. (94,95,103) Some expanded midwifery care models are prioritizing and supporting access to healthcare for people with complex needs at increased risk for poor outcomes due to barriers, inequities, and discrimination, such as people who are new to Canada or uninsured, homeless or precariously housed, living with food insecurity, disabled people, and folks who use substances or receive treatment for substance use disorders. (100) In the three expanded care practices selected for this study, organizational conditions were optimal for promoting system change to meet individual and community needs and allowed teams of midwives to provide expanded sexual and reproductive healthcare under medical directives, overcoming professional barriers imposed by policy and legislation. (205)

Reproductive Justice

As a midwife, I have a role in increasing access to high-quality sexual and reproductive healthcare by working to address the intersecting barriers and discrimination that prevent people from reaching sexual and reproductive health and well-being. (256,269) Reproductive Justice, as a framework, a movement, a praxis, and a vision, underpins my understanding of how midwifery-led abortion care recognizes and helps to address the systemic inequities that exist within healthcare systems.

Reproductive Justice moves beyond the concept of pro-choice by centring fundamental human rights, autonomy, equality, and self-determination in sexual and reproductive wellness, including

- ✓ the human right to a healthy and safe sex life without fear of discrimination, coercion, or violence
- ✓ the freedom to decide whether, when, and how often to have children
- ✓ the right to have the information and ability to make autonomous decisions on reproductive health
- ✓ The right to parent children in a safe and healthy environment (19,134,135,257,270)

Furthermore, Reproductive Justice identifies the social, economic, and political conditions such as race, class, sexuality, disability, marginalization, geographical location, and other markers of difference that prevent people from accessing sexual and reproductive healthcare and impact their ability to make meaningful choices and have healthy reproductive and sexual lives. (19,257,260,271) To achieve Reproductive Justice, those of us working in healthcare systems must address the quality, acceptability, and cultural safety of the services we provide by

addressing the everyday acts of power, dominance, discrimination, and racism that equity-deserving people are facing. (19,135,257,271) Health facilities such as hospitals and clinics, educational institutions such as colleges and universities, and professional regulatory bodies are key systems responsible for ensuring equitable, safe, informed, and accessible abortion services. (257) Reproductive Justice is strengthened by healthcare professionals who continue to be well-informed and aware of systemic discrimination, such as colonialism's historical impacts on Indigenous, Black and People of Colour, ongoing culturally inappropriate healthcare delivery, and persistently poor socioeconomic determinants of health that people face and how this intersectionality affects sexual and reproductive rights, access, safety, and outcomes. (19,134,135,257,261)

By engaging in abortion research, I position myself and my work in broader social and political contexts. (271) I have reflected on my positionality and privilege within and across this research process to help recognize, identify, and propose actions for how my work can address inequities and close the gap between science and practice. (257) I supported a sense of joint ownership and respect between myself as the researcher and the participants to ensure my findings are meaningful and contribute to change for those that will benefit the most. (271) By viewing my research through a Reproductive Justice lens, I centre the needs and rights of equity-deserving people while exploring and identifying how midwifery can help actively dismantle systematic barriers and address discrimination within our healthcare systems to respect and support all clients' reproductive rights and promote social justice. (162,257,260,261,272)

The organization SisterSong constructs its collective identity through storytelling. (19,134) Based on the three tenets of Reproductive Justice – equitable access to care, bodily autonomy, and self-determination - I will share three stories of midwifery-led abortion

experiences to illustrate how and why my beliefs, values, and growing knowledge have shaped this research.

Equitable access: self-managed abortion

May, an uninsured newcomer, contacted our program requesting abortion care after learning about midwifery-led abortion care from a nurse at a walk-in clinic. May had experienced a medication abortion two months earlier by prescription from another healthcare professional. At that time, May chose not to attend follow-up visits as they felt the abortion was complete without complication. Their current pregnancy was unplanned and unwanted, and May requested a medication abortion. May was sure of their last menstrual period, having had one menstrual cycle since the abortion, which dated the pregnancy at less than seven weeks gestation. I offered a diagnostic ultrasound in the community to confirm gestational duration, but May declined, commenting that the ultrasound was too expensive last time. As I am trained to provide point-of-care ultrasounds, I offered a point-of-care ultrasound scan, explaining that it would not be diagnostic but could confirm the pregnancy location and possibly provide an estimated gestational duration. I also offered to do bloodwork for a pregnancy hormone (βHcG) level to compare to after the abortion was complete and sexually transmitted infection screening, asking May if the cost for these tests was reasonable and affordable. After our phone discussion, May attended an in-person visit the next day, requesting a scan, bloodwork, and sexually transmitted infection screening. The point-of-care ultrasound identified an intrauterine gestational sac of approximately six weeks since May's last menstrual period, I drew bloodwork, and May collected self-administered vaginal swabs. After an informed choice discussion on pregnancy options, May requested a medication abortion. I asked if May could read English and reviewed our written information on what to expect and how to take the medications, pain management

strategies, and when to seek urgent care. When I provided May with a tote bag with some supplies we offer to clients experiencing a pregnancy loss or abortion, May thanked me, sharing how they appreciated having things to make this abortion more comfortable. With the help of our collaborating medical doctor and prescriber, we also applied for a compassionate medication abortion prescription through the drug company, as May said they would find it difficult to afford a second prescription within such a short time. I contacted May within four days of our office visit, and they had since received the medication abortion prescription. We discussed the ideal and preferred timing for completing a medication abortion, and May chose to take the medications following their student exams two weeks later. Subsequently, May was seen for an in-person visit five days after the medication abortion was completed and requested a repeat βHcG. Contraceptive counselling was offered, and May was considering having a copper intrauterine device placed for pregnancy prevention. May made an appointment two weeks later for an intrauterine device insertion but chose to cancel this and requested a phone visit instead. I phoned May to inquire into any unmet post-abortion needs and to offer support. May did not want an intrauterine device inserted at that time, did not wish to start another form of contraception, understood the risks of unintended pregnancy, and planned to use condoms for sexually transmitted infection protection and pregnancy prevention for now. I encouraged May to contact our program for future sexual and reproductive healthcare needs. May expressed gratitude for our care and said they would happily contact a midwife in the future.

Through May's story, we see that barriers to safe abortion in Canada persist despite legalization and 'universal' funding when social resources determine access to services. (49) Many people in Canada face inequitable or lack of access to comprehensive abortion care, magnified for those affected by precarious migration status and lack of health insurance.

(14,20,257,271) In this story, May's self-managed abortion promoted health equity and made care more accessible, acceptable, and appropriate by weaving it into the fabric of their everyday life. (49) Treating clients with dignity, respecting them as primary decision-makers, creating safe spaces, allowing extra time in visits for addressing complex health and social needs, being knowledgeable about local resources for specific challenges, and having the resources, training, and ongoing support to provide comprehensive care is essential for equitable access to abortion. (25,273)

Autonomy: disability and abortion

Trina identifies as having a disability and lives with their partner, who is not disabled. They presented to a walk-in clinic with an unintended and unwanted pregnancy for early abortion care. Trina had a dating ultrasound and initial βHcG bloodwork. The walk-in clinician referred Trina to our program as they thought Trina would benefit from client-centred information sharing and support. Upon receiving the referral, I organized a phone visit with Trina the same day. We briefly reviewed their unwanted pregnancy, including the ultrasound, which dated the pregnancy to nine weeks. I asked Trina questions to explore her unique needs, and we made an in-person appointment for the next day around her work schedule. Trina attended this visit with their partner and clearly stated they did not want to be pregnant, give birth, or raise a child and that they did not feel they could support. Their partner expressed concerns about Trina's ability to handle having an abortion. In addition, their partner expressed they wanted Trina to continue the pregnancy but supported Trina's decision to terminate the pregnancy. By the end of the visit, Trina requested a medication abortion prescription, concluding that they wanted to be at home with their partner for the abortion and felt they could handle it with support. I organized a medication abortion prescription with our centre's on-call

clinician to be sent to the pharmacy of their choice. I gave Trina a bag of supplies along with visually descriptive paperwork, reviewing the information with the couple by asking if how I explained the information made sense to them. We arranged a follow-up phone call the next day, so Trina had time to ask more questions or voice any concerns that might arise. The next day, Trina discussed the plan to take the medication abortion prescription over the weekend to avoid missing work and when their partner could be home. Trina expressed concern with waiting until the weekend to have an abortion but said that it was important for them not to miss work during the week. We discussed the guidelines for medication abortion, determined it would be safe to proceed with abortion at home over the weekend based on their unique needs, and reviewed when and how to seek urgent care through the emergency department for complications or concerns after our office hours. We scheduled a phone visit following the weekend on Monday and planned an in-person visit one week later for post-abortion care. At the phone visit, Trina reported the pregnancy had passed, as I had explained, that they felt supported by their partner and felt relieved to no longer be pregnant. Trina confirmed that the blood loss was minimal now, they were feeling physically well enough, and they wanted to return to work. One week later, I met with Trina in person for post-abortion care, where they requested a referral for counselling and expressed thanks for the care the midwives provided. After an informed choice discussion on sexually transmitted infections and cervical screening, contraception, and reproductive planning, Trina chose to take more time to consider post-abortion options. Subsequently, Trina attended two more visits, where they had cervical cancer screening and sexually transmitted infections screening and requested a prescription for oral contraception, stating they would also use condoms for pregnancy and infection prevention. We encouraged Trina to contact our

program for care in the future. Following their last visit, Trina dropped off colourful, heartfelt, and personalized thank you cards for both midwives involved in her care.

The principles of autonomy dictate that healthcare professionals aid decision-making by engaging in discussions and mutual understanding of unique personal choices, accepting both action and inaction. Agency is vital for human rights and body autonomy, and access to abortion and contraception needs to be empowering. (134,135) Offering abortion as a regular part of healthcare includes getting a prescription from primary healthcare clinicians without restrictions and improving personal autonomy. Within a supportive system, medication abortion prescriptions can be self-administered at home when the person deems it appropriate, with follow-up support as needed. (274) Autonomous choices within self-managed abortion can be a source of reprieve from indignities such as mistreatment and stigma people with disabilities made vulnerable may encounter in more formal settings. (20,49)

Self-determined: pregnancy decision-making

Lynn identifies as an Indigenous person and struggles with health concerns and low socioeconomic status. Lynn had midwifery care through an expanded midwifery care program, receiving care for two previous pregnancies. Lynn's postpartum care included extended well-baby care, postpartum care, and contraceptive counselling. Lynn did not choose to start a form of contraception despite contraceptive counselling at the postpartum and well-baby visits and a history of having a return of menses three months postpartum with previous births. Lynn was concerned that they had not had a period since their most recent birth and took a home pregnancy test, which was positive. Lynn called the midwives and requested an abortion, explaining they had experienced a medication abortion in the past with no concerns and did not want to have more children. The next day, Lynn had an in-person visit, βHcG bloodwork, and made an

appointment for a dating ultrasound. When the midwife provided abortion-related information and supplies to take home, Lynn commented that her previous abortion experience did not involve much care and expressed gratitude for the extra support. The ultrasound facility contacted the midwives two days later, stating that Lynn had missed the appointment. When the midwife called to ask if Lynn needed help rebooking the ultrasound, they discovered Lynn's had experienced an immediate family member's death. Lynn stated they did not know what to do about the current pregnancy. The midwife offered compassionate listening, acknowledged Lynn's tragic loss and the complex circumstances surrounding the current pregnancy, and offered to provide whatever care was needed when Lynn was ready. Lynn appreciated the support and requested a phone visit in five days. At the next phone visit, Lynn was unsure how to proceed and asked the midwife for help to rebook a dating ultrasound as soon as possible. The following day, Lynn's pregnancy was dated at six weeks and five days gestation. The midwife followed up with Lynn by phone, explained her pregnancy dating and options, and offered visits whenever Lynn felt it might be most helpful. Lynn scheduled weekly phone visits for support and pregnancy planning. A month later, Lynn continued their pregnancy and prenatal care with the midwives.

The World Health Organization defines social determinants of health as the conditions in which people are born, grow, work, live, and age. (273) Social determinants are the broader forces and systems that shape daily life, including income, social support, early childhood development, education, employment, housing, and gender. (273,275) Many conditions people face result from upstream and insidious structural forces like the ongoing challenges and impacts of colonization, intergenerational trauma, systemic racism, and lack of self-determination, which further influence determinants of health. (276–278) Healthcare professionals support clients in

achieving self-determination by inviting respectful discussions and sharing compassionately and caringly. (25) Empowering those who seek abortion care to make decisions autonomously outside of the healthcare setting may improve comfort and privacy and provide better access for equity-deserving populations at greater risk for poor health. (15,134)

Study design

Ethics

Before, during, and after a study, researchers need to protect professional ethics and respect participants. To avoid imbalances of power, participants should understand the meaning of the study and freely volunteer to participate to the best of their abilities. (248,279,280) Before starting, the researcher must consider the study's reasons and goals, commit to protecting the population's well-being and privacy, and ensure their ability to present the research clearly and honestly. (279) During the process, the researcher must consider how they present themselves, carefully select the language they will use, acknowledge power relations during data collection, inform participants about the nature of the research, acknowledge both researcher and participant thoughts and feelings as they emerge, and ensure a reasonable balance between potential benefits and possible burdens. (248,279,280) Following data collection, the researcher should recheck the well-being of participants and stay true to the meaning of their voices. (248,279)

Ethics approval was obtained for this study within the larger multiple-case study that I helped develop from the Hamilton Integrated Research Ethics Board at McMaster University. All research team members were accountable for the study protocol and maintained appropriate ethical standards throughout the study. Regular check-ins with my supervisor, thesis committee

meetings, and monthly graduate student group sessions guided the investigation and ensured the research was appropriately and ethically conducted.

Potential risks to participants

The risks to the study participants were minimal. However, as participants were asked questions regarding abortion care, some of the risks involved imbalances of power and privilege, privacy concerns related to the stigmatized nature of the phenomenon in question, and concerns regarding breaches of confidentiality of their personal information. Furthermore, participants were from various socio-economic backgrounds and may have had disadvantages that made involvement in the study more challenging. Finally, participants were asked questions that recalled sensitive and potentially complex life events, which may have involved psychological discomfort, distress, or experiences they wished to keep private.

To manage and minimize potential risks, the research team applied and maintained the Tri-Council Policy Statement's three core principles. (281) Participants could choose not to answer any given question or to withdraw from the study at any time up until data synthesis was commenced. In addition, the research team carefully considered the quality of participants' experiences to minimize possible psychological pain or distress by utilizing social and mental health services embedded in the community health centre and family health team settings when needed. The researchers immediately anonymized the information collected, transcribing raw data as soon as possible, extracted quotations carefully to exclude contextual details that may have made the participant identifiable, and shredded all hard copies with sensitive information (e.g., handwritten notes taken during interviews) as soon as feasible.

Privacy, data storage, and protection

Participants' personal contact information was collected and stored in REDCap separately from the survey responses, so they could not be linked. Consent forms were securely stored using REDCap. Survey data was collected and managed in REDCap. Survey data were de-identified and organized by assigning study codes to participants, giving each participant a unique code and storing the encrypted, password-protected study key in a secure, online data storage platform, MacDrive, hosted by McMaster University. I only kept an electronic copy of the study key. Raw interview data was initially stored using secure McMaster University Zoom cloud storage. The researchers did not record audio-visual files onto devices. Recorded interview files were transcribed as soon as possible and destroyed once the transcription was completed. De-identified and completed transcripts were stored on MacDrive. See Appendix B: Blank study key.

Equity, diversity, and inclusion

Considerations for equity-deserving groups and respect for participants included accountability and transparency throughout the research process. (281) While the research team was not comprised of people who identify as Indigenous, Black, and People of Colour, the participants recruited included midwives, healthcare clinicians, and clients who identified as racialized and equity-seeking people facing social and structural barriers to healthcare in northern, urban, and underserved locations across Ontario. Because the Northern healthcare organization and expanded midwifery care program are located in areas where under-served populations reside, participants included equity-seeking people with diverse social determinants of health such as disability, mental health challenges, substance involvement, housing insecurity, low socioeconomic status, racialized identities, Indigenous identities, learning issues.

Client participants were recruited through midwives who were familiar with their care and sensitive to their unique needs. Clients with vulnerable circumstances were given special consideration to be able to participate. We could offer clients accommodations such as interpretation services, transportation assistance, device access, and flexible interview times and locations (phone, online, home, clinic, and community) if needed. If there was no internet device access, we could offer a verbal consent process and for the individual to complete the consent with privacy, on-site with a tablet. We could provide verbal support for clients with visual or literacy issues. We had grant funding to provide additional accessibility (e.g., translation) services as needed.

This research considers how experiences of medication abortion care might have been affected by intersecting factors such as language, gender, sexual orientation, racial/ethnic group, racialized identity, Indigenous identity, disability identity, services received, and geographical location (19,255–257). Our health equity survey collected demographic data and information related to social determinants of health and services received. (282–285) In addition, qualitative interviews allowed participants to describe their experiences, needs, and preferences in their own words. Finally, the research findings will be shared with midwifery stakeholders and policymakers to expand understanding about access to abortion services and to meet the unique and everyday sexual and reproductive healthcare needs of equity-seeking and underserved people.

Consent

Consent was obtained through informed choice before each part of the study. Information letters were emailed to participants, and consent was reviewed before the interview. The researchers emailed participants a unique link to REDCap to provide online consent and

confidentially complete the health equity survey. Consent was obtained directly from participants over the age of 16. Parental consent and participant assent would be obtained for any participant between the ages of established menarche and fifteen. Finally, all participants were competent enough to consent and participate freely.

Participants were securely mailed or given a signed copy of the information letter and verbal consent form following the discussion. After providing consent, no survey or interview questions were mandatory. Participants received a unique REDCap link to the health equity survey that allowed the research team to identify and remove their data should they wish to withdraw after submitting their data. The participants could contact the supervising investigator on the provided information sheet to request removal from the study during the interviews until data analysis was completed. See Appendices D, E, and F: Participant information letters.

Methods

Purposeful sampling

This research focused on the medication abortion experiences of the midwives, collaborating healthcare clinicians, and clients from three expanded midwifery care practices across Ontario that offer and provide abortion services. (94,95,103) My study aimed to produce knowledge about midwife-led medication abortion from individualized and shared experiences to apply to clinical practice and not generalizations that would pertain to the general public; thus, I used purposive sampling so that the findings would best represent the experiences of midwives providing care for people needing medication abortions. (225,286) Three groups were invited to participate: 1) midwives providing abortion services within expanded midwifery care models, 2) healthcare clinicians with experiences of midwifery-led abortion care, and 3) clients who had

received abortion services from midwives. I chose these three groups to explore their knowledge and experiences relevant to midwifery-led medication abortion care. (286)

Recruitment strategies

Expanded care midwives providing comprehensive abortion care were identified from a publicly available list through the Association of Ontario Midwives of Ontario and known to me through mutual learning and peer review opportunities. Midwives were approached in person, by phone, or by email and provided with information on the study. Those who expressed interest in participating were contacted again by email or text, provided a link to review the study information, and sent a link to collect virtual consent to participate. Virtual consent was obtained before completing the health equity survey in REDCap.

Next, midwives enrolled in the study were asked to introduce the research directly to clients and clinicians with experience in midwifery-led medication abortion care and to obtain permission for those interested to be contacted for research purposes. The recruiting midwives could enter potential participants' contact information directly into REDCap for those who gave permission. (287) Recruitment to the study occurred after client and healthcare clinician participants responded to the invitation from the research team. The researchers contacted client and clinician participants by phone, email, or text with a letter of information and an invitation to participate. As with midwife participants, virtual consent was obtained before completing the health equity survey in REDCap.

I am one of three midwives providing midwifery-led medication abortion services at the Northern location. While the midwife-client relationship is non-authoritarian, there is an inherent power imbalance in my relationship with participants connected to me. To minimize the negative

impact on participants, I was not involved in the care or interviewing of midwife, client, or healthcare clinician participants who had been actively engaged in my care at the Northern location. See Appendix C: Recruitment script.

Sample size

Invitations to participate in the research were sent to midwives known to be providing or supporting medication abortion services at the three sites included in this study. Four midwives at the Northern location, four at the Southern 1 location, and five at the Southern 2 location were invited to participate and to help purposefully recruit collaborating healthcare clinicians and clients who had had experiences with midwifery-led medication abortion within their organizations. The final number of midwife, client, and clinician interviews depended on the response rate and time constraints for completing my thesis. See Chapter 4: Findings for the final number and description of participants.

Data collection

Four data types were collected from three locations and multiple participant types: health equity surveys, interview audio recordings and transcripts, internal clinical practice documents, and field notes. A confidential health equity survey developed for the larger multiple-case study was used to collect demographic information like language, gender, sexual orientation, racial/ethnic group, racialized identity, Indigenous identity, disability identity, and expanded midwifery care services received and information about location-specific expanded midwifery care services. All participants completed similar versions of the health equity survey except for rephrasing questions related to services offered (midwives, clinicians) or received (clients). Participants gave online consent through a unique REDCap link before virtually completing the

health equity survey. As no question was mandatory, some participants chose the "prefer not to answer" option. In addition, participants could quit the health-equity survey at any time. Of note is that participant demographics are not reported in my study to protect participant confidentiality. See Appendices H & I: Health equity surveys.

In-depth, semi-structured interviews were planned to generate subjective textual data exploring participants' thoughts, perceptions, and experiences of midwifery-led medication abortion care within unique expanded midwifery care settings. The semi-structured interviewing technique allowed the researchers flexibility to follow ideas of interest raised by participants while continuing to focus on the topic of interest. (244,288) It also allowed participants to describe their perceptions of expanded midwifery care and experiences of midwifery-led abortion in their own words. Questions related to experiences, impressions, concerns, and satisfaction with midwifery-led medication abortion care allowed documentation of thoughts, values, and beliefs about midwives as abortion providers. Interviews were conducted via Zoom or telephone. Informed consent was confirmed immediately before each interview. All interviews were audio recorded through Zoom, and the interviewer took field notes during the data collection period. (289,290) The study's theoretical scaffolding informed interview questions to explore how expanded midwifery care models integrate the philosophy of midwifery care into abortion services, impact abortion experiences, and ultimately contribute to Reproductive Justice. See Appendices J, K, L: Interview guides.

The midwife participants were asked to identify practice and organizational documents that could inform the study. The purpose of including documentary data for this study was to review information on how midwives provide medication abortion care under medical directives, what may be shared with clients, and what the clinical pathways are for interprofessional

medication abortion care at the three expanded midwifery care sites. In addition, field notes kept during the participant interviews and meetings with my thesis committee members were considered throughout the research to inspire reflexivity, iteration, and data analysis. (225,253,291)

Data analysis

Multiple-layered readings, writing, comparison, coding, and self-reflection are standard in qualitative analysis. (243,292,293) Early in the process, I recorded what I saw in the data and created tentative codes to explore further, direct, and focus further on data collection. (294,295) Later-stage memo writing helped me to place initial codes and categories within themes and subthemes to describe, compare, categorize, subcategorize, refine, and make conjectures about the data. (291,295) In addition, memo writing helped me to challenge assumptions, thoughts, actions, relationships, and decisions that shape the study through reflexive research practice. (291,295) Furthermore, I employed the six steps of Thematic Analysis, as outlined by Braun and Clarke, commonly used in qualitative research, including familiarizing myself with multiple readings, selecting keywords from transcripts, coding keywords while staying true to the participant's meanings and experiences, developing themes that relate to my data set, research question, and aim and purpose of this study, and conceptualizing the data into findings to produce co-constructed new truths. (293,296,297) Using interpretive description methods and thematic analysis has helped me see through and beyond the data, develop meaningful relationships between themes for analysis, and synthesize the data into meaningful findings. (295)

Within this interpretive description study, I led the data analysis and made informed connections and associations between the participant's unique and shared experiences to generate

new knowledge. (293) As Thorne suggests, my initial open coding was made simple by memo-writing and field notes taken during transcript review that effectively highlighted thematic similarities. (293) Through constant comparative analysis, my themes were developed and left open well into my analysis and synthesis of the data to prevent misinterpreting code frequencies as themes. (293) To increase rigor and produce trustworthy findings, I was encouraged to confirm my biases, expand associations, and study relationships, and consider alternative hypotheses throughout the research process with ongoing feedback from my supervisor and committee members. (225,292,297–299)

For my thesis, memo writing, coding, and analysis occurred concurrently using qualitative software. (300) My theoretical scaffolding, interpretive description methodology, and Thematic Analysis guided this iterative process and helped me understand, describe, interpret, and synthesize the data collected. (301–303) I conducted an open-coding qualitative analysis of interview transcripts, personal emails, and field notes using NVivo software. (300) Finally, my analysis involved reviewing documents internal to the expanded midwifery care programs shared with me, such as protocols, clinical pathways, medical directives, and client information related to expanded midwifery-led medication abortion care. I iteratively analyzed the transcripts, memos, and documents within my research process, and preliminary thematic insights informed my subsequent sampling and data collection. Finally, the analysis and conceptualization of the data created individualized descriptions within unique contexts of midwifery-led medication abortion that were synthesized across three locations and multiple participant types to produce co-constructed and meaningful truths. (244,304)

Data synthesis

Unlike the formal structures for organizing quantitative research, there is no set style for writing and reporting qualitative findings. (225,298,305) Synthesizing my qualitative data has involved academic and creative skills, balancing scholarly and original writing to maintain credibility while exciting the reader. (225,298) As *thinking* comes before *writing*, I read my notes, reviewed other studies related to this research, and talked to my colleagues to generate ideas. (225,298,305) Sandelowski encourages qualitative researchers to transform or *re-present* data by balancing the facts, analyzing to manage and see data in new ways, and interpreting to generate new meanings. (305) My choice of *what story to tell* fits my research purpose and methods. (305) Thorne explains how interpretive descriptive studies describe elements of human subjective experience to expand the ability of a practice discipline to solve problems. (225) Following interpretive description methodology, I created a clear outline before writing, separated the 'whole' into parts, and organized and ordered the parts into a sequential argument. (225) Next, I returned to the data to distinguish what was contextually essential from what was peripheral or diverting. (225,298,305) Finally, I identified and explored common threads across participant interviews, compared data and themes between locations, and considered unexpected findings to build a story from multiple accounts of midwifery-led abortion within primary healthcare settings. (297,301,306)

Trustworthiness and rigor

A clear intention is vital to rigorous research and encourages consideration beyond theoretical understanding to determine whether findings will be applied to improve research quality. (247) By identifying theoretical underpinnings, using multiple data collection methods,

and studying different aspects of a phenomenon, I have enriched my study and increased the credibility and validity of my findings. (307,308)

Thorne suggests enhancing the quality and credibility of interpretive description research through four principles: epistemological integrity, representative credibility, analytic logic, and interpretive authority. (225) As such, I have collected data that supports the social construction of new knowledge. Decisions regarding what expanded midwifery care locations, participant types, and interview questions to include were informed by my professional knowledge, skills, and experience, and I carefully chose to offer multiple views of the phenomena. My study's analytic logic included appropriate methodology, methods, analysis, synthesis, descriptions, and interpretations to answer the research question. My professional designation as a registered midwife working in expanded midwifery care supports my interpretive authority: it gives readers confidence that my findings represent a rich understanding of participants' subjective experiences of midwifery-led medication abortion and my interpretation of how the findings relate to midwifery and contribute to Reproductive Justice. While some readers may not agree with my thoughts, values, and beliefs, they can follow my story, understand the phenomena experienced from multiple perspectives, appreciate how I constructed my findings, and choose how the knowledge presented may be used in practice.

The McMaster Midwifery Research Centre supported my research through the 2023 Grant Program Graduate Research Award and mentorship from experienced staff. In addition, data about experiences of midwifery-led medication abortion was collected within participant interviews for a multiple-case study investigating the impact of midwifery integrating into primary care settings across Ontario, facilitating input and member checking with a larger research team. Rigor was ensured through the triangulation of methods (health equity surveys,

interviews, and document analysis), different data sources (midwife, clinician, and client informants), and member checking with my supervisor and thesis committee members. My thesis committee included Dr. Liz Darling, RM, Ph.D. (Director/Assistant Dean, Midwifery Education Program, Associate Professor, Department of Obstetrics and Gynecology, Associate Member, Department of Health Research Methods), Dr. Susan Jack, RN, Ph.D. (Professor, School of Nursing, Associate Member, Department of Health Research Methods), and Dr. Meredith Vanstone, Ph.D., (Associate Professor, Department of Family Medicine). The experiences of my committee members related to midwifery knowledge and qualitative health research supported my study's development, conduction, rigour, trustworthiness, and completion.

Summary

This study viewed participants' experiences of midwifery-led medication abortion through a Reproductive Justice lens to explore the impact of midwifery care on abortion experiences when provided through expanded care models within primary healthcare settings. I chose interpretive description methodology to examine and compare midwifery-led medication abortion experiences through participant interviews, demographic surveys, and location-specific practice document review. As a midwife and researcher, I analyzed, described, and interpreted the data using interpretive description and thematic analysis to consolidate meanings, theorize relationships, and produce co-constructed truths to apply to clinical practice. The knowledge generated may help inform midwifery practice, meet the needs of clients, healthcare professionals, communities, and the midwifery profession, and be of interest to decision-makers and policymakers.

Chapter 4: Findings

This chapter describes the initiation, provision, understanding, and experiences of midwifery-led medication abortion within three expanded midwifery care models across Ontario. I begin with a brief explanation of the participants interviewed. Next, my findings are organized within constructed themes from my data analysis and synthesis. A Reproductive Justice lens continually informs this description of midwifery-led medication abortion experiences.

Participants

A total of 18 participants were interviewed. This study will not report personal information to protect the confidentiality of the organizations, midwives, healthcare clinicians, and clients who participated. See Table 1 for participant types, locations, and numbers.

Table 1: Interviews by participant type and location

Participant type	Location	N	Total
Midwives (RM=Registered Midwife)	Northern Southern 1 Southern 2	4 2 2	8
Clinicians (NP=Nurse Practitioner, MD=Medical Doctor)	Northern Southern 1 Southern 2	3 1 1	5
Clients (C=Client)	Northern Southern 1 Southern 2	5 0 0	5
Total	3		18

Eight midwives who work within interprofessional teams participated. The expanded midwifery care model programs were located within primary healthcare organizations funded and located to increase access and promote health services for diverse clients and communities, including two community health centres and one family health centre. (93,102)

All midwife participants were familiar with members of the research team through shared professional opportunities and experiences in abortion care. See Table 2 for a collective description of the midwives' roles in medication abortion care within their organizations.

Table 2: Midwife participant experiences in medication abortion care

Midwife participants have or currently are:	Northern	Southern 1	Southern 2
Initiated and established expanded midwifery care services	✓	✓	✓
Co-lead program development	✓	✓	✓
Work within the organization before medication abortion was offered	✓	✓	✓
Work to support midwifery-led abortion in other communities	✓	✓	✓
Work as an employee midwife	✓	✓	✓
Develop and implement medical directives	✓	✓	✓
Offer care in Northern communities	✓		
Participate in abortion-related leadership and professional education	✓	✓	✓
Work in midwifery practice groups	✓	✓	
Collaborate with Indigenous midwifery practices	✓		✓
Collaborate with other expanded midwifery programs offering abortion services	✓	✓	✓
Refer clients to expanded midwifery care for abortion and contraception care	✓		
Provide post-abortion care, including contraceptive counselling, screening, and treatments	✓	✓	✓
Insert and remove long-acting reversible contraceptives	✓	✓	

We interviewed two nurse practitioners and three medical doctors across the three locations who worked interprofessionally with midwives to support some aspects of expanded

midwifery care. The healthcare clinicians who participated offered varying degrees of collaboration for comprehensive abortion care, including authorizing midwives to provide abortion medications and contraception through medical directives or ordering services for tests and procedures that may arise during comprehensive abortion care like thyroid screening, pelvic ultrasounds, sexually transmitted infection treatments, and contraceptive prescriptions listed within Ontario midwives' pharmacopeia as defined by the Midwifery Act of 1991 and the Laboratory and Specimen Collection Centre Licensing Act, R.S.O. 1990, c. L.1. (136,216)

Five clients were recruited midwives familiar with their care and voluntarily agreed to be interviewed. Clients were only recruited from the Northern location due to the time constraints for purposeful recruitment and completing a master's thesis. The clients had unique midwifery-led medication abortion experiences, including multiple pregnancies with the same midwives, repeat medication abortion experiences, and medication abortions for incomplete miscarriages. All clients had post-abortion care with their midwifery team.

Findings

Themes were constructed during the research process and finalized after collecting, analyzing, and synthesizing the data to describe where, why, and how midwives are providing expanded midwifery care and medication abortion services through primary care organizations. First, I describe access to medication abortion from multiple perspectives. Next, themes and subthemes related to *building relationships*, *developing expertise*, and *gaining credibility* describe the development and provision of medication abortion within the three locations. Finally, the themes of *increasing access* and *normalizing abortion* help to explain midwifery models of medication abortion care and how midwives impact abortion experiences.

My thoughts, values, and experiences as a midwife providing medication abortion services inform these findings. Concepts related to Reproductive Justice were considered throughout my analysis of interviews, practice documents, slide decks of presentations, medical directives, charting templates, personal and professional observations, and reflections I have collected along the way.

The nature of the problem: access to medication abortion

In their interviews, midwives and clinicians described the barriers, hurdles, and pathways they negotiated when midwifery-led medication abortion care was initiated, including managing some hesitations around conscientious objections and concerns about on-call responsibilities. Midwives and clinicians from all locations described how midwives worked to educate other team members about medication abortion and explained how midwives designed comprehensive abortion care services to meet community needs.

Before the integration of midwifery-led abortion into these primary care locations, midwives, nurse practitioners, and medical doctors recalled barriers to abortion, such as a lack of services, few or no clinicians offering abortion, long wait times to see specialists, and negative attitudes and discrimination towards clients needing abortion care, all of which made getting contraception and abortion more difficult or impossible for some clients. In the Southern 2 location, participants commented on the lack of medication abortion services in their region before midwives established expanded midwifery-led medical abortion care, recalling that no outpatient clinics and few primary healthcare clinicians were comfortable offering medication abortions at that time. Despite being a large urban centre, clients often had to “leave the city” if they wanted a medication abortion. (MD3, RM7, RM8) In the Northern location, before midwives offered abortion services, midwives, nurse practitioners, and medical doctors

interviewed explained that very few clinicians offered medication abortion across their region, and people who presented for early abortion had to navigate services through a free-standing sexual health clinic or referral to a specialist for medication abortion prescriptions. A Northern clinician explained the hesitation from primary care doctors to provide medication abortions:

> *I don't think there's a lot of physicians actually prescribing [mifepristone and misoprostol] or feeling comfortable with the knowledge to prescribe…the SOGC [Society for Obstetricians and Gynecologists] has a course, but you have to pay for it, you know? So, there's a lot of barriers for physicians to be prescribing. (MD1)*

In the Southern 2 location, midwives and the nurse practitioner described how, despite being a major centre with more abortion services, they were seeing uninsured people without residency status who could not afford an abortion and would often present for care later in pregnancy before midwives started offering low-barrier abortion care.

The clients interviewed identified one of the barriers to getting medication abortion care including a lack of support from their family, friends, and other healthcare professionals. One client explained, "the people I hang around with are kind of, like, close-minded" and said they did not know how to find an abortion provider in the community. (C4) Some clients called multiple healthcare facilities to see a clinician willing to offer medication abortion care. One client remembered thinking: "What am I supposed to do now? Like…the [midwifery practice group] midwives don't want me. Like, my doctor's not calling me back. Like, what do I do now?" before being referred to the expanded midwifery care program. (C5) Several clients said they had previously experienced poor treatment when accessing healthcare for unwanted pregnancies. One client who faced negative attitudes and a lack of compassion at the emergency department compared that experience to having a medication abortion with midwives:

> *…in the hospital, my experiences there have been so poor. Like, in the emerg department when everyone there is like, 'go, go, go, go, go' and has no time to see you. So, going through the midwife program, it was really good 'cuz they actually, you know, could sit with me and understand the pain that I was going through. (C4)*

Midwives and clinicians described how their primary healthcare organizations cared for diverse clients and described some of the priority populations as *lower income, newcomers, uninsured, substance involved, precariously housed, racialized, Indigenous,* and *complex,* with disproportionate barriers to care and increased needs for comprehensive health services. Midwives, nurse practitioners, and medical doctors from all locations described how their clients often had poorer social determinants of health and higher rates of unintended pregnancies. In addition, in the Northern location, participants described geographical challenges, a shortage of primary healthcare professionals, and inadequate access to specialists, hindering people from getting timely abortion care. All three locations reported seeing increased needs in terms of access to abortion care with uninsured clients such as new Canadians and international students, people who have lost or stolen health cards, unable to keep track of their healthcare because of substance use, street involvement, or living in precarious and unsafe environments. In addition, every location described how wrap-around services within their organizations, including dieticians, diabetes specialists, counsellors, psychiatrists, health workers, addictions support, drop-ins at shelters and community agencies, and outreach workers try to address social and ecological determinants of health by bring together health workers and equity-deserving people at risk with increased barriers to care. To address community needs for better access to abortion services, midwives and clinicians credited their organizations for encouraging healthcare tailored to individual needs and circumstances.

Initiation of midwifery-led abortion care

The midwives initiated, developed, and integrated comprehensive medication abortion care in their locations, introducing midwifery-led abortion services at different stages for various reasons. The Southern 1 location midwives started providing medication abortion in partnership

with an external obstetrician-gynecologist soon after their expanded midwifery services began in 2018 to address the lack of medication abortion care in their region. As some of the first midwives to provide medication abortion through expanded midwifery care, these midwives described how developing medical directives and clinical pathways for midwifery-led abortion was challenging and time-consuming work:

> *We did our own independent research, developed our own care pathways, administrative pathways, medical directives, and documentation templates and handout for clients…. I mean, I think because we started at the very beginning, we were one of the first; it felt a lot like creating the wheel for the first time. (RM7)*

The Southern 1 location participants explained that because their organization was the only option offering outpatient medication abortion services within a large region, they started caring for clients from other communities who had to travel long distances for midwifery-led medication abortion. Since the midwives initiated abortion services through their expanded care program, two other outpatient clinics began providing medication abortion in their city. However, the midwives and clinicians interviewed identified an ongoing need for low-barrier medication abortion access for people experiencing barriers to accessing care in their region.

When the Southern 2 location midwives began seeing clients in 2018, they supported clients rostered to primary healthcare professionals internal to their organization who were referred to the expanded midwifery care program for extra support. A Southern 2 location midwife remembered their first call for abortion services:

> *Our first request for abortion care came through the [addictions program]. So, it was a patient who was an opioid user, and one of the harm reduction outreach workers called upstairs and said, 'Is there a midwife? Could you come down to us? We know somebody's pregnant and doesn't want to come upstairs. Can you come down and talk to her?' (RM6)*

The midwives explained that despite living in a large city, many clients who needed an abortion had issues accessing care, like not having access to a phone or transportation, struggling with substance use disorders, living in precarious environments, or not having health insurance to pay

for services. To help address these challenges, the Southern 2 location midwives decided to offer low-barrier services in partnership with medical doctors, nurse practitioners, and leadership within their organization, accepting referrals for anyone needing an abortion across their large region. Midwives from every location commented on the number of clients who needed an abortion but could not afford the associated costs and how their expanded midwifery programs and organizations have worked to reduce or eliminate some of the costs for uninsured health services for people who could not afford them.

The Northern midwives started seeing abortion clients in a supportive role in 2018. Their expanded midwifery care program was initially aimed at increasing access to perinatal and postpartum care, providing sexual and reproductive services, and extending care for parents and babies to six months of age. When their organization started to receive more requests for abortion support, including post-abortion contraception, the midwives began offering post-abortion follow-up. They partner with an external obstetrician-gynecologist to train in intrauterine contraceptive device insertions and an internal clinician for support placing subdermal contraceptive implants beyond the initial postpartum period. One Northern midwife explained how, within their expanded postpartum and well-baby care, some parents were presenting with unplanned pregnancies and requesting medication abortions:

> *It became more and more that clients would be saying, 'Well, why do I have to go see this person? Why have to go see another person get this medication prescription?... And we kept saying, 'Well, you know, this is at the limits of how midwives work, and this is what we were able to do here.' And then people would have trouble getting to the appointments, or they would just be reluctant to go and see a new provider. (RM1)*

The Northern location participants identified two ways of accessing medication abortion before the midwives offered this care: through a central intake and referral to specialist care or from the only free-standing health clinic that provided openly available medication abortion.

Unfortunately, the free-standing clinic closed suddenly in 2020 at the height of the COVID-19 pandemic. Consequently, the Northern location experienced a sharp increase in abortion requests, and the midwives approached their management to initiate midwifery-led medication abortion services. When the idea was introduced at an organizational staff meeting, one nurse practitioner recalled how the team was primed to offer support: "I think that the team was fed up with the lack of services and how long it was taking. And so, we were really all excited when they brought this idea." (NP1) However, there were initial hesitations and low uptake for the idea, particularly from healthcare professionals who expressed conscientious objections or worried about on-call responsibilities, as one medical doctor explained:

> *We have 5 [medical doctors] on site, and most of them have some religious belief or whatnot that they don't, and they won't provide medication abortion. It's not necessarily that they don't support it, but they won't be the ones to prescribe it…. So, by having [midwives], we've been actually able to provide this service. (MD1)*

To address these concerns, the Northern midwives presented virtually at another all-staff round on medication abortion, inviting midwives and clinicians from the two Southern locations to attend and provide insight into how midwifery-led medication abortion was being delivered in similar settings. This event was highly successful and encouraged several clinicians to offer support by signing a medication abortion directive the next day and facilitating comprehensive midwifery-led medical services to begin immediately.

Clinicians from all three locations explained initial concerns about managing abortion responsibilities and complications after hours, as described by a Southern 1 location clinician:

> *… there's the 4 [medical doctors] in our office which are similarly minded, but I can guarantee you and tell you that out of the 23 of us [on-call] we are not all going to approach a situation like this in the same or similar way. So, it's difficult for us to, you know, be expected to support something like that, given the constraints of our on-call system. (MD3)*

To address concerns raised by on-call clinicians within their organizations, midwives at every location described creating open communication pathways, on-call services, and outreach care, helping to alleviate the other clinicians' concerns about managing abortion-related work. In addition, the impact and timing of the COVID-19 pandemic affected access to abortion everywhere, and healthcare systems tried to minimize the number of places and professionals that clients needed to see to access abortion care. One Northern midwife described how "people themselves were more reluctant to go to all these different sets." (RM1). The timing of the pandemic coincided with increased requests for medication abortions across all three locations, and midwives felt prepared to meet rising needs.

Location-specific challenges to initiating midwifery-led abortion included creating pathways for the first time, realizing the unique barriers faced by their organization's client populations, and a sudden lack of services in an already under-resourced region. Midwives and clinicians from two locations identified initial hesitation around midwives providing medication abortion care related to personal values and concerns about on-call responsibilities. Common gaps, barriers, and issues across the three locations included a lack of accessible services, populations with increased socioeconomic barriers and diverse abortion needs, and the COVID-19 pandemic's influence on access. Initiating midwifery-led abortion care in these three primary care locations has provided solutions for de-fragmenting and centralizing abortion services before, during, and since the pandemic.

Midwives and clinicians from these three expanded midwifery care programs described similarities and differences between their midwifery workforce and abortion-related services. Table 3 compares the three locations' services, which are described within the following themes.

Table 3: Location-specific abortion services

Location	Northern	Southern 1	Southern 2
Healthcare organization	community health centre	family health team	community health centre
Number of midwives	3 (2 full-time, 1 part-time)	4 (one fill-time, divided)	6 (full-time)
Authorizing clinicians	Internal MDs and NPs	External MD specialist	Internal MDs and NPs
Open referral pathway	✓	✓	✓
Community-based outreach services	✓	✓	✓
Option for virtual care	✓	✓	✓
On-call availability during clinic hours	✓	✓	✓
After-hours/weekend care	Not funded	✓	✓
Point-of-care ultrasound (when required)	✓	infrequent	✓
Dispensing prescriptions	✓		✓
Providing abortion-related supplies	✓	✓	✓
Upper gestational duration for low-risk medication abortion	11 weeks	11 weeks	11 weeks
LARC insertions and removals	midwifery-led	midwifery-led	MD, internal referral

Themes

Five themes and related subthemes describe the experiences of midwifery-led abortion and explain why and how midwifery-led medication abortion was initiated and continues to be supported. The data have been interpreted through my disciplinary lens and theoretical scaffolding. While creating the findings, my supervisor and committee members helped challenge and name themes and subthemes that represent the data and relate to my study's

foregrounding. I have identified patterns, similarities, and differences in how participants experience midwifery-led medication abortion. See Table 4: Overview of thematic analysis.

Table 4: Overview of thematic analysis

Themes	Subthemes
Building relationships	Knowing each other Collaborating Centring the client
Developing expertise	Expanding abilities Leading services Working with medical directives
Gaining credibility	Task shifting and sharing Appreciating the midwifery philosophy Feeling valued
Increasing access	Timely access, better care Providing person-centred care
Normalizing abortion	Expanding midwifery-led abortion care Educating midwives

Theme 1: Building relationships

'Cause, it's really about building the relationship. Yeah, that was huge for us. (MD1)

Midwives have built relationships through continuity, information sharing, and mutual respect. From the introduction, we saw how relationships between midwives, other healthcare professionals, and clients have supported and expanded midwifery care to include medication abortion. Pre-existing relationships, mutual goals, supportive communities of practice, and working within like-minded organizations that centre the needs of diverse clients have facilitated midwifery-led sexual and reproductive services. Thus, *relationship building* is associated with the integration of medication abortion in these primary care settings.

Knowing each other

The midwives' preexisting relationships have contributed to creating medication abortion services new to midwifery and Ontario healthcare systems and helped support midwives to lead the care. Midwife and clinician participants described working together in many ways through connecting, collaborating, supporting, and informing one another. Participants met each other through professional experiences, educational opportunities, conferences, mutual acquaintances, and attending each other's presentations. The expanded midwifery care programs shared practice documents, consulted each other on care-related questions and challenges, and referred clients between locations. Midwife participants described mutual connections within and between the emerging expanded midwifery care models. A Southern 2 location midwife recalled the Northern location reaching out for help when applying for funding and developing protocols. When they discovered that a friend and colleague was working at the Northern location, one Southern 2 location midwife said it "felt good" to help another expanded midwifery care model and create a community of practice, stating, "we've been like orbiting around each other all this time." (RM6) In addition, midwife participants from each described working with other expanded care midwives within and outside of their organizations through midwifery practice groups. For example, a Northern midwife who had worked with another midwife participant as their preceptor, practice partner, midwife, and co-initiator of the expanded midwifery care program recalled co-conceptualizing midwifery-led medication abortion in 2018 when the expanded midwifery care model was founded to address the regional gap in services and need for better access to abortion care.

Midwives and clinicians described how understanding the midwifery model of care before working together within their organization was instrumental to the success of midwifery-

led medication abortion because of their mutual trust built from previous relationships and experiences of midwifery care. A Northern midwife who refers to the expanded midwifery care program suggested these strong relationships helped to build credibility and support for one of the midwives to work in an expanded way within the Northern location: "[this midwife] is a known, well-reputable healthcare provider in our community…. I have no doubt that [those relationships] helped." (RM3) Nurse practitioners and medical doctors from all three locations commented how trusting the midwives' care has helped them feel comfortable referring clients to the expanded midwifery care programs for medication abortion care.

Clinicians and midwives at every location have worked within the same interprofessional teams since their expanded midwifery care program started and credited this continuous relationship to the ongoing support for midwives leading medication abortion care. Southern 1 and Northern location clinicians described building relationships from previous connections, such as providing health and midwifery care for each other, mutually referring clients, precepting and learning from each other within interprofessional education and teaching opportunities and sharing acquaintances within social circles. A Southern 1 location clinician explained how personal experiences of receiving midwifery care helped integrate an expanded midwifery care model into their organization:

> *I have family experience with midwifery care…. And my [partner's] always saying,…been saying ever since the kids were babies, 'you know, I wish we could just take the kids to the midwives…. It certainly made a whole lot of sense when I heard about the proposal for the [expanded midwifery care model] (MD3)*

In addition, midwives from all locations said good relationships between midwives and other healthcare professionals within their region have helped to "pave the way for these kinds of projects." (RM7). For example, the idea to have midwives work within the Southern 1 location sprouted from a community event where a medical doctor sat with a midwife. The two discussed

how a broader population would benefit from midwifery services offered through primary healthcare, and the medical doctor's personal experience in midwifery care influenced their support for midwives to join their organization.

Midwives and clinicians from all locations explained how locating expanded midwifery care within interprofessional primary healthcare organizations facilitated medication abortion services. The organizations' built environments have encouraged relationships and collaboration. Midwives and clinicians from all locations commented that having established staffing, locating midwives "just down the hall" from other healthcare professionals, and working within shared administrative spaces have contributed to integrating midwifery services. Participants spoke about how collaborations within shared workspaces, staff meetings, and *hallway chats* have enabled them to get to know one another, encouraged daily connections, and helped them to better understand how midwives provide care. Clinicians from all locations commented on how sharing space helps them see midwives as part of the team, as a Southern 1 location medical doctor explained:

> *… because they work out of, you know, the same types of exam rooms as we do, and we're all kind of at the same hallways and things, and you know we run into each other…. It's easy to have those kind of 'quick' conversations…if there are any difficult cases… as opposed to a formal consult." (MD3)*

Midwives from all three locations described how positive relationships with their management teams have helped establish and support midwifery-led medication abortion. A Southern 2 location midwife described working with their organization as an external consultant years before initiating the expanded midwifery care model. Thus, midwives were already known within the organization when the call came to offer expanded midwifery care services. Midwives from all locations described fast support and autonomy for leading medication abortion services to meet community needs, as one Southern 2 location midwife stated:

> *We've never had any input where leadership has said, 'No, that's not the direction you're gonna go'….[The] program is totally developed and based on our needs and interests and desires, and we've only ever had support from leadership (RM6)*

In addition, midwives from all locations commented on how their organization's management encouraged support from other staff and helped authorize abortion-related medical directives in timely ways.

Midwives from all locations had support from management and primary care teams to create and revise their medication abortion-related directives based on evidence and community needs. Examples included increasing gestational durations (all locations), dispensing mifepristone and misoprostol for medication abortion directly (Northern, Southern 2 locations), decreasing or removing age limits for services (Northern, Southern 1 locations), removing requirements such as dating ultrasounds and in-person visits (all locations), and adding medication abortion for missed or incomplete spontaneous abortions (all locations). Furthermore, midwives from the Southern 2 and Northern locations explained how they successfully advocated for organizational funds to provide prescriptions, supplies for clients, point-of-care ultrasound, and continued education to improve the quality of medication abortion services. Participants attributed the enthusiastic support for midwives to lead medication abortion services to their relationships of mutual trust built over time and working within organizations that encourage midwives and other healthcare professionals to work together.

Collaborating

> *I've learned a lot from them. It's been a really good experience. (MD1)*

The relationships midwives have built support interprofessional collaboration to improve abortion access. The midwives and clinicians described the ways they work together to offer medication abortion. Collaborating for program development, medical directives, informal

consultations, and formal referrals were identified by midwives and clinicians from all three locations as ways they provide medication abortion intra- and inter-professionally. Midwives have been supported by clinicians who provide prescriptions not included in the midwifery drug list, like mifepristone and misoprostol for medication abortion, sexually transmitted infection treatments, and contraceptives through prescriptions provided within electronic medical record pathways and through medical directives. In addition, nurse practitioners and medical doctors from all locations described organizing tests that midwives are not permitted to order for clients upon request from the midwives for needs that arise. One Northern clinician described how working with the midwives over time has helped them feel comfortable collaborating to support expanded midwifery care:

> *…if I was handing over my prenatal [patient] to them, or if they were asking me to order things or certain antibiotics, or you know, something that maybe a little bit technically out of their scope, but they have much experience with to help guide and treat the patient, I might be hesitant with without knowing them. (MD1)*

Different values, opinions, and responsibilities involved in medication abortion care have created some tensions. Some members of the Northern locations' healthcare team expressed conscientious objections to providing abortion. However, as the organization is large, the team wanted to make medication abortion services available and was able to accommodate requests to opt out by having supportive clinicians sign the medical directives. One clinician who is not involved in medication abortion care expressed support and respect for expanding midwifery care within their organization:

> *It's been terrific that we have had midwives integrated into practice, for I found that they have levels of knowledge in areas that exceed my own. And it's not uncommon where I refer patients to the midwives because they have questions that I don't know how to answer. They have somebody with more experience to answer those questions. They have improved access to care. There are more providers. You can see there are shorter wait times. They've improved the quality of care and all around. (MD2)*

Clinicians from each location recalled being introduced to the idea of midwifery-led medication abortion. They described initial concerns around on-call responsibilities and how they were mitigated by understanding how midwives can provide support outside and within their regular scheduled clinic. Nurse practitioners and medical doctors said midwives often consult with them on weekdays while they are the on-call clinicians, specifically for care outside the midwives' ordering ability or scope of practice. Midwives and clinicians from all locations explained how this system of consulting within the clinic day for timely needs that may arise, such as contraceptive prescriptions or additional tests, has worked well to increase access to care. However, every midwife and clinician interviewed commented on how consulting for care midwives should be able to provide is extra work and seems unnecessary, as one Southern 2 location nurse practitioner commented:

> *When I think sometimes of the things I'm consulted on, like some of the blood work and stuff that [midwives] can't order… I'm just blown away when it's the logical next step in this workup. (NP2)*

Nurse practitioners and medical doctors from each location credited the midwives for enabling other healthcare professionals to support medication abortion, and those from the Southern 1 and Northern locations said abortion care would not be provided within their organizations if it were not for the expanded midwifery care programs initiating services. A Southern 2 location nurse practitioner explained how midwives support other clinicians to offer medication abortion services:

> *So, when I do have somebody who presents in early pregnancy, unwanted, for abortion… often my brain kind of explodes a bit…. And so, I send a message or a text, or I walk down the hall, and the midwifery team is always really available to help and guide whatever needs to happen at that point. (NP2)*

Midwives interact and collaborate between the three expanded midwifery care programs. Northern midwives explained how they have referred clients who are more than 14 weeks

pregnant and required to travel for an abortion to a larger centre for continuous midwifery support when possible. One client who received collaborative care from the Northern and Southern 2 locations for medication abortion care described their inter-practice abortion experience:

> *Because I was in [Southern 2 community], where I personally don't have any healthcare providers, I was able to connect with [my midwife] right away and have it sorted out because they connected me with people at [Southern 2 location] who were totally great….I had everything sorted out by the midwives. (C3)*

Some Northern and Southern 1 location midwives interviewed also work in midwifery practice groups and refer clients to expanded midwifery care programs for management of both incomplete spontaneous and therapeutic abortions. They explained how referring to midwifery-led abortion care offers access to timely appointments, personalized follow-up, and continuity. A Northern midwife who works within an Indigenous midwifery practice described how the two practices collaborate when one or the other program can meet clients' needs: they said there is a mutual feeling of confidence that referring to other midwives provides person-centred, safe, and culturally sensitive care. Midwives from all locations described increased comfort with intra-midwifery practice referrals, knowing that their clients will receive continuous midwifery care for medication abortions.

Providing continuity

Midwives, clinicians, and clients from every location described how continuity of care improved their abortion experiences and encouraged healthcare uptake. Midwives explained how their relationships with clients were fundamental to understanding personal contexts influencing decisions, helping respect unique needs, and increasing satisfaction with care. Nurse practitioners, medical doctors, and clients from every location commented on the extra time midwives spent with clients, getting to know them within appointments. In addition, clinicians

and clients remarked how having continuity of midwifery care across multiple pregnancy experiences has helped clients who need an abortion access services sooner through a known healthcare professional within a familiar organization, improving their comfort and confidence when having an abortion.

Experiences of continuity, such as receiving care with the same midwives for multiple pregnancies, post-abortion care, and reproductive life planning, were described by participants at all locations. A Northern nurse practitioner saw continuity as a significant benefit to midwifery-led abortion for addressing clients' ongoing sexual and reproductive healthcare needs:

> *They're seeing the woman prenatally and postpartum, and they're in the perfect position…to discuss birth control with them in the post-period…and if they do want an intrauterine contraceptive or Nexplanon, they can set up that appointment…. These same women feel way more comfortable coming back to them if they do want abortion care if they want…a change in their family planning care,…if they have a subsequent pregnancy. That door is always open, they have that connection. (NP1)*

Midwives from all locations reported caring for clients for different pregnancy experiences. One of the Northern midwives articulated how continuity through midwifery-led medication abortion has helped clients access abortion care with more trust:

> *I've had several clients now, even in 4 years, where I've seen them for one or two initial pregnancies and then seen them for a termination experience….They express so much gratitude for having that continuity across their pregnancies, for knowing me, for being able to just book in with me and say, 'Hey, I'm pregnant again.' (RM1)*

One client described how the same team of midwives had provided their care for pregnancy and a fetal loss, a term birth, two postpartum periods, post-partum contraception and removal, well-baby care, and a missed spontaneous abortion. They articulated how having the same midwifery team has helped improve their comfort in accessing care for questions or concerns:

> *I know I'd be able to get a hold of them, you know...that brings comfort… especially after stillbirth…I could just pick up the phone and get answers…. [My midwives] all knew what was going on. It must be hard. I wasn't their only patient. (C3)*

Furthermore, clients commented on how the amount of time their midwives provided within appointments allowed them to get to know each other, improved their understanding of care options, and helped them make personalized choices that accommodated their unique needs. One client who had a medication abortion over the holidays explained how their medication abortion experience was comfortable because midwives were easy to reach and took time to answer questions:

> *They're not a hard person to get a hold of. They explain more of, like, the part of the situation that you're gonna go through or 'you're going to feel this…'. It was like daily conversations…. I had a very, very good relationship with them. (C2)*

Two clients interviewed described having continuous midwifery care for more than one medication abortion. Both clients commented that their midwives were non-judgemental, friendly, and encouraged open communication on reproductive life planning, as one client described: "I didn't feel like I was doing something wrong, like taking care of myself…when I came to see [my midwife], [they] made everything feel better." (C4) Some clients also recognized that the continuous care they received with midwives was unique within healthcare and expressed a special connection with their midwifery team. Some compared their midwifery care to other healthcare experiences and highlighted how they valued the continuity, information sharing, and respectful care they received.

Participants emphasized how the midwifery model of abortion care helped to build relationships through continuity of care and improved abortion experiences. These descriptions of how midwives have initiated medication abortion care continue through the next themes, *developing expertise* and *gaining credibility*.

Theme 2: Developing expertise

It's been a process for our entire team of starting to really believe in our expertise and skills. (RM6)

The theme of *developing expertise* describes how midwives have learned to provide quality, comprehensive abortion care and how clients and other healthcare professionals see midwives as specialists within their organizations. I analyzed the interview transcripts and site-specific practice documents and drew from my professional experiences of medication abortion care to understand how midwives are developing their expertise. There are similarities and differences between the three locations, including the ways that midwifery-led medication abortion care has evolved, the number of midwives working, differences in funding for their expanded midwifery care programs, and the services midwives offer.

Expanding abilities

Midwives from all locations described how support from other healthcare professionals and continuing education related to comprehensive medication abortion practices have helped to increase the quality of midwifery-led medication abortion care.

The Southern 1 location midwives have partnered with an external obstetrician-gynecologist for their medical directives. The midwives credited their previous and ongoing connection with the authorizing specialist in abortion care for helping support the development of their expertise. The midwives have also completed the Society of Obstetrician and Gynecologists of Canada's training courses related to comprehensive abortion care, including the *Intrauterine Contraception Insertion Preceptorship*, *Extended-Release Subdermal Implant Preceptorship Program,* and the *Medication Abortion Training Program*. In addition, Southern 1 location midwives provide leadership as clinical instructors for Canada's Society of Obstetricians

and Gynecologists and within midwifery education programs for intrauterine and subdermal contraceptive care.

Midwives from the Southern 2 location described how the National Abortion Federation of Canada's *Medication Abortion Training for Primary Care Providers* and related resources informed their model of medication abortion through well-informed client handouts, online support, virtual education sessions, and research-based, up-to-date guidelines:

> *We follow the [National Abortion Federation] recommendations like to a 't' because, like, it says it's reasonable to offer [medication abortion] up to 11 weeks if you have close follow-up, and we do, that we do…. I don't think we have specific like protocols. We don't have like a specific protocol on how to do [medication abortion]. But we do have a directive. (RM5)*

Like the Southern 1 program, some Southern 2 location midwives provide leadership in abortion by instructing medication abortion training for other primary healthcare professionals through the National Abortion Federation of Canada.

Northern midwives have completed the above-listed courses from the Society of Obstetricians and Gynecologists and the National Abortion Federation, in addition to Organon Canada's etonogestrel extended-release subdermal implant course. They have listed these training resources within their medical directives to encourage high-quality midwifery-led abortion service provision. Two Northern midwives are preceptors for the Society of Obstetricians and Gynecologists of Canada and Organon Canada's training programs to support other healthcare professionals to learn skills for comprehensive post-abortion contraception. In addition, the midwives from all locations mentioned utilizing the World Health Organization's 2022 *Abortion Care Guidelines* to ensure up-to-date best practices for comprehensive abortion care. (17)

Interestingly, the nurse practitioners and medical doctors interviewed were divided in their knowledge about what training midwives had for expanded midwifery and medication abortion care. As expected, participants who signed the medical directives has knowledge of the midwives' comprehensive training and experience. They explained how the midwives wrote and revised the medical directives and expressed respect for the ways midwives lead abortion care. The two clinicians interviewed who were not authorizers for directives said they were unsure how the midwives had learned to offer expanded midwifery care. Despite this, these clinicians confidently referred clients for expanded midwifery and medication abortion services based on their experiences of seeing how midwives provide care, as one medical doctor explained:

> *I'll be honest: I don't know all the training of advanced [midwives]…But I think anyone with the level of training the midwives that I work with have, that level absolutely should be integrated more into primary care. (MD2)*

Point-of-care ultrasound is a skill that midwives in all three locations have completed training to provide within their medication abortion care. Midwives at each location said they use ultrasound occasionally for abortion care as per the changing landscape and recommendation that a dating ultrasound is not always necessary. The Southern 2 and Northern location midwives have offered point-of-care ultrasounds for clients without health insurance and for clients with limited abilities to follow up due to challenging circumstances. All midwives described offering other point-of-care services like dispensing medications, giving supplies, testing and treating sexually transmitted infections, and offering contraceptives, especially for clients with poorer social and ecological determinants of health, to encourage timely access to healthcare and reproductive life planning.

We asked midwives how they thought providing medication abortion care influenced their practice. They described an enhanced ability to encourage open communication on

pregnancy intention, counsel clients on abortion options, be more mindful of the wording and language they use, offer violence-and trauma-informed care, provide non-judgemental and harm-reducing care, and work to meet their clients "where they are at". (RM1, RM3, RM6, RM7) Midwives from each location had gained a better understanding and appreciation of how difficult accessing abortion care can be for both clients and the healthcare professionals who are caring for them, especially for clients facing intersecting discrimination.

Midwives from all locations described how supporting clients through abortion has increased their desire to offer more support and "do a little bit extra" (RM4) during abortion experiences and post-abortion care, encouraging them to develop skills and gain knowledge to provide high-quality medication abortion care.

Leading services

In response to community needs, midwives have led the provision of medication abortion within their organization. In the Southern 1 and Southern 2 locations, midwifery-led medication abortion was one of the first expanded midwifery care services their programs offered. In contrast, in the Northern location, midwives initiated medication abortion care after other services like intrauterine contraceptive care and expanded well-baby care were successfully established. Seeing how the Northern midwives provided high-quality care for different sexual and reproductive health needs has encouraged other healthcare professionals to recommend midwifery-led medication abortion, as one medical doctor interviewed explained: "my level of comfort was even that much more because we had already built that relationship and knowing that their skills are fantastic, they go above and beyond the call of duty, and so forth." (MD1)

Nurse practitioners and medical doctors said the midwives introduced medication abortion care to their organization. As a nurse practitioner commented, “they're like a force…they're leading a lot of the care initiatives…bringing things to the table, seeing needs.” (NP2) However, midwives from all locations recognized how their organizations have supported midwifery-led comprehensive medication abortion care, acknowledging the shared values, positive work cultures, respect for midwifery care within the broader community, and partnerships with like-minded professionals. Midwives and clinicians from each location described how midwives have become the landing place for pregnancy care and that nurse practitioners and medical doctors support midwives to work as autonomously as possible and lead medication abortion care despite requiring medical directives. However, some midwives spoke about protecting their autonomy as primary healthcare professionals within employees’ models and large organizations, as one Northern midwife explained:

> *[The organizations] do let the midwives guide them to a certain degree, but on the negative side, it's been more of, ‘we could get a little bit further,’ where there's perhaps a manager that needs to make that decision but doesn't fully understand the potential or the capacity of a midwife working. So, it's just increasing knowledge…. We are really cautious that we don't get on that runaway train after all of that we've worked for. (RM2)*

Across all locations, the demand for midwifery-led medication abortion has grown. However, some locations have faced difficulty securing additional funding through the Ministry of Health to hire more midwives. The Southern 2 location began with four midwives funded for on-call work and now has six full-time midwifery positions. These midwives described how they have organized into two teams with different on-call responsibilities focusing on early pregnancy services or intrapartum care. They say their teams’ responsibilities are “driven by the needs of all midwives.” (RM6) The Northern location began with one full-time position without on-call funding. The Northern midwives interviewed said having one midwife working without

on-call availability was an initial barrier to offering medication abortion services. The Northern location applied for more midwifery positions with on-call funding to support better access for two years without success. Finally, they received funding to hire one more full-time midwife without on-call compensation. It took two more applications for the Northern location to secure its current complement of three full-time midwives, but they have not received funding for on-call work. Despite these challenges, the Northern midwives provide medication abortion care successfully within the weekdays with informed choice and creative scheduling. The Southern 1 location has only been funded for one full-time position despite applying for more midwifery positions each year to support community midwifery outreach programs. Four local midwives share one full-time position while working within a midwifery practice group, coordinating their expanded midwifery services and on-call support accordingly.

Although there are differences in how the expanded midwifery care programs are funded, the three locations have created innovative ways of providing medication abortion safely and effectively through writing medical directives, optimizing the delivery of services and on-call work, and creatively organizing their midwifery workforce.

Working with medical directives

> *Don't be fooled. Like, it's so nice we work together, I've enjoyed it. And we never should have had to do that in the first place. We're making the best of the day. (RM6)*

Midwives, nurse practitioners, and medical doctors described medical directives as both helpful and problematic. In addition, medical directives have served different purposes at each location. Southern 1 location midwives provide comprehensive medication abortion services within their organization by partnering with an external obstetrician-gynecologist for mentorship, collaboration, and authorization of their medical directives. The Southern 1 location midwives

organize medication abortion prescriptions through a pharmacy across the street from their organization, ensuring the medications are stocked. Under medical directives, these midwives provide comprehensive post-abortion care such as long-acting reversible contraception insertions, cervical screening, and sexually transmitted infection screening and treatment beyond the ordinary midwifery course of six weeks postpartum care. The midwives felt that having an obstetrician-gynecologist sign their directives directly allowed clients to access specialist services. They also commented that providing medication abortion under medical directives has increased the visibility and acceptability of expanded midwifery care in their community. Based on new research supporting virtual care, the Southern 1 location midwives have drafted a medical directive for completely no-touch services, offering prescriptions and support entirely over the phone.

At the Southern 2 location, midwives began providing medication abortions soon after their program was initiated by consulting internal clinicians for prescriptions and referring internally for post-abortion long-acting reversible contraception insertions. More recently, the Southern 2 location midwives implemented a medical directive to dispense medication abortion prescriptions during clinical visits. One midwife explained how their pathway has evolved and how collaborating with other clinicians has generated credibility for midwives doing abortion work:

> *When we did [medication abortion] early on, I consulted on every single case. And when we moved to the directive, now I don't….I do a full abortion visit. I give out the med, and I don't talk to a doctor. But, because of all the cases that we had done in the past, especially with this one doctor...I can go to [them] and feel like, 'Yeah, [they] trust me. [They] see my skill. [They're] really curious about and interested in this work. (RM6)*

Southern 2 location midwives felt that medical directives encourage interprofessional understanding, save midwives and clinicians time, and help clients get prescriptions quickly.

The Northern midwives work with internal clinicians for their medication abortion directives to define quality abortion services, dispense prescriptions, and place subdermal contraceptives. As previously explained, their intrauterine contraceptive directive is signed by an external obstetrician-gynecologist who precepted them as no clinicians at their location insert intrauterine devices, allowing midwives to provide comprehensive contraception care beyond six weeks postpartum. One Northern midwife explained how creating research-based medical directives that cover most clinical situations has allowed midwives to work autonomously and supported trust in expanded midwifery care within their interprofessional healthcare team.

Although midwives expressed feeling supported by medical directors, most were uncomfortable relying on the willingness of other clinicians to authorize their abortion care. One Northern midwife commented on how authorized medical directives depended on the "goodwill" of everyone involved because "abortion can be stigmatized." (RM1) Midwives at every location felt that having systems that rely on medical directives puts access to midwifery-led medication abortion in a precarious position.

Despite describing the advantages of working collaboratively, midwives were critical of medical directives and wanted to provide medication abortion services independently. Midwives from the Southern 1 and Southern 2 locations expressed how having directives authorized by clinicians who potentially have less experience than those implementing the care is complicated and problematic from a medical-legal standpoint when the professionals involved "may not fully understand their responsibilities." (RM8) Midwives from all locations felt that medical directives essentially become redundant when implementors develop more knowledge, skills, and experience providing the delegated care than the clinicians who are authorizing it. In addition, Southern 1 and Northern location midwives explained how updating their directives has

been time-consuming and has affected their ability to make autonomous decisions as primary healthcare professionals with the most experience and up-to-date information. One Southern 1 location midwife commented:

> *I wish that the systems and the legislation were set up in a way where I didn't have to ask permission to switch who I give Rhogam to, whether I do virtual visits, whether I go from 9 to 10 to 11 weeks. Those are all things that I feel comfortable making decisions about now, and it is extremely frustrating that I need to get permission from somebody else to make those changes. (RM7)*

Another example of the time-consuming nature of updating directives was provided by Northern midwives when they described revising their medical directive in the fall of 2023 to incorporate recommendations from the most recent National Abortion Federation of Canada's Clinical policy guidelines for abortion care and World Health Organization's Abortion Care Guidelines. (17,70) In order to implement the updated recommendations, the midwives had to first revise their medical directive, explain and review the revisions with management and authorizing clinicians, and obtain new signatures. The midwives described how working within a supportive organization that prioritized abortion access in their community helped approve the new directive promptly. However, as previously highlighted, balancing medication abortion systems on the willingness of others created a potential barrier to providing the most up-to-date care and meeting community needs.

The Southern 1 location midwives gave examples of how directives have impacted their professional decision-making and access to care for younger clients. The midwives created abortion-related directives that did not overly limit the ages for care. However, their medical director suggested adding an age limit for intrauterine contraceptive insertions that ultimately conflicted with comprehensive medication abortion care, making it challenging for younger

clients to have intrauterine contraceptives inserted post-abortion. One midwife described the process of changing this limitation:

> *A couple of years later, I came back, and I said, 'Hey, I want to drop the age,'…and I presented a new medical directive for intrauterine contraceptive insertion and emergency contraception, and it was approved at that time. So, like, there has been a bit of an evolution…. Over time, we've definitely been achieving some of the goals that we initially wanted. (RM8)*

When recalling this situation, the midwife stated that directives created barriers to providing autonomous, person-centred care, especially when authorizers not delivering the care do not fully understand the issues medical directives can present.

When exploring thoughts about how and why midwives initiated interprofessional medication abortion, clinicians from all locations believed it was in response to population needs and the lack of services in their community. A Southern 2 location clinician optimistically expressed how they thought midwifery-led interprofessional medication abortion could be offered in any organization, stating, "I don't see why it couldn't work in another space if there were the support of management and clinicians." (NP2) However, midwives, nurse practitioners, and medical doctors from all three locations suggested their organizations were primed to integrate midwifery-led medication abortion from established relationships and similar philosophies of care, as one Southern 1 location midwife commented:

> *I think that if we had been paired with somebody else that hadn't been in the same area, that didn't work with the same population, that didn't historically really work with folks who experience barriers to care, they may not have recognized the benefit of working collaboratively…and may not have been as open to doing the specific work that we're doing with those populations (RM7)*

Despite the value of collaboration, one Southern 1 location medical doctor questioned the transferability of offering midwifery-led medical-abortion care through medical directives in other primary care settings, stating that support for interprofessional medication abortion " may

not always be the case" due to personal and professional priorities, particularly within fee-for-service models. (MD3)

Midwives from all locations noted that other clinicians seemed comfortable task-sharing with midwives through well-developed medical directives. In addition, midwives, nurse practitioners, and medical doctors from every location remarked that interprofessional collaboration through medical directives facilitated consultations and referrals when unusual or complicated situations arose. However, the midwives who have developed expertise in comprehensive medication abortion care felt that task-sharing for abortion care now seemed unnecessary.

Theme 3: Gaining credibility

> *Certainly, one benefit is in the expertise level of knowledge from somebody who focuses on a topic and does that topic very frequently. (MD2)*

Midwives providing comprehensive expanded midwifery services have gained respect and trust through task-shifting and -sharing abortion care, where other healthcare professionals and clients have gained an appreciation for the midwifery model of care, and midwives have felt valued as abortion providers.

Task-shifting and sharing

Participants associated midwifery-led abortion services with better use of healthcare resources and improved access. Midwives, nurse practitioners, and medical doctors explained task-shifting and task-sharing in different ways. Clinicians from all locations identified with task-shifting through interprofessional consultations, authorizing medical directives, providing tests and prescriptions, referring pregnancy-related care to midwives, and warmly referring to expanded care midwives for more complex pregnancy needs. A "warm referral" is a term that

describes the essential aspects of equity-oriented healthcare and relates to a trauma- and violence-informed approach to facilitating referrals where a warm referral focuses on helping clients who face structural, systemic, and institutional disadvantages to engage with health and community services. (309) A warm referral from another healthcare professional to a midwife involves encouraging relationships between midwives, other healthcare professionals, and clients by confirming the referral meets the client's needs, facilitating introductions, and providing follow-up to ensure the referral has been successful. (309) Clinicians from all locations expressed warmly referring clients with more complex needs for midwifery-led abortion care with satisfaction and relief, as one Northern medical doctor explained:

> *So I think [this community] being unique in the sense that we don't have the amount of providers that we need, and also midwives…have a little bit more time to spend with the patients. Our health literacy is lower. We have many refugees that speak second languages. So, midwives are perfectly poised to be able to help in that situation as well, as these people may be unattached. They actually need more than the average person who is probably more likely to be attached to a primary provider. So I think it helps fill a wonderful gap for that too. (MD1)*

Midwives and clinicians highlighted how relationships of trust help them feel more comfortable and confident with shifting and sharing responsibilities. When we asked nurse practitioners and medical doctors about their experiences supporting midwives to provide abortion services through medical directives, all clinicians thought that, in general, midwives were better suited for abortion work than other primary care clinicians because of their model of care and experience providing on-call support for urgent care and that shifting abortion and post-abortion services to midwives ultimately improved clients' continuity and experiences of care.

While Southern 1 location midwives work with an external specialist to provide medication abortion and long-acting reversible contraceptive care, other clinicians internal to the organization continue to offer some sexual and reproductive services for clients. However, a Southern 1 location medical doctor explained how the midwifery team does the majority of the

care for abortions and long-acting reversible contraceptive insertions and removals. The clinician who works with the Southern 2 location appreciated having access to midwifery knowledge and experience and frequently consulted the midwives with clinical questions or referred clients to for midwifery care. When describing the services midwives offer in the three locations, nurse practitioners and medical doctors said having midwives provide sexual and reproductive health services has benefitted clients by offering a clinician with more experience in providing this care as one Northern medical doctor explained:

> *If I was doing my own [intrauterine contraceptive insertions], I would probably maybe do a couple a year, so I don't think it's the best experience for a patient to have me put in an intrauterine contraceptive…versus [the midwives] doing it every single day…I can be confident and comfortable sending my patients with them. (MD1)*

This same clinician raised a potential concern for maintaining their knowledge and skills while task-shifting most sexual and reproductive care to midwives. However, although specific skills may not be well maintained, referring clients to the most appropriate clinician has freed them up to offer care for other primary healthcare needs. In addition, A Northern midwife described how having midwives who are willing and able to provide extra time and support for sexual and reproductive needs optimally distributes healthcare responsibilities and potentially takes work "off of the plates of the other physicians…who maybe never wanted to do it anyway." (RM3)

Midwives expressed negative feelings when explaining how Ontario's restrictive legislation makes task-sharing necessary for midwives to offer abortion-related services, limiting the midwifery profession, creating unnecessary systems where one professional group is giving orders or making clinical decisions on behalf of another group with more skill, knowledge, and expertise, and potentially causing injury to the midwives' dignity.

Appreciating the midwifery philosophy

Many participants highlighted ways midwives have applied their model of care to medication abortion. Clinicians from all locations have referred clients to midwifery-led medication abortion care because of the continuity and support midwifery offers. Nurse practitioners and medical doctors explained how midwifery offered flexible care in different locations such as the main clinics, through outreach in the community, at drop-ins, in remote communities, by phone, text, and email, and within other programs in the organization.

When exploring how nurse practitioners and medical doctors see midwifery care impacting abortion experiences, a Southern 1 location doctor compared midwifery care to what they feel family physicians should be offering in primary healthcare settings:

> *…theoretically, the philosophy of care that family doctors are supposed to have…the same being, you know, patient-centred and being a resource to the community…. That's the ideal for what primary care should be from a medicine perspective…but it doesn't always happen. So, I think [the expanded midwifery care models] worked out well because of that. (MD3)*

A Northern nurse practitioner who worked within a walk-in and satellite clinic in a low-income area of the city explained how the midwifery team started to travel there weekly to offer comprehensive sexual and reproductive care, including medication abortion services, providing continuity and building relationships with clients who may not otherwise access midwifery services. A Southern 2 location nurse practitioner highlighted how the midwives at their location have made extra efforts to connect with clients who live "all over the city" to improve medication abortion accessibility and experiences by couriering supplies, providing home and community visits, offering flexible appointments, and providing care virtually and by phone. (NP3)

In their interviews, clients highlighted the holistic nature of midwifery-led medication abortion care. Each client commented on the flexible care they received and reported accessing care in different locations depending on their unique needs like at the clinics, in their homes, and by phone, email, or text. Clients liked being able to reach a midwife by phone, text, or email to address questions or concerns between appointments. In addition, every client commented on the longer appointments that midwives offered to ensure information sharing, answer questions, and build relationships. Clients also described receiving extra services during their midwifery appointments, such as supplies to increase their comfort while having an abortion, prescriptions for contraceptives or infections, blood work, and point-of-care ultrasound, highlighting the number of services midwives offered within medication abortion visits.

Clinicians who supported for midwifery-led medication abortion services expressed appreciation for the midwifery model of care, commenting on how medication abortion seems like a natural extension of midwifery as a Southern 1 location medical doctor explained:

> *It makes sense, given what [midwives] are already doing….I think it makes complete sense. And that [midwifery] is sort of focused on people and their own, you know, autonomy and choices that they want to make, their own agency over their bodies and things…And so, I think that all fits in with what's already happening and what [midwives] are already doing. (MD3)*

Nurse practitioners and medical doctors at each location noted the efforts midwives made to support clients with complex care needs, like organizing interpretation services and going out into the community to reach people who may not receive timely care, such as newcomers, international students, people living precariously, and those using substances. One Northern nurse practitioner stated that "not every office is that flexible" and that the model of medication abortion care midwives provide is "in fact, very rare." (NP1)

One Northern midwife hoping to offer medication abortion care commented on wanting to initiate midwifery-led abortion services at their primary healthcare organization that primarily cares for Indigenous clients and explained how abortion services aligned with their philosophy of care. They described that, although specialists have traditionally been the go-to for abortion in their region, they felt that abortion should not be "medicalized more than it needs to be" and explained how midwifery-led abortion offers clients a more normalized and supported experience through flexible, culturally safe, and person-centred care. (RM4)

Midwives from all three locations described how they have integrated the midwifery philosophy into their organizations' medical directives and expanded midwifery services to encourage person-centred care by embedding continuity, accessible information sharing, and extended visits for all sexual and reproductive services. One Northern midwife explained that offering the midwifery philosophy of care for different pregnancy experiences utilizes "all the different aspects of midwifery" to improve abortion experiences and health outcomes. (RM3)

All three locations reported commonly receiving external referrals for midwifery-led medication abortion from nurse practitioners, medical doctors, health units, walk-in clinics, outreach workers, health workers, organizations, and other communities. Midwives described how referrals from other healthcare professionals and organizations are often warm and appreciative, especially from those who have experienced midwifery care, received positive feedback from clients, or have gained an appreciation for the ways midwives are providing abortion services.

Feeling valued

All midwives interviewed felt valued and fulfilled through providing abortion care. The midwives' job satisfaction was reported as high, and every midwife described a growing confidence and pride in their profession by working within interdisciplinary teams that valued how midwives provide medication abortion services, as one Southern 2 location midwife explained:

> *Working in this way…has just increased my confidence and my pride in midwifery… I have skills that my physician colleagues don't have… in my training and knowledge, to be able to work alongside people with different skill sets and to have that reflected back over time has been really positive. (RM5)*

Midwives have realized their potential for learning new skills by integrating their experience working within midwifery into medication abortion care. Midwives believed their expanded midwifery services had improved access to abortion within their communities, and they described how referrals from other clinicians, allied health professionals, and organizations make them feel valued as sexual and reproductive healthcare providers. For example, the midwives interviewed who consult or refer to the Northern location for medication abortion care highlighted the value that midwifery-led abortion offered. One Northern midwife described how a recent consultation with a midwife providing abortion care at the Northern location helped their client make an informed choice to have a procedural abortion. They described the interactions between the midwives and the client as role affirming:

> *[They] had come out of the appointment [with the physician who provides procedural abortion]and said, 'I felt so informed going into that. I had all the information. There was no new information that I didn't know going into the appointment…I was kind of nervous in the office, so I didn't really ask any questions…Thankfully, I didn't have any because they were all answered ahead of time.' That was reassurance or reaffirmance, like, 'Okay, making a difference. Yeah, [midwives] do this, like, we make a big difference.' (RM4)*

Midwives expressed satisfaction with abortion work through phrases like "I love abortion work" (RM5, RM7), "I would do this 100% of the time" (RM6), and "it's good work." (RM1) Midwives felt like they were making a difference by providing low-barrier, comprehensive care for people facing obstacles to getting an abortion. Some midwives expressed a preference for abortion work because of the increased sense of credibility and confidence that comes with providing accessible care and contributing to better abortion experiences. Midwives said leading expanded midwifery care within their organizations and communities of practice has helped them gain credibility and generated appreciation for the profession.

Midwives from every location linked continuity of care with greater job satisfaction, and many explained how caring for returning clients throughout their reproductive lives made them feel more helpful as providers. For example, while treating an abortion client and their partner for concurrent sexually transmitted infections, a Southern 2 location midwife described how satisfying and affirming it was to provide the care that was needed:

> *I felt like that little Saturday chlamydia visit was one of my favourite visits. I left there being like, 'Yeah, so good'. And so yeah, I think …dignity, self-confidence, and all those pieces…. I didn't realize how shitty it has felt that I couldn't treat chlamydia for ten years. And, like, it turns out, I love treating it. (RM6)*

Midwives described how positive feedback from clients and other professionals helped them feel their care was trustworthy and important. Nurse practitioners and medical doctors from all locations expressed their appreciation for expanded midwifery care and for midwifery-led abortion services. One Northern clinician said they had gain knowledge about abortion services from midwives leading the care within their organization, stating, "I know this, we're talking more creatively about medication abortion…. so, it's been excellent continuing medical education as well." (MD1) A Southern 2 location clinician expressed regard for midwifery team, explaining how they are helpful, accessible, and well-liked within the organization:

> *You can always 'e-consult' or find someone…. This particular group of midwives is very, very kind and very approachable….[They] never make me feel like the question is silly. Like, they're fantastic. It's made a huge difference. It's been great. Yeah, I love them. I hope they never leave us. (NP2)*

In all locations, midwives reported high job satisfaction, felt valued, and had gained credibility by leading abortion services within their communities of practice.

Theme 4: Increasing access

> *I think it's made medication abortion seem a lot more accessible and definitely more successful. (NP1)*

Midwives providing abortion services are working to address intersecting factors that hinder timely access to care by offering solutions for transportation, childcare, communication and information-sharing needs, flexible clinical appointments, point-of-care services, affordable medications, services closer to where people live and work, safer practice environments, and outreach.

Timely access, better care

All participants described how the fragmented nature of abortion-related services made accessing care more challenging. Nurse practitioners and medical doctors explained the obstacles clients typically navigated, like finding abortion services, booking timely appointments, having to access care through walk-ins with inexperienced clinicians, waiting for specialist referrals, attending ultrasounds, finding pharmacies with stocked medications and up-to-date information, trying to coordinate disjointed services, and coping with discrimination and racism within the healthcare system.

Before integrating expanded midwifery care programs, clients of the Southern 1 and Northern organizations faced geographical challenges and few clinicians offering medication

abortions within large regions. One Northern client experienced difficulty finding a medication abortion provider, contacting several healthcare organizations, including a midwifery practice, the local health unit, and another sexual health clinic, before locating the midwives at the Northern location for medication abortion support for an incomplete miscarriage.

Nurse practitioners and medical doctors from each location highlighted robust pathways that midwives have created to facilitate care, such as verbal, electronic, fax, email, phone, text, and self-referral options, offering timely intakes for clients needing an abortion. By locating comprehensive services within primary care organizations that clients and other healthcare professionals are familiar with, midwifery-led medication abortion has increased accessibility and comfort. In addition, all three locations reported offering clients help with transportation and child-care needs, providing services in different locations like satellite clinics, hospital-based early-pregnancy programs, and in the community through outreach services, and prioritizing non-judgemental, person-centred and safe healthcare environments.

Participants from each location highlighted how midwifery outreach services have helped encourage timely access and more sensitive abortion care for people living precariously who experience systemic violence and discrimination. One Southern 1 location midwife described how midwives have addressed barriers to care by going to where people live and offering flexibility:

> *…[midwives'] ability to move and meet people outside of the clinical setting….whether that's within the shelter system, whether that's in homes, whether that's going to the hospital for people that aren't sort of core midwifery care….We are a group of people who bring our stuff with us and can provide care anywhere. And for some populations, that makes a really big difference. (RM7)*

Midwives from all locations described giving extra support during abortions, like phone visits on the day clients take medications, client handouts that visually explain the process and

when to contact a midwife or go to the hospital, and supplies such as menstrual pads, clean underwear, snacks, thermometers, and over-the-counter medications that relieve uncomfortable symptoms such as antipyretics and anti-emetics. A Southern 2 location clinician commented on the increased comfort for clients being able to contact their midwife with questions, concerns, or rising needs, especially for those with complex lives:

> *They're available. 24/7. There's a pager. They will call people…. I don't have the ability to do that over a weekend…. I refer my patient primarily for, you know, that extra support, should it be needed. (NP2)*

In addition, midwives who refer to expanded midwifery care for abortion services explained how having a connection with other midwives offering medication abortion care "speeds up the referral process" and brings midwives and clients reassurance in knowing how they will be treated and what they can expect from their interactions with expanded care midwives. (RM4)

As previously reported, midwives at the Northern location provide abortion support during clinic hours as they are not funded to be on-call. To manage abortion needs, they have one midwife available every day for outreach and community care happening outside of regularly scheduled appointments. Northern midwives explained how medication abortion clients are given an informed choice and know their midwives' available hours. The midwives explained that some clients choose to take the abortion medications earlier in the week to align with the midwives' availability. The midwives described how they provide detailed information about what clients should expect, give comprehensive handouts to help answer questions that may arise, and inform clients when to access the hospital's emergency department for urgent concerns as they would if they were receiving abortion care from any other abortion provider. To facilitate timely access to care, the Northern midwives have implemented more ways for clients to reach them, including a mobile number to contact the outreach midwife for urgent

questions during the day and a direct phone number to their office space to leave private, non-urgent messages.

Midwives, nurse practitioners, and medical doctors from all locations recognized the experience midwifery brings to supporting medication abortions at home. Some participants commented on how midwives are very well-positioned from providing perinatal and postpartum care, confidently triage common abortion-related questions and concerns, and have the experience to manage uncomfortable symptoms and side effects outside of a clinical setting, as one Southern 2 location midwife explained:

> *…we are confident and comfortable in doing that work…in a way that very few if any, other providers in the system have been trained to do…. And there's a confidence in our skill…to do an auditory assessment over the phone the way that we do with labour… we've been able to apply [our experience] to abortion care and miscarriage management…to make diagnoses and care plans with confidence outside of any kind of formal setting…. Nobody else gets that kind of training. (RM5)*

Participants at each location described how the flexibility of midwives providing abortion care in different locations had increased access to abortion, facilitated timely intakes, met childcare needs, addressed geographical issues by reducing travel barriers, and decreased barriers to abortion due to other life circumstances such as substance use and unstable housing. One client who lives outside of the Northern location's city described how their midwives improved access to medication abortion by providing care over a holiday through telemedicine, therefore decreasing their need to travel far from home and find childcare. Another client who has several children described accessing medication abortion services where and when it worked best for their family. This client described attending appointments at the main clinic, a satellite centre near their home, and by phone and text, expressing how the midwives' flexibility offered the convenience of "just picking up the phone and getting answers" during their medication abortion experience. (C3) A third client with a history of substance use explained how having access to

midwifery care from the midwifery team attending a satellite clinic close to their home where they could walk in for care helped support their reproductive and sexual health needs.

Participants from the Southern 2 and Northern locations described how expanded midwifery care improved access for people unattached to a primary healthcare provider. The Northern clinicians explained how many clients that their expanded midwifery program cares for do not have a primary clinician, and these unattached clients often have complex needs. The Northen clinicians described how midwifery-led abortion is filling "gaps" in their healthcare system by offering care for anyone who needs it, providing point-of-care services, organizing interpreters and culturally appropriate care, and connecting clients with community health workers to facilitate addressing unmet healthcare needs. (NP1, MD1, MD3)

Midwives from every location described providing virtual abortion care during and since the COVID-19 pandemic with support from emerging research and best practice guidelines. Virtual abortion care has also extended all three organizations' catchment areas significantly. Midwives routinely offer virtual abortion care for clients who prefer it or need it. In addition, all locations have removed dating ultrasound as a requirement for low-risk medication abortion and reduced the minimum number of in-person visits to increase access to low-barrier care.

Finally, participants noted that continuity of midwifery care for repeated unwanted pregnancies has helped clients to seek abortion care sooner and increased their potential for better experiences and outcomes, especially for Northern location clients who must travel far from home after 14 weeks gestation to access abortion services. One Northern midwife explained:

> *We see some clients coming late into care because they didn't know where to go or didn't know what to do. But then we see a scenario happen again, whether it is a pregnancy that they want to continue or not… being able to come back knowing that they don't have to*

> *get a referral or go to a clinic where they don't know anyone…knowing that [our program] exists and is accessible…means for that individual [care] happens a lot sooner the second time when they feel connected. (RM1)*

With support from large healthcare organizations that prioritize person-centred, non-judgemental healthcare, outreach services, and flexible care coordination, expanded-care midwives have effectively reduced barriers, improved access, and offered clients safe, client-centred abortion experiences.

Providing person-centred care

Midwives are providing medication abortions through person-centred models of care. Each midwife spoke about offering care for different types of abortions, including counselling on options and providing post-abortion follow-up and contraceptive support. One Northern midwife who worked primarily with pregnant clients who use substances described how flexibility and choice of location for services improve comfort and confidence within the healthcare system for clients who experience discrimination and feel unsafe in hospital settings. This midwife said midwifery-led medication abortion has made having an abortion "a lot easier" and more successful for their clients who request medication abortion care. (RM4) Midwives, nurse practitioners, and medical doctors at all three locations described caring for clients who use substances and experience discrimination by offering a low-barrier, nonjudgmental, harm-reduction model of abortion care.

All participants highlighted the services midwives provide within visits that encourage more continuity and consideration for unique needs and barriers, such as bloodwork, point-of-care services, extra supplies, and medications free of charge. In addition, midwives, nurse practitioners, and medical doctors from the Southern 2 and Northern locations explained how midwives have advocated for their organizations to support dispensing medication abortion

prescriptions directly to clients free of charge to address rising concerns that clients have reported, such as pharmacies' negative attitudes, misinformation, or attempts to charge for medications during pickup that created unnecessary delays.

Clients appreciated being offered availability and flexibility within midwifery care. Some commented that, even though they did not need to contact a midwife during their abortion or between scheduled appointments, they felt more comfortable and confident having a medication abortion at home because of their option to contact a midwife if they needed to. One client who chose to have a medication abortion in their remote community needed to contact their midwife for information about bleeding patterns. This client explained how reassured they felt after speaking with their midwife by phone and how they felt comfortable staying home. Another client who had two medication abortions with the same midwifery team explained that being able to contact a midwife between appointments with questions or concerns increased their comfort:

> *I called once because, like, we did the prescription for, um, the abortion pill. And, um, and I called after it came out. I was worried about the bleeding, and, um, I just felt like [my midwife] made sure that I was ok…she comforted me, she gave me tips, and she told me that if I bled a little too long to go to the hospital. So, she made sure that I knew what to do if it continued to get worse. Like, it relieved a lot of stress. (C4)*

Clients said having midwifery-led abortions helped them decide what types of abortion were best for them and offered a choice for service locations, making their abortion more accessible and possible within their everyday lives. Clients expressed that seeing a midwife soon after being referred or leaving a message helped them access timely care, commenting: "I called and left a voicemail and got a call back on probably the next day. It was swift, and I didn't wait too long." (C4), and "I was able to talk to them right away and have it sorted." (C1) In addition, clients reported only needing to see their midwives for abortion care and did not need to see another healthcare clinician. A Southern 2 location midwife described this pathway:

> *…in terms of a patient experience…they see me. I do all the things; I give them the [prescription]…. In the background, I have either sent a message or had a conversation and said, "Hey, this person… ". That's it. It's a prescription from [another clinician]. (RM6)*

Clients described how having the same midwives for contraception, cervical and sexually transmitted infection screening, family planning, and well-baby care was convenient, more personal, and "more comfortable" than having to see different clinicians (C1, C2, C3, C4) One client expressed that seeing midwives for sexual and reproductive needs felt more supportive, like receiving care from one of their "favourite Aunties." (C4)

Northern and Southern 1 location midwives described inserting and removing long-acting reversible contraceptives, and midwives from all locations provided comprehensive contraception counselling and facilitated prescriptions. The Southern 2 location midwives refer clients for long-acting contraceptive care to medical doctors internal to their organization who wish to provide sexual and reproductive healthcare services for their organization. However, midwives from this location noticed that clients often did not show up for their insertion appointments and wondered if this was a result of a loss of continuity and lack of comfort seeing a new healthcare clinician. In contrast, the Northern and Southern 1 location participants described good uptake and attendance for midwifery-led long-acting reversible contraception insertions. All clients received post-abortion care from midwives; two had intrauterine contraceptive insertions, one had a subdermal implant placed, and two requested a prescription for combined oral contraception. Interestingly, two clients reported subsequently having their midwives remove their intrauterine contraceptive devices, one for planned pregnancy and another to change contraceptives due to uncomfortable side effects. Clients receiving comprehensive midwifery-led medication abortion described increased support for personalized abortion care, contraception, and reproductive life planning.

Theme 5: Normalizing abortion

> *Midwives are ideally suited to provide both contraception and abortion because we know pregnancy so well. (RM1)*

Midwives have worked to reduce barriers and make abortion a routine part of healthcare within their organizations and communities. Both clients and midwives described how midwifery-led care had de-medicalized medication abortion and centralized services. Midwives from all locations described their role in abortion the same way they described their role in pregnancy and birth, as providers of person-centred care and informed choice, as a Northern midwife described:

> *… choice of option and location, and choice of provider for termination is just as important as being able to pick their provider to deliver a baby…. Being able to have a baby is just as important as being able not to have a baby if you're not ready… we don't look at midwifery care as just being the delivery of a baby. (RM4)*

Participants from all locations believed that having midwives offer abortion services reduces stigma by providing non-judgemental support for different pregnancies. Midwives described how working in abortion care has expanded their ability to "really be present with someone without any judgment" (RM1), enhanced their ability to counsel on pregnancy options, and helped them learn about the ways clients experience pregnancies and make choices.

Clients explained how normal and comfortable their abortion experiences were. Some recalled other experiences of pregnancy loss, such as previous abortions or miscarriages, and felt they may have been better supported by midwifery care. One client who had a prior pregnancy loss before having expanded midwifery care for an incomplete spontaneous abortion stated how happy they were that midwives were offering medication abortion "regardless of why they need the [abortion] medication or care." (C5)

Midwives from all locations explained how providing abortion care has felt like a natural extension of midwifery and gave examples of how abortion fits into their everyday practice. For example, a Southern 1 location midwife had just finished an abortion visit and was dropping bloodwork off at a lab on their way home during our interview for this research and commented lightly on how abortion work was "just part of [their] day." (RM8) A Northern midwife said they were grateful to offer more continuous care and believed that midwifery-led abortion normalizes that pregnancies end, stating: "there are miscarriages and abortions and all kinds of other pregnancy outcomes, and people still need really good continuity of care." (RM1) Illustrating this, a client who had two comprehensive midwifery-led medication abortions for unwanted pregnancies described how their continuity with midwives helped them to feel safe and cared for:

> *I got pregnant by accident, and I wasn't planning it, so it was very stressful… and [my midwife] explained that there were options and that there were different kinds of birth controls. …And so, I knew that I could go on birth control to prevent this from happening and having to go through the same process again…. I didn't feel like I was doing something wrong, taking care of myself. (C4)*

Participants from every location credited midwifery-led care for making abortion services feel like regular healthcare. Southern 1 location participants described how other facilities now offer medication abortion since their expanded midwifery care program initiated outpatient medication abortion care, offering clients more places to access abortion services. Midwives who referred intraprofessionally to other midwives for medication abortion said they have been inspired to provide medication abortion within other organizations. Nurse practitioners and medical doctors from all locations commented on how midwifery has informed them about abortion safety, efficacy, acceptability, and best practices through presentations at staff meetings, informal and formal consultations, hallway chats, and shared clinical spaces, encouraging other healthcare professionals and staff to support medication abortion services.

Midwives have normalized medication abortion by offering virtual care for people in rural and remote areas in collaboration with other local midwives or healthcare professionals who can be available for urgent needs. Midwives from all locations reported providing low- and no-touch care in combination with in-person support as needed or wanted for low-risk abortions. An example of how midwives have normalized medication abortion occurred when a Southern 2 location clinician explained how they were inspired to offer a virtual abortion with the support of the midwives for one of their primary care clients who requested continuity and lived 40 minutes away from the healthcare centre.

Clients described their abortion experiences with words like *normal, comfortable, less clinical, more homey, non-judgemental, positive, right, less stressful,* and *routine*. They expressed liking their midwives, feeling comfortable talking with midwives about pregnancy options, feeling like they were listened to and supported to take care of themselves, and feeling like they were treated with care. One client who had multiple pregnancy experiences in midwifery care explained: "…with the midwives, it's more like…there's the technical aspect, but then there's also, I don't know, like, a more homey feel" (C1)

Expanding midwifery-led abortion care

Participants from every location mentioned the disjointed nature of abortion services. They felt that de-centralizing abortion care away from everyday health services was challenging for healthcare professionals and harmful to clients. Many clinicians and clients described how having access to midwifery-led abortion has helped to centralize abortion services. However, participants from every location observed a lack of knowledge within their community about what services expanded midwifery care programs could provide and wondered if people who are

not aware of expanded midwifery care have different perceptions of "what midwives can do with their schooling." (MD3)

Midwives called for a shift in the midwifery paradigm to fully support reproductive rights by enabling midwives to meet more sexual and reproductive healthcare needs. In addition, midwives from all three locations explained how the midwifery model of care is suited for abortion work and supported expanding the role of midwifery to fully embrace expanded midwifery care, as one Northern midwife commented:

> *…it would be amazing to get to a point where people automatically call a midwife when they are pregnant or maybe go to walk in under their family physician and then go to the midwife…. [Then], you know, some people will continue, some will terminate, and it's figuring out your risk factor…. [Midwives] need to be able to do everything. (RM3)*

Midwives who worked outside of an expanded midwifery care model said they looked forward to when all midwives could offer care beyond what their model currently allows and believed that midwives are ideal providers for abortion. (RM3, RM4)

Midwives expressed the need for more low-touch and no-touch options in abortion care, especially for people living with geographical barriers and for people unable to attend in-person visits. Some midwives explained that requiring clients who live far away to come for in-person visits was a massive barrier to abortion, and requiring clients from communities that do not offer medication abortion services to attend in-person appointments is not convenient or even necessary if they do not need an ultrasound, as one Northern midwife illustrated:

> *A person should not have to come in, especially in an outlying community. I should just be able to prescribe [mifepristone and misoprostol] for them to go get the medication and get it done. That's how I see it." (RM3)*

Seeing the benefit of midwifery-led medication abortion, clinicians from each location and every client interviewed mentioned that they would like more people to know about how midwives provide abortion care.

Educating midwives

As previously discussed, midwives providing abortion care have completed Canadian-based training and rely on publicly available, up-to-date medication abortion guidelines to inform their practice. The Northern midwives recognized how other expanded midwifery care programs providing abortion services were instrumental when initiating medication abortion care at the Northern location. In addition, all midwives explained how peer reviews, conferences for abortion providers, and educational opportunities through Ontario's midwifery education program have supported midwifery-led medical-abortion models of care. However, every midwife mentioned an interest in medication abortion training specifically for midwives.

In addition, midwives imagined midwifery-led abortion care expanding to other services, such as early procedural options like manual vacuum aspiration and supporting abortions beyond the first trimester, such as midwifery-led abortion inductions. However, one midwife new to medication abortion questioned the upper limits of expanding their scope:

> *At what point do I stop expanding my scope? Because it feels like my skills are definitely going to build. I can build upon it so much, but at some point, does it fit within what a midwife should be doing? (RM3)*

This question highlighted the need for midwifery-led education, information sharing, and design for expanding midwifery-led abortion care.

Summary

Participants described how medication abortion is more accessible and acceptable within the three primary care organizations and their surrounding communities because of expanded midwifery care programs initiating comprehensive midwifery-led medication abortion care. Midwives have provided abortion care since 2018 when funding supported their integration into primary care organizations, aided by pre-existing and new relationships and supported by

interprofessional healthcare teams and organizations. Despite some initial concerns and professional regulations and policy limitations, midwives led the development and provision of high-quality abortion care, creatively managing funding limitations, embracing intra- and inter-professional collaboration, and prioritizing low-barrier, client-centred access to abortion services. All participants described high satisfaction and acceptability with midwifery-led abortion care and expressed respect and enthusiasm for midwives in this role. Finally, midwives wished to see midwifery care expand to include education and autonomy to offer sexual and reproductive healthcare independently to support reproductive rights, improve access to care, and help to normalize abortion.

Chapter 5: Discussion

This research described experiences of midwifery-led medication abortion within three primary healthcare organizations across diverse regions in Ontario. I aimed to generate conclusions and highlight opportunities for further thought and action to apply to clinical practice in a consistent, logical, and credible way that aligns with the principles and values of the profession of midwifery. (247) As this is the first Canadian study to describe midwifery-led medication abortion from diverse perspectives, the review of relevant literature from Chapter 2 situated my research within experiences of midwifery-led comprehensive medication abortion care internationally. Next, Chapter 3 introduced the midwifery model of care and Reproductive Justice as guiding frameworks for my thesis to emphasize the human right to healthy sexuality, the freedom to decide on reproduction, and the right to autonomy in reproductive health. In Chapter 4, I detailed and interpreted my qualitative findings related to the experiences of midwifery-led medication abortion across three regions in Ontario. I will now discuss my research findings and review how midwifery models of abortion care help to overcome political, social, and economic conditions that prevent people from getting timely care and normalize abortion experiences within primary healthcare.

I interpreted the co-constructed knowledge within what is known and not known about midwifery-led medication abortion and aligned my discussion with the call for midwives to deliver abortion care in Canada. My professional disciplinary knowledge as a midwife and my subjective experiences, values and beliefs have shaped how I viewed, documented, shared, and interpreted the experiences of midwifery-led medication abortion within this research. (247) With knowledge and experience working as a midwife providing expanded care in an

interprofessional healthcare environment, I clarify what can be taken to inform practice and what may require further study. (225)

Summary of findings

This research explored the midwifery-led provision of medication abortion services in three distinct primary healthcare locations across Ontario, including a Northern city and surrounding community, a Southern urban city, and a Southern major centre. The hurdles that clinicians and clients faced before midwives began offering comprehensive abortion care included uninsured costs for prescriptions, transportation, and supplies, navigating referrals and multiple appointments, locating abortion providers, and fragmented, suboptimal care. The participants interviewed emphasized the need for more streamlined and comprehensive abortion services in their communities to ensure universal access and coverage to this essential healthcare as recommended by the World Health Organization. (17,45) To better meet community needs, midwives working in these expanded care models initiated, developed, and gained expertise in abortion services. Some clinicians described the initial hesitations and concerns within their organizations when midwives proposed integrating medication abortion services into their practice, such as conscientious objections from other clinicians and concerns about abortion-related on-call responsibilities. The concerns raised were addressed by midwives sharing information and educating other healthcare professionals about medication abortion, engaging with other expanded midwifery programs, collaborating with like-minded professionals, creating comprehensive medical directives, and offering direct referral and communication pathways. In addition, my findings explored how midwives are addressing the barriers that clients struggle with while having an abortion, working to make medication abortion care more accessible, especially for equity-deserving populations facing discrimination and intersecting social and

ecological barriers to sexual and reproductive health. Overall, the integration of expanded midwifery care into these three primary care settings has improved access to medication abortion and addressed the diverse needs of their communities.

From clients' perspectives, this research demonstrated how midwives improved sexual and reproductive healthcare access by providing low-barrier and continuous care such as point-of-care services, pregnancy options counselling, supportive self-managed medication abortion care, comprehensive post-abortion follow-up, sexual and reproductive care, and full-spectrum of contraception services. Furthermore, these midwifery programs offer comprehensive abortion services free of charge for all current, referred, or presenting clients through direct referral pathways, outreach services, flexible communication, and accessible service delivery.

Leading comprehensive medication abortion care has increased the midwives' job satisfaction, where midwives interviewed reported feeling more helpful to clients and valued within their healthcare systems. In addition, nurse practitioners and medical doctors explained how they refer pregnant clients for midwifery-led sexual and reproductive services because many were aware that midwives offer expertise with this care, prioritize person-centred support during abortion experiences, and deliver abortion services through a model that can remove barriers and provide more time for relationship building and information sharing. Finally, clients with experiences of midwifery-led medication abortions appreciated the continuous midwifery care they received, especially across different pregnancy and post-pregnancy experiences.

Key research findings and how they align with what is known

Despite laws that protect abortion as essential healthcare in Canada, universal access to abortion services has not been established, and people continue to face barriers when seeking

early abortion services. (8,14,45) Participants described how the ability to get an abortion is more difficult for underserved and equity-deserving populations due to intersecting political, social, and economic factors such as uninsured status, new residency, low income, poorer determinants of health, racialization, discrimination, homelessness, and precarious living. (14,82) Midwives described systemic barriers to offering abortion, including their profession's limiting regulations, poorly designed healthcare delivery systems, and few healthcare professionals who support medication abortion in primary care settings. (96,148) Integrating midwifery care into primary healthcare organizations has improved the accessibility and quality of sexual and reproductive health services. In addition, midwifery models of abortion care support and provide trauma and violence-informed care to protect the safety and privacy of clients having abortions. (310,311) Midwifery-led medication abortion is made possible because of strong relationships between midwives, healthcare professionals, supportive organizations, and clients that endorse abortion care within these organizations. The midwives leading the abortion services have developed expertise in sexual and reproductive healthcare delivery to be able to offer accessible client-centred care and normalize abortion within primary healthcare. (96)

Theme 1: Building relationships

The key finding in *building relationships* revolves around the initiation, development, and provision of midwifery-led medication abortion. Continuous relationships between midwives, other healthcare professionals, and clients are essential to successfully offering midwifery-led medication abortion. As research on the importance of relationships for successful models of interprofessional collaboration in reproductive healthcare indicates, this study highlights the significance of pre-existing relationships, mutual goals, supportive

communities of practice, and organizations that prioritize the needs of diverse and equity-deserving people that promote midwifery-led sexual and reproductive services. (148,262,263)

Midwives across the globe face barriers to autonomously providing abortion services, such as professional restrictions and limitations and over-regulation of medication abortion care. (96,99,154,155) Although Canada does not limit the provision of abortion to physicians, Ontario's legislation prevents midwives from providing all aspects of abortion care by limiting what medications, tests, and procedures midwives can order and conduct and containing renumerations for midwifery care within the perinatal and immediate postpartum periods. (18,90,122) Collaborating with other clinicians is necessary for midwives to provide comprehensive sexual and reproductive services within primary healthcare systems. (100,191,215) This research showcases how midwives and other healthcare professionals continue to work in partnership for program development, medical directives, informal consultations, and formal referrals to support midwifery-led abortion. In alignment with prior research on models of midwifery-led abortion, the findings demonstrate how interprofessional collaboration that supports midwives to deliver abortion care promotes better access to services, accommodates healthcare professionals who conscientiously object, and negates factors that limit the provision of medication abortion within primary care. (62,147,170,173,312) In addition, clients appreciate having informational, management, and, in particular, relational continuity with midwives for different pregnancy experiences and care needs to help inform, support, and improve their sexual and reproductive healthcare experiences. These findings align with previous research demonstrating how interprofessional relationships improve the accessibility and acceptability of sexual and reproductive healthcare and support midwifery-led services. (61,96,109,154,162,313–315)

In summary, this research underscores how midwives build and maintain relationships within healthcare systems to integrate and implement models of midwifery-led medication abortion successfully. Although these relationships, characterized by collaboration, mutual trust, and continuity of care, significantly improve access to abortion and promote client-centred healthcare, midwives providing abortion services feel they should be able to deliver abortion care autonomously as primary healthcare professionals.

Theme 2: Developing expertise

The key finding of *developing expertise* centres around the multifaceted aspects of how midwives lead medication abortion services within their organizations, including challenges and innovations that arose in different locations. My findings align with international research and demonstrate midwives successfully delivering medication abortion care safely and effectively with high satisfaction within primary healthcare. Midwives in this study have taken training, promoted organizational support, established medical directives, and creatively organized their midwifery work to offer high-quality medication abortion care, underscoring their commitment to improving their midwifery skills and services. As previously established, the benefit of working through medical directives to provide prescriptions for medication abortion relates to building interprofessional relationships of trust, where midwives work within primary healthcare teams through interprofessional education and learning, informal and formal consultations and referrals, and prioritizing the needs of clients, supporting the concept of having the right healthcare professional offering the right care to the right client. (316) However, midwives see working through directives as problematic as they unnecessarily confound professional responsibilities, hamper the ability to provide up-to-date care, and ultimately make delivering abortion services more complicated. These findings highlight the negative impacts of requiring

midwives to work through medical directives on their autonomy as primary care providers and ultimately limit the evolving nature of expanding midwifery roles. (110,118) Despite facing challenges with regulatory limitations, medical directives, and program funding, midwives provide comprehensive medication abortion safely and effectively through organizational support, partnerships between and within expanded midwifery care programs, and incorporating abortion-related work within their regular practice. As such, these expanded midwifery care programs compare to other international models of midwifery-led abortion and support the essential role midwives play in ensuring equitable access to healthcare. (61,96,99,147,154,162)

Professional guidelines and policy statements from across the globe outline the optimal delivery of comprehensive abortion services. (17,69,70,84,97,187) This study demonstrate how midwives are providing comprehensive abortion care through person-centred models that support individual needs and reproductive rights by embedding the midwifery philosophy within abortion care and empowering clients to decide how, what, and where their abortion care is received. (84,110,120,121) In addition, this research shows how enabling midwives to offer abortion services integrates midwifery knowledge, skills, and experience for managing concerns and complications, providing comprehensive contraceptive services, and offering ongoing reproductive health planning within familiar primary healthcare organizations, supporting high-quality, comprehensive abortion care. (17,37,45,70,96)

Theme 3: Gaining credibility

The key finding from *gaining credibility* emphasizes how midwives are valued providers of medication abortion and advocates for Reproductive Justice. Despite professional limitations, midwives in these locations provide medication abortion care for anyone who needs their support. (151,256) This study highlights how midwives can take a leading role in medication

abortion and contraceptive care. As the participants explained, shifting pregnancy and medication abortion-related care to midwives can allow for confident sharing of professional responsibilities and meet the unique needs of diverse reproductive-aged clients efficiently and effectively. (86,313) In addition, midwifery-led medication abortion resonates positively with referring healthcare clinicians and clients. Clinicians describe midwifery models of abortion care that align with client-centred philosophies promoted by their primary healthcare organizations. Clients see expanded midwifery care as beneficial, trustworthy, safe, and appreciated.

Contrary to literature that acknowledges the potential for moral distress and safety concerns for clinicians, midwives, and clients when delivering abortion services (16,24,39,50,51), my findings grounded in the experiences of Ontario midwives who choose to provide abortion services reflect feelings of confidence in working as abortion providers that contribute to job satisfaction. Similar to other studies exploring midwives' experiences of providing abortion care within supportive healthcare systems, midwives in this study feel that providing abortion care in a way that increases continuity of care has resulted in their work being more valued than when they worked in the course of care model, and report positive feedback from their clients and other healthcare professionals. (162,182) Overall, the midwives were in consensus in their assessment that their practices contribute to positive outcomes for clients through their provision of high-quality, low-barrier abortion within supportive healthcare organizations. The degree of professional experience these midwives have, the safety and support their large healthcare organizations offer, and the accomplishments like overcoming professional limitations, learning new skills, and filling gaps in their communities likely contribute to the satisfaction and credibility midwives feel as medication abortion providers.

Theme 4: Increasing access

The key finding of *increasing access* relates to how midwives offer low-barrier abortion services to address the practical aspects of accessing care. Access to abortion varies by province and is affected by geography, administrative barriers, ongoing impacts of colonialism, racism, and institutional disregard for abortion services. (14,83,260) In addition, uninsured individuals in Canada often cannot afford abortion care, undermining Canada's human rights obligation for universal abortion access and affordability. (14) In this study, participants identified existing and ongoing barriers to abortion that are not being adequately addressed within their communities, like geographical challenges to care, fragmented services, and socioecological disparities.

Studies related to abortion for rural, remote, and equity-deserving people show gaps in sexual and reproductive healthcare that negatively affect their health and well-being. (55,57–59,144,217) To address the challenges people face when accessing healthcare services, these midwives have created robust referral and communication pathways to facilitate low-barrier abortion care and provide flexible, client-centred services within and beyond their healthcare facilities to prioritize access to safe, non-judgmental abortion care. Since the COVID-19 pandemic, access to low-touch and no-touch abortion through telemedicine has increased across the world. (74,77,317) Virtually provided abortion improves access for underserved populations, protects privacy, and increases autonomy. (77,219,317,318) In addition, sexual and reproductive health experts support respecting clients' autonomy to choose what elements of care are possible and acceptable for them within supportive healthcare environments. (17,18,55,70,182,217) Midwives in all locations describe offering hybrid models of medication abortion that encourage clients to tailor low-risk abortions to unique lives and needs. By integrating the midwifery model into abortion services, midwives support abortion experiences through longer visits, different

options for service locations, building relationships, and safer healthcare and abortion experiences. (4,17,31,45,70,260)

Continuity within midwifery care helps clients seek care sooner, promotes greater uptake of sexual and reproductive health services, and enhances the potential for better healthcare experiences and long-term outcomes. (61,86,155,156,182) Low socioeconomic status increases the likelihood that an individual may experience unintended and unwanted pregnancy and can delay seeking care: this outcome is related to lower expectations of healthcare, experiences of disrespect and lack of compassion, and distrust in healthcare professionals due to stigma and discrimination towards their poverty that act as barriers to accessing care. (24,143,260) In addition, relations of power between clients and healthcare professionals within healthcare settings can lead to interpersonal tensions, embarrassment, silence, and judgment. (319,320) The flexible, continuous, and trauma- and violence-informed approach to care midwives provide significantly contributes to building stronger relationships, addressing the complex needs of clients underserved by healthcare systems, and providing safe environments for people who have faced disrespectful care in the past. (14,24,82,162,256,257,318) The findings from this research demonstrate that access to comprehensive and respectful abortion care with trusted healthcare professionals within familiar environments helps clients who face discrimination feel safe and improves their abortion experiences.

Theme 5: Normalizing abortion

The key finding from the theme of *normalizing abortion* involves how integrating midwifery-led abortion care within familiar healthcare environments improves the accessibility of abortion and reduces stigma. The persistent lack of knowledge about the safety, efficacy, and acceptability of medication abortion is a known barrier to providing and accessing abortion

services across Canada. (14,16,55,83,257) The clinicians interviewed acknowledge the barriers to medication abortion in primary care, such as pharmacies that do not stock mifepristone and misoprostol for medication abortion, conscientious objectors who will not provide abortion, and clinicians who feel unprepared or unsupported to offer on-call support for abortion-related concerns. (16,35,46,55) Through building relationships, developing expertise, and gaining credibility, midwives have raised awareness about the acceptability of medication abortion and normalized abortion care within primary healthcare.

Expanded midwifery care models aim to integrate midwifery services into primary healthcare settings and improve access to care by reshaping community perceptions of what midwives can offer. (100,101) Illustrating this, the findings describe how midwives actively work to de-medicalize and centralize services by providing abortion care as an extension of midwifery practice. Midwives offer low-barrier, non-judgmental support for all pregnancy experiences, actively reducing abortion stigma. Clients describe their experiences of midwifery-led abortion care as comfortable, flexible, and less clinical, highlighting how they felt listened to, supported, and treated with care. Continuity with the same midwives is beneficial for receiving care across multiple pregnancy experiences that support personalized needs and promote sexual and reproductive health within established relationships of trust. (120,121,162,264,266)

Other healthcare professionals see midwifery-led medication abortion as a natural extension of midwifery care and describe how midwives are centralizing services, offering support outside of clinical settings, and expanding the availability of medication abortion in large regions. In addition, midwives play a crucial role in educating other healthcare professionals about medication abortion best practices. Clients emphasize the positive aspects of having midwifery-led medication abortion offered within everyday primary healthcare. (316,321,322)

The comprehensive, low-barrier services provided within expanded midwifery care align with recommendations from the World Health Organization for increasing abortion access and respecting human rights. (17) The convenience and comfort participants expressed with midwifery-led abortion care stems from the midwives' flexibility, availability, and support for unique needs that make having an abortion more successful. The findings also highlight the advantages of clients to self-managing aspects of medication abortion with access to healthcare when needed to promote empowering and client-centred care. Midwifery-led services offer medication abortion through hybrid models of virtual and in-person care, such as low- or no-touch options that reduce barriers and promote self-managing elements of low-risk abortions. Some research suggests that self-managed abortions can be a purposeful act of bodily autonomy rather than a less desirable option where the perceived risks are less than expected and can be predictable features that clients can manage with accurate information and access to emergency care if necessary. (49,51,137,323)

Nurse practitioners and medical doctors interviewed credit midwives for making medication abortion accessible, acceptable, and normalized within their organizations. These findings challenge assumptions about where medication abortion services can be safely provided and expand the definition of who can manage abortion care, reducing power dynamics in support of reproductive rights and social justice. (11,256,257,260)

Relevance of the findings to midwifery-led abortion in Canada

In this research, midwives were seen by other healthcare professionals, organizations, and clients as ideal abortion providers because of their extensive knowledge and experience and flexible model of person-centred care. Clinicians and clients described positive experiences of centralized midwifery-led services and non-judgmental support for different pregnancy

outcomes, highlighting the normalcy that research associates with midwifery-led abortion care. (18,61,82,84,97,137,156)

Canada approved mifepristone and misoprostol for medication abortion in 2015 and made it publicly available in 2017, years after the medication's availability in many other countries. (22,37,324) The perceived barriers to offering abortion services within primary care limit or prevent organizations from providing medication abortion care. (62,90,170,173,312,325,325,326) Despite the international calls for action, governments and professional bodies have failed to establish policies that support midwives as autonomous abortion providers. The suggested reasons that governments limit midwives' ability to provide medication abortion care include ambivalence or lack of commitment to abortion, failure to update outdated policies to reflect current clinical and scientific evidence, lack of experience due to delays in approval and implementation of mifepristone and misoprostol for medication abortion, and competing interests caused by siloed remuneration structures that incentivize or restrict who can provide abortion care. (18,147,150,189) This rings true in most Canadian jurisdictions, including the province of Ontario, where midwifery continues to be limited, preventing midwives from autonomously providing comprehensive, low-risk sexual and reproductive healthcare. (82,90,189,256)

This research highlights the need for expanding midwifery services to include comprehensive abortion care to help increase equitable access to safe, accessible, and culturally sensitive services. The findings emphasize the suitability of midwives to address a broader range of pregnancy-related needs with acceptability and value, aligning with calls from international and national midwifery and abortion stakeholders. (82,84,85,89,97,189) Furthermore, this study shows that midwives can conscientiously choose to provide abortion services and that many look

forward to seeing their professional role expand to a broader spectrum of healthcare needs. (18,90,162,182) This research underlines the importance of educating midwives and raising public awareness about midwifery's role in providing quality abortion care. Midwifery-led abortion is improving the accessibility and acceptability of sexual and reproductive services for equity-deserving people who face intersecting social, political, and economic barriers to health and systemic discrimination within healthcare and society.

Strengths

This research was created and completed by skilled midwives with experience practicing in midwifery practice groups and expanded models of midwifery care. In alignment with Thorne's criteria for enhancing the credibility and dependability of interpretive descriptive studies, the investigators' disciplinary designations offered an informed perspective on the philosophy, model, and core values of midwifery as they apply to comprehensive abortion care. (225) In addition, as midwives in Ontario, the investigators recognized the professional limitations imposed by provincial midwifery legislation and understood how restrictions impact interprofessional relationships and experiences of midwives leading medication abortion services. My professional knowledge allowed me to understand and interpret unique and shared experiences of midwifery-led medication abortions and describe how midwifery care influences the quality of abortion services. In addition, the knowledge my committee members offered related to qualitative health research supported my study's development, conduction, rigor, trustworthiness, and completion.

This study explored experiences of midwifery-led medication abortion from multiple perspectives across Ontario, providing triangulated and co-constructed knowledge to increase the trustworthiness and reliability of the findings. Data source triangulation included exploring

medication abortion experiences within three distinct locations, employing multiple data collection methods, and collecting data through interviews with different participant types to ensure diverse perspectives, contributing to the rigor and trustworthiness of my research. In addition, variances in midwifery-led medication abortion services were compared and contrasted between three expanded midwifery care programs in distinct regions across Ontario. Furthermore, clients who voluntarily agreed to be interviewed identified as populations deserving of Reproductive Justice. This research has allowed different people to voice their experiences of midwifery-led abortion care.

Limitations

When designing this research, I intended to interview midwives, healthcare clinicians, and clients from all three locations. This study's findings are informed by the experiences of midwives, nurse practitioners, medical doctors, and clients within three primary healthcare organizations in different locations across Ontario. However, the nature and delivery of medication abortion services and the experiences of comprehensive abortion care were not explored from the perspectives of clients from all locations due to constraints related to completing a master's thesis and my inability to recruit clients from the Southern 1 and Southern 2 locations. Exploring clients' experiences from all three locations would provide information on the shared and unique aspects of midwifery-led medication abortion relevant to different expanded midwifery care programs and healthcare environments. In addition, missing from the data are the experiences of support staff, outreach workers, and management, whom some participants identified as instrumental in supporting midwifery-led medication abortion. This study is continuing beyond the submission of my Master of Science thesis, and our research team

hopes to interview clients and staff from all three locations for a larger multiple-case study. Any future participant contributions will be included in scholarly papers submitted for publication.

Despite collecting demographic information as part of the larger multiple case study, participant demographics have not been reported to maintain privacy. Some participants voluntarily identified as racialized or Indigenous; however, I acknowledge the limited representation of Indigenous, Black, and racialized midwives, nurse practitioners, medical doctors, and researchers who understand the potential health impacts of systemic racism on individual and population level health outcomes and who are instrumental in championing change within and across the healthcare system to ensure equitable healthcare access. (257)

Finally, no midwives interviewed reported conscientious objection to providing abortion care. Although collaborating clinicians had unique personal opinions of abortion, they represented a small percentage of the healthcare workforce within the three primary healthcare organizations featured. Within the purposeful sampling and recruitment frame utilized, there was consensus among the midwives who participated that abortion care is suitable for the profession, provides an opportunity for professional growth, and increases credibility and value within the healthcare system, contributing to job satisfaction. However, as research suggests, one can anticipate that there are midwives who conscientiously object to providing abortion care in Canada. (173,174,312) Therefore, for future research in this area, utilizing a process of negative case sampling may help find and interview individuals who hold these views and would provide more dimensionality to future findings.

Implications for clinical practice, policy, and research

This research supports the ongoing discourse advocating for midwives to provide abortion services in Canada and calls for a shift in the midwifery paradigm to meet a broader spectrum of sexual and reproductive healthcare needs. (18,82,90,189,191,204) The findings describe how people experience midwifery-led medication abortion within primary healthcare, which is relevant to clinical practice and may be of interest to midwifery and abortion stakeholders. Although midwifery-led abortion is not yet common in Canada, these expanded midwifery care models demonstrate tangible ways for midwives to improve the accessibility, acceptability, and quality of medication abortion for commonly underserved people.

The joint stakeholders' submission to the United Nation's 44th Universal Periodic Review suggests that Canada needs better information on the needs and experiences of people who face complex systemic barriers to reproductive health to inform service delivery and create low-barrier pathways to abortion care. (14) This research describes how midwives, referring and collaborating healthcare professionals, and clients experience midwifery-led medication abortion within primary healthcare across three distinct communities across Ontario. Further research is needed to contrast and compare clients' experiences of medication abortions in different settings with other healthcare professionals to fully understand what people face when seeking abortion care.

In terms of applying the findings to midwifery practice, this study provides information on the groundwork, training, challenges, successes, and impact of midwives leading medication abortion care within primary healthcare organizations. It offers advice on how to improve the overall quality and accessibility of low-risk medication abortion care within midwifery practice. In addition, the research demonstrates how providing low-barrier medication abortion services

within regular clinic hours is possible within supportive healthcare environments. In addition, midwifery-led medication abortion can be supported through interprofessional collaboration and education on the safety, efficacy, and acceptability of medication abortion with midwifery care. Finally, this study provides new knowledge illuminating midwives' suitability for addressing a more comprehensive range of pregnancy-related needs. (82,84,85,89,97)

Midwifery has been shown to improve health outcomes for populations that are underserved by current systems, such as people with low socioeconomic status facing discrimination and racism, by empowering clients to tailor care to their unique lives and circumstances. (24,137,205) This research supports how midwifery-led models of medication abortion increase access to essential sexual and reproductive healthcare for equity-deserving people and support Reproductive Justice. (19,57,58,144,256) Furthermore, expanded midwifery care provides a possible solution for under-resourced areas such as Northern, rural, and remote communities that may have smaller volumes of clients needing perinatal and birth care and more need for other high-quality sexual and reproductive health services and the provision of a broader mix of services would help create a sustainable workload. (327,328) In addition, enabling midwives to provide autonomous care across reproductive lifespans may improve sustainability and address attrition within the profession by offering opportunities to work in new ways.

The World Health Organization states that high-quality abortion care is "supportive, universally accessible, affordable and well-functioning." (17) Integrating midwifery-led medication abortion into supportive primary healthcare organizations promotes the safe delivery of medication abortion for populations at risk for poorer outcomes. By demonstrating how expanded midwifery care models offer comprehensive sexual and reproductive health services

with acceptability, satisfaction, and value, other settings may be inspired to increase the quality of medication abortion care. (14,82,84,204)

As current research suggests, my findings suggest that little is known about the education and training available for midwives to provide abortion-related care. (96,267,329) In addition, a recent qualitative study on the nurse practitioners' role in medication abortion provision shows that other healthcare professionals report having no formal training in abortion and learn to provide medication abortion through independent pathways similar to the midwives in this study through self-education, developing protocols, supporting and mentoring colleagues, providing informal education to other healthcare professionals, and advocating with allied healthcare services. (46) These comparative findings support a need to create, improve, and incorporate discipline-specific medication abortion education within primary healthcare education.

Training programs for medication abortion in Canada are primarily aimed at primary healthcare clinicians who can order mifepristone and misoprostol. (330,331) Research with medical doctors who prescribe mifepristone and misoprostol shows that providing medication abortion in primary care is "relatively simple, compatible with…practice, and easy to learn through self-study." (45,326) Likewise, the midwives in this study used their knowledge, skills, and experience in perinatal and postpartum healthcare to provide abortion care and state that delivering medication abortion services is fairly simple, acceptable, and satisfying work. Midwife participants expressed an interest in creating midwifery-specific education for comprehensive medication abortion care to raise awareness about midwifery's unique role in improving continuity, accessibility, and choice in sexual and reproductive health services.

Canadian midwifery regulators, with the necessary support of lawmakers, can eliminate barriers to medication abortion by ensuring that healthcare regulation and policy include

midwifery in the provision of expanded sexual and reproductive services so as to improve reproductive life planning, reduce the rate of unintended pregnancies and provide more people with access to high-quality sexual and reproductive healthcare. (17)

Summary

Improving the quality of abortion care can reduce stigma, increase access, and enhance knowledge about pregnancy prevention and reproductive health. (17) Midwifery-led medication abortion is considered "effective, efficient, accessible, person-centred, equitable, and safe" in alignment with the World Health Organization's framework on quality abortion care. (17) As research on client-centred access to healthcare recommends, Ontario's expanded midwifery care models are improving the ease with which people can find and use sexual and reproductive services most appropriate to their unique needs. (210) The expanded midwifery care presented in this study demonstrates how midwifery-led medication abortion provides high-quality services, decreases stigma, and improves access to safe, acceptable, and client-centred abortion care, particularly for commonly underserved populations deserving of health equity and Reproductive Justice.

Chapter 6: Conclusion

While international research has explored midwifery-led abortion with positive results, there is a lack of evidence specific to Canada as midwifery-led abortion is not yet common due to legislative and regulatory constraints on the midwifery profession. As Canada does not restrict the provision of abortion care to physicians, many Canadian experts and stakeholders endorse midwives as abortion providers within a framework of offering midwifery care for all normal pregnancies. Midwives across the country express willingness to offer abortion care, and some are already providing services. Some midwives working within expanded midwifery care models in Ontario provide comprehensive sexual and reproductive health services in collaboration with nurse practitioners and medical doctors. Under the current system, interprofessional collaboration is necessary for the successful delivery of comprehensive midwifery-led medication abortion care.

This research provides an understanding of midwifery-led medication abortion across three distinct primary healthcare organizations in Ontario, aligning with the World Health Organization's recommendation to integrate abortion into primary care to ensure universal coverage. Understanding the barriers and facilitators to abortion is crucial for optimizing midwifery's role in improving access to equitable, high-quality abortion care. The midwives, nurse practitioners, medical doctors, and clients featured in this research have illuminated how expanded midwifery care improves medication abortion experiences. This study offers new knowledge to inform clinical practice and engage policymakers. The findings underscore the positive impact midwifery has on normalizing abortion and improving the quality of care. Through this research, I hope to promote midwifery-led abortion care to achieve meaningful change and support equitable access to sexual and reproductive healthcare.

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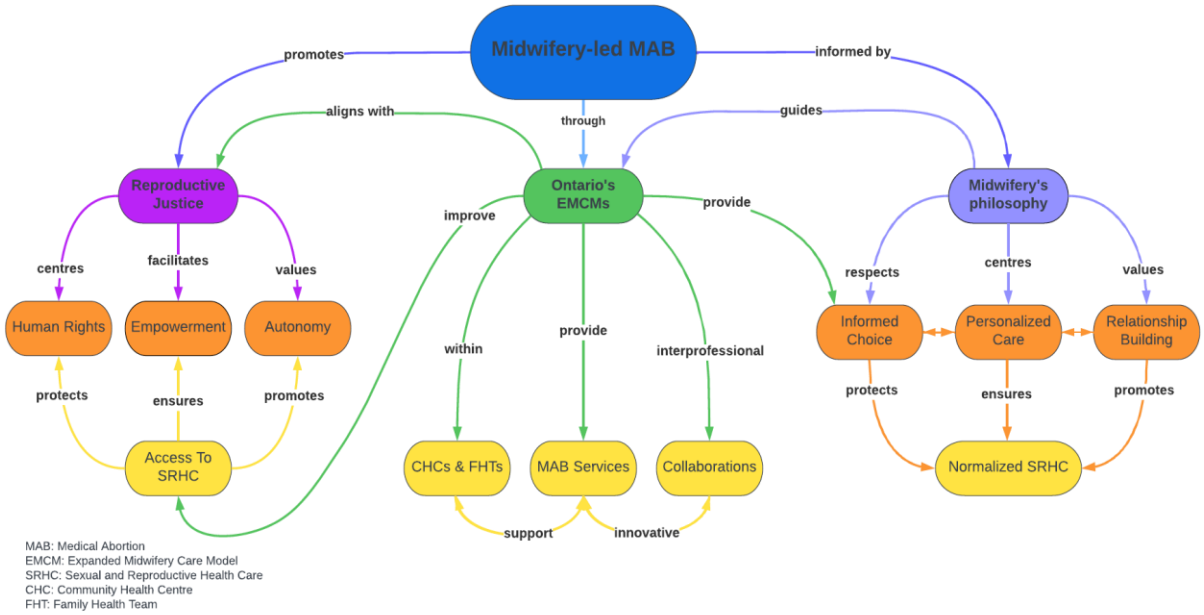
Appendix A: Theoretical scaffolding



Appendix B: Blank study key

Participant	Phone	Email	Study ID	Preferred contact

Key to study ID:
Participant = first name
Study ID = site by initials (N=Northern, S1=Southern 1, S2=Southern 2) + participant category by initials (RM = Registered Midwife, C = client, MD = Medical Doctor, NP = Nurse Partitioner) + number in order of interview at site

Appendix C: Recruitment scripts

Midwife invitation: initial contact (in person or by phone):

I want to tell you about a research project some of my colleagues are conducting where midwives are researching new ways of working in healthcare across Ontario. The research team consists of two midwife researchers exploring how having midwives join primary healthcare organizations helps people access high-quality sexual and reproductive care.

If you are interested in joining the project, the team will invite you to fill out a short online survey and participate in a virtual interview with one of the research team members. They will ask questions about you and the care you provide as a midwife to learn more about your experiences with expanded midwifery services in primary care settings. It takes five to ten minutes to complete the survey and about one hour to participate in the interview. All the collected information will be de-identified. If you are interested, I will provide your contact information (name, phone number, email) to the research team so they can tell you more about the project and answer any questions.

Would you be ok if I shared your information with the researchers? If so, how do you prefer to be contacted (by email, text, or phone call)?

Follow-up text/telephone message from the research team:

Hi, I am contacting you today because you are listed as an expanded midwifery care model provider through the Association of Ontario Midwives website to invite you to participate in a research study we are conducting about midwifery integration into the healthcare system.

Our study is exploring new ways midwives are working in primary care settings. As part of this project, we welcome midwives, clients, and other healthcare providers (HCPs) to share their experiences with health services led and delivered by midwives in primary care settings. We will invite you to answer a short survey and participate in an online interview with one of our team members. We will also ask you to invite potential clients and HCP participants who work with expanded midwifery care model programs to be contacted by the research team for recruitment to the study. Within our study's budget, we can offer client participants only an honorarium as a gesture of appreciation.

I have sent you an email with more information. Please feel free to contact me at this number via text or phone call or reply to our email.

Thanks again!
_____[name of researcher]

A follow-up email from the research team:

Hi, I am contacting you today because you gave your consent to your midwife for our research team to contact you and tell you more about a research study we are conducting about midwifery integration.

I am a midwife and researcher with McMaster University's Midwifery Graduate Program. As part of our research study, our team will ask midwives, clients, and healthcare providers (HCPs) about their experiences with the health services midwives deliver in primary care settings.
If you choose to participate in our study, we will ask you to:

1. complete a short online survey with questions to help us learn about who is being cared for by midwives (5-10 minutes),
2. be interviewed virtually, online through Zoom, about your experience of midwifery care by a member of our team (30-60 minutes) and,
3. invite potential client and HCP participants to be contacted by our research team.

For both the survey and the interview, you may choose to answer or not answer any of the questions at any time.

Please review our letter of the information below and feel free to contact us at:
email:_____
text/phone:_____

Take good care,
Rebecca Hautala, pronouns: she/her
Registered Midwife, Master of Science in Midwifery student
Research Coordinator, EMC^2 Study

Healthcare provider invitation

Initial contact by a recruiting midwife participant (in person or by phone):

I would like to tell you about a research project some of my colleagues are conducting. These midwives are researching new ways of working in healthcare across Ontario. The research team is exploring how having midwives join primary healthcare organizations helps people access high-quality sexual and reproductive care.
If you are interested in joining the project, the team will invite you to fill out a short online survey and participate in a virtual interview with one of the research team members. They will ask questions about you and the care you see midwives providing and the ways you may collaborate to learn more about your experiences with expanded midwifery services in primary care settings. It takes five to ten minutes to complete the survey and about one hour to participate in the interview. All the collected information will be de-identified. If you are interested, I will provide your contact information (name, phone number, email) to the research team so they can tell you more about the project and answer any questions.

Would you be ok for me to share your information with the researchers? If so, how do you prefer to be contacted (by email, text, or phone call)?

Follow-up text/telephone message from the research team:

Hi, I am contacting you today because you gave consent to tell you more about a research study we are conducting exploring new ways midwives work in primary care settings. As part of this project, we welcome healthcare providers to share their experiences with healthcare services led and delivered by midwives. We invite you to answer a short survey and participate in an online interview with one of our team members.

I have sent you an email with more information. Please feel free to contact me at this number via text or phone call or reply to our email.

Thanks again!
_____[name of researcher]

A follow-up email from the research team:

Hi, I am contacting you today because you gave your consent for our research team to contact you and tell you more about our research study exploring midwifery integration into primary care.

I am a midwife and researcher with McMaster University's Midwifery Graduate Program. As part of our research study, our team will ask healthcare providers about their experiences working with midwives providing expanded health services in their primary care settings.

If you choose to participate in our study, we will ask you to:

2. complete a short, online survey with questions to help us learn about who is being cared for by midwives (5-10 minutes) and,
4. be interviewed virtually, online through Zoom, about your experience of expanded midwifery care by a member of our team (30-60 minutes).

For both the survey and the interview, you may choose to answer or not answer any of the questions at any time.

Please review our letter of the information below and feel free to contact us at:
email:_____
text/phone:_____

Take good care,
Rebecca Hautala, pronouns: she/her
Registered Midwife, Master of Science in Midwifery student
Research Coordinator, EMC^2 Study

Client invitation

Initial contact by a midwife (in person or by phone):
I would like to tell you about a research project other midwives are doing. The midwife researchers are exploring new ways of working in healthcare across Ontario. The research team is exploring how having midwives join primary healthcare organizations helps people access high-quality sexual and reproductive care

If you are interested in joining this project, the midwife researcher will invite you to fill out a short online survey and participate in a virtual interview with one of the research team members.

They will be asking questions about you and the care you received from your midwives to learn more about people's experiences while accessing expanded midwifery care. It takes five to ten minutes to complete the survey and about one hour to participate in the interview. All the collected information will be de-identified and not contain your personal information, so it cannot be linked to you or your health care records.

If you are interested, I can provide your contact details, such as your name, phone number, and email address, to our research team so they can tell you more about the project and answer any questions you may have.

Would you be ok for me to share your information with the researchers? If so, how do you prefer to be contacted (by email, text, or phone call)?

Follow-up text/telephone message from the research team:

Hi, I am contacting you today because you gave your consent to your midwife for our research team to contact you and tell you more about a research study we are conducting about midwifery.

Our study is exploring new ways of midwives working in primary care settings. As part of this project, we welcome clients to share their experiences with health care led by midwives. We will invite you to answer a short survey and participate in an online interview with one of our team members.

I have sent you an email with more information. Please feel free to contact me at this number via text or phone call or reply to our email.

Thanks again!
_____[name of researcher]

A follow-up email from the research team:
[If the client has no email, the following will be sent via text message]

Hi, I am contacting you today because you gave your consent to your midwife for our research team to contact you and tell you more about a research study we are conducting about midwifery.

I am a midwife and researcher with McMaster University's Midwifery Graduate Program. As part of our research study, our team will ask clients/patients about their experiences receiving health services from midwives in primary care settings.

If you choose to participate in our study, we will ask you to:

3. complete a short, online survey with questions to help us learn about who is being cared for by midwives (5-10 minutes) and,
5. be interviewed virtually, online through Zoom about your experience of midwifery care by a member of our team (30-60 minutes).

For both the survey and the interview, you may choose to answer or not answer any of the questions at any time.

Please review our letter of the information below and feel free to contact us at:
email:_____
text/phone:_____

Take good care,
Rebecca Hautala, pronouns: she/her
Registered Midwife, Master of Science in Midwifery student
Research Coordinator, EMC^2 Study

Appendix D: Midwife information letter

MIDWIFE PARTICIPANT INFORMATION (EMC ^{2} STUDY)

Title of Study: Expanded Midwifery Care Models Multiple-Case Study (EMC^2 Study): Integrating midwifery into primary care settings across Ontario
Principal Investigator: Dr. Liz Darling, RM, MSc, PhD
Student-Investigators: Rebecca Hautala, RM, MSc Candidate

Invitation to participate in research
Expanded Midwifery Care models are a new way for midwives to work in primary care settings across Ontario. We invite midwives working within expanded midwifery care models to share about their midwifery services, their experiences of delivering expanded midwifery care, their collaborations with other healthcare providers (HCPs), and basic information about themselves. Participation in this research is voluntary.

Why is this study being done?
This project will explore how midwives working in new ways help people access high-quality sexual and reproductive care. We are also collecting information from clients and other HCPs to understand who is accessing midwifery services and how they experienced this care.

How many participants will be in this study?
People with experiences of expanded midwifery care through one of seven expanded midwifery care model sites across Ontario will be asked to participate. Each site will talk to 10-15 people, including clients/patients, midwives, and collaborating HCPs.

What will happen to participants in this study?
If you consent to participate, you agree to fill out a short online survey that collects information such as language, gender, identity, and postal code. Next, participants will have a 30–60-minute online interview with a team member. Your total time commitment will be approximately 1-1.5 hours.

In addition, you will be asked to approach clients and other HCPs you know with experiences of expanded scope midwifery care for consent to provide their contact information (name, phone number, email) to the research team to offer them information on the research project and an invitation to participate in the study.

Are there any risks or discomforts associated with participating?
The risks to study participants are minimal. Some of the risks may involve discomfort in answering sensitive questions, concerns for privacy related to the sensitive nature of some of the

topics we are exploring, and concerns regarding breaches of privacy of your personal information. Furthermore, you may have personal challenges and responsibilities that make participation more challenging.

You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. Following your interview, we can connect you with healthcare professionals who have experience with debriefing after difficult conversations should you want or need additional support. Below, we explain the steps we are taking to protect your privacy.

Are there any benefits for me and/or society?
This research will not benefit you directly. Participation may benefit others in the future as the information you provide will be used to inform expanded midwifery services and improve quality sexual and reproductive health care in Ontario. This research will also be used to decide if similar midwife-led projects should be created in other parts of the province and country.

Will I be paid to participate in this study?
There is no payment for participating.

Will there be any costs to me in this study?
There are no costs for participating.

What will happen to my personal information?
Every effort will be made to protect your confidentiality and privacy. Your name and any information that would identify you will not be used throughout data collection and analysis. Participants will be de-identified upon entry into the survey. The research coordinator will assign each participant a unique code and keep an electronic study key. The key will be, password-protected, and storedin a securely encrypted database to protect research data. The research team can only access the data through a password-protected system. To allow you the option to withdraw from the study, you will be given a unique code linked to the password-protected study key to access the REDCap survey that will allow the research team to remove your data if you change your mind about participating. Once the study is complete, an anonymous record of the information you provided will be kept for ten years and then destroyed.

Can participation end early?
Your participation in this study is voluntary. If you decide to be part of the study, you can change your mind for any reason, even after completing the consent form. You can also participate in the study but not answer all the questions. If you decide to withdraw, there will be no effects to you. If you withdraw, any information you have provided will be destroyed unless you indicate otherwise. To withdraw from the study, call or email a team member using the contact information below.

Who should I call if I have questions about this study or want to withdraw my participation?

If you have any questions or wish to withdraw from the study, please get in touch with Dr. Liz Darling, RM MSc PhD, McMaster University:

Dr. Liz Darling
darlinek@mcmaster.ca
905-525-9140 ext. 21597

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB). The HIREB is responsible for ensuring that participants are informed of the risks associated with the research and are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the REB Chair, HiREB, at 905-521-2100 x 42013.

Appendix E: Healthcare provider information letter

HEALTHCARE PROVIDER PARTICIPANT INFORMATION (EMC ^{2} STUDY)

Title of Study: Expanded Midwifery Care Models Multiple-Case Study (EMC^2 Study): Integrating midwifery into primary care settings across Ontario
Principal Investigator: Dr. Liz Darling, RM, MSc, PhD
Student-Investigators: Rebecca Hautala, RM, MSc Candidate

Invitation to participate in research
Expanded Midwifery Care models are a new way for midwives to work in primary care settings across Ontario. We are inviting people to share about the midwifery services they received, their experiences of midwifery care, and basic information about themselves. Participation in this research is voluntary.

Why is this study being done?
This project will explore how midwives working in new ways help people access high-quality sexual and reproductive care. We are also collecting information from clients to understand who is accessing midwifery services and how they experienced this care.

How many participants will be in this study?
People who receive expanded midwifery care through one of seven sites across Ontario will be asked to participate. Each site will talk to 10-15 people, including clients/patients, midwives, and other care providers.

What will happen to participants in this study?
If you consent to participate, you agree to fill out a short online survey that collects information such as language, gender, identity, and postal code. Next, participants will have a 30–60-minute online interview with a team member. Your total time commitment will be approximately 1-1.5 hours.

Are there any risks or discomforts associated with participating?
The risks to study participants are minimal. Some of the risks may involve discomfort in answering sensitive questions, concerns for privacy related to the sensitive nature of some of the topics we are exploring, and concerns regarding breaches of privacy of your personal information. Furthermore, you may have personal challenges and responsibilities that make participation more challenging.

You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. Following your interview, we can connect you with healthcare professionals who

have experience with debriefing after difficult conversations should you want or need additional support. Below, we explain the steps we are taking to protect your privacy.

Are there any benefits for me and/or society?
This research will not benefit you directly. Participation may help others in the future as the information you provide will be used to inform expanded midwifery services and improve quality sexual and reproductive health care in Ontario. This research will also be used to decide if similar midwife-led projects should be created in other parts of the province and country.

Will I be paid to participate in this study?
There is no payment for participating.

Will there be any costs to me in this study?
There are no costs for participating.

What will happen to my personal information?
Every effort will be made to protect your confidentiality and privacy. Your name and any information that would identify you will not be used throughout data collection and analysis. Participants will be de-identified upon entry into the survey. The research coordinator will assign each participant a unique code and keep an electronic study key. The key will be encrypted, password-protected, and stored. Your information will be kept in a securely encrypted database to protect research data. The research team can only access the data through a password-protected system. To allow you the option to withdraw from the study, you will be given a unique code linked to the password-protected study key to access the REDCap survey that will allow the research team to remove your data if you change your mind about participating. Once the study is complete, an anonymous record of the information you provided will be kept for ten years and then destroyed.

Can participation end early?
Your participation in this study is voluntary. If you decide to be part of the study, you can change your mind for any reason, even after completing the consent form. You can also participate in the study but not answer all the questions. If you decide to withdraw, there will be no effects to you. If you withdraw, any information you have provided will be destroyed unless you indicate otherwise. To withdraw from the study, call or email a team member using the contact information below.

Who should I call if I have questions about this study or want to withdraw my participation?

If you have any questions or wish to withdraw from the study, please get in touch with Dr. Liz Darling, RM MSc PhD, McMaster University:

Dr. Liz Darling darlinek@mcmaster.ca 905-525-9140 ext. 21597

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB). The HIREB is responsible for ensuring that participants are informed of the risks associated with the research and are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the REB Chair, HiREB, at 905-521-2100 x 42013.

Appendix F: Client information letter

CLIENT PARTICIPANT INFORMATION (EMC ^{2} STUDY)

Title of Study: Investigating the impact of Expanded Midwifery Care Model funding on midwifery integration in primary care settings across Ontario

Principal Investigator: Dr. Liz Darling, RM, MSc, PhD
Student-Investigators: Rebecca Hautala, RM, MSc Candidate

Invitation to participate in research
Expanded Midwifery Care models are a new way for midwives to work in primary care settings across Ontario. We are inviting people to share about the midwifery services they received, their experiences of midwifery care, and basic information about themselves. Participation in this research is voluntary.

Why is this study being done?
This project will explore how midwives working in new ways help people access high-quality sexual and reproductive care. We are also collecting information from clients to understand who is accessing midwifery services and how they experienced this care.

How many participants will be in this study?
People who receive expanded midwifery care through one of seven sites across Ontario will be asked to participate. Each site will talk to 10-15 people, including clients/patients, midwives, and other care healthcare providers.

What will happen to participants in this study?
If you consent to participate, you agree to fill out a short online survey that collects information such as language, gender, identity, and postal code. Next, participants will have a 30–60-minute online interview with a member of the team. Your total time commitment will be approximately 1-1.5 hours.

Are there any risks or discomforts associated with participating?
The risks to study participants are minimal. However, you will be asked questions regarding health care you have received, and some of the risks may involve discomfort in answering sensitive questions, concerns for privacy related to the sensitive nature of some of the topics we are exploring, and concerns regarding breaches of privacy of your personal information. Furthermore, you may have personal challenges and responsibilities that make participation more challenging.

Whether or not you choose to participate will not impact your care now or in the future. You do not need to answer questions that you do not want to answer or that make you feel uncomfortable. Following your interview, we can connect you with healthcare professionals who have experience with debriefing after difficult conversations should you want or need additional support. Below, we explain the steps we are taking to protect your privacy.

Are there any benefits for me and society?
This research will not benefit you directly. Participation may benefit others in the future as the information you provide will be used to inform expanded midwifery services and improve quality sexual and reproductive health care in Ontario. This research will also decide if similar midwife-led projects should be created in other parts of the province and country.

Will I be paid to participate in this study?
You will be offered an honorarium in the form of a $25 gift card for completing the health equity survey and participating in the interview.

Will there be any costs to me in this study?
There are no costs for participating.

What will happen to my personal information?
Every effort will be made to protect your confidentiality and privacy. Your name and any information that would identify you will not be used. Your information will be kept in a secure database designed to protect research data. The research team will only be able to access the data through a password-protected system. To allow you the option to withdraw from the study, you will be given a unique code linked to the password-protected study key to access the REDCap survey that will allow the research team to remove your data if you change your mind about participating. Once the study is complete, an anonymous record of the information you provided will be kept for ten years and then destroyed.

Can participation end early?
Your participation in this study is voluntary. If you decide to be part of the study, you can change your mind for any reason, even after completing the consent form. You can also choose to participate in the study but only answer some of the questions. If you decide to withdraw, there will be no effects to you. If you withdraw, any information you have provided will be destroyed unless you indicate otherwise. To withdraw from the study, use the contact information below to call or email a team member.

If I have questions about this study or want to withdraw my participation, who should I call?

If you have any questions or wish to withdraw from the study, University please get in touch with Dr. Liz Darling, RM MSc PhD, McMaster University:

Dr. Liz Darling
darlinek@mcmaster.ca
905-525-9140 ext. 21597

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB). The HIREB is responsible for ensuring that participants are informed of the risks associated with the research and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the REB Chair, HiREB, at 905-521-2100 x 42013.

Appendix G: Participant electronic consent: REDCap

CONSENT STATEMENT

[ELECTRONIC CONSENT] Consenting below indicates that:

- You have read the above information.
- You voluntarily agree to participate.

You may choose one of the following options:

☐I consent to provide this information to the research team for the EMC^2 Study to be used in a research study in which my information will remain anonymous.

OR

☐I do not consent.

[NOTE: Participants will not be able to access or answer the remainder of the survey in REDCap without providing consent]

Appendix H: Midwife and Healthcare provider health equity survey

HEALTH EQUITY SURVEY

[Consent Embedded in REDCap. Consenting provides access to the survey.]

Thank you for agreeing to participate in our online survey!

1. What language are you most comfortable speaking?
   [open text field]

2. What is your gender? Please choose all that apply.
   1, Man
   2, Non-binary
   3, Two-Spirit
   4, Woman
   5, Another gender not listed (Please specify)
   6, Unsure
   55, I do not wish to answer this question
   Please specify:[open text field]

3. Do you identify as trans or transgender?
   1, Yes
   2, No
   3, Unsure
   55, I do not wish to answer this question

4. What is your sexual orientation? Please choose all that apply:
   1, Bisexual
   2, Gay
   3, Heterosexual

4, Lesbian

5, Pansexual

6, Queer

7, Two-Spirit

8, Another sexual orientation not listed (Please specify):

9, Unsure

55, I do not wish to answer this question

Please specify:[open text field]

5. Do you self-identify as First Nations, Metis or Inuk/Inuit? Please check all that apply
   1, Yes, First Nations

   2, Yes, Metis

   3, Yes, Inuk/Inuit

   4, No

   55, I do not wish to answer this question

6. Do you identify as racialized?

The term racialized is defined by the Government of Canada in the Employment Equity Act as persons, other than Indigenous peoples, who do not identify as Caucasian, European, and/or White in race, ethnicity, origin, and/or colour, regardless of birthplace or citizenship.

1, Yes

0, No

55, I do not wish to answer this question

7. Which of the following best describes your racial and/or ethnic group(s)? Check ALL that apply.

   1, Asian – East (e.g., Chinese, Japanese, Korean)

   2, Asian – South (e.g., Indian, Pakistani, Sri Lankan)

   3, Asian – South East (e.g., Malaysian, Filipino, Vietnamese)

   4, Black – African (e.g., Ghanaian, Kenyan, Somali)

   5, Black – Caribbean (e.g., Bajan, Trinidadian, Jamaican)

6, Black – North American (e.g., Canadian, American)

7, Indo – Caribbean (e.g., Guyanese with origins in India)

8, Jewish

9, Latin, Central, or South American (e.g., Argentinean, Chilean, Salvadorian, Mexican)

10, Indigenous (e.g., First Nations, Metis, Inuk/Inuit)

11, Middle Eastern (e.g., Afghani, Armenian, Egyptian, Iranian, Iraqi, Jordanian, Algerian, Lebanese, Palestinian, Syrian, Yemeni)

12, Pacific Islander or Polynesian/Melanesian/Micronesian (e.g., Cook Island Maori, Hawaiian Maori, Fijian, Marquesan, Marshallese, Niuean, Samoans, Tahitian, Maori, Tongan, New Zealand Maori)

13, White (including European, White-Canadian/American/Australian/South African)

14, Another identity not listed (Please specify below)

15, Do not know

55, I do not wish to answer this question

Please specify:[open text field]

8. Whether or not it affects your day-to-day life, are you a person with a disability?

A person with a disability is someone who has a long-term or recurring physical, mental, sensory, psychiatric, or learning disability and considers oneself to be disadvantaged by reason of that disability or believes that society is likely to consider them to be disadvantaged by reason of that disability. A person with a disability may also be someone whose functional limitations owing to their disability have been accommodated in their environment.

1, Yes

0, No

55, I do not wish to answer this question

[If yes to disability] What type of disability do you have? Please check ALL that apply

1, Chronic illness

2, Chronic pain

3, Developmental disability

4, Drug or alcohol dependence

5, Learning disability

6, Mental illness and/or psychiatric disability

7, Physical, functional, or mobility disability

8, Sensory disability (i.e. hearing or vision loss)

9, Speech disability

10, Another disability not listed

Please specify:[open text field]

11, Do not know

55, I do not wish to answer this question

10. Services offered through the expanded midwifery care model? Check ALL that apply.

1, Prenatal visit

2, Medication abortion

3, Abortion referral

4, PAP test

5, Sexual health screening

6, STI treatment

7, IUD insertion/removal

8, Nexplanon insertion/removal

9, Contraception

10, Infant feeding consultation

11, Menopause counseling

12, Well baby care

13, mental health

14, Postpartum visit

15, Immunization

16, Another reason not listed (Please specify:)

Please specify:[open text field]

55, I do not wish to answer this question

10. How did you hear about the expanded midwifery care model?

    1, Physician

    2, Midwife/Midwifery practice group

    3, Nurse Practitioner

    4, Nurse

    5, Health Unit referral

    6, Social media

    7, Friend or family member

    8, Poster

    9, Referral from anther health centre

    10, Other

    Please specify:[open text field]

55, I do not wish to answer this question

Appendix I: Client health equity survey

HEALTH EQUITY SURVEY (EMC ^{2} STUDY)

[Consent Embedded in REDCap. Consenting provides access to the survey.]

Thank you for agreeing to participate in our online survey!

9. What language are you most comfortable speaking?
   [open text field]

10. What is your gender? Please choose all that apply.

    1, Man

    2, Non-binary

    3, Two-Spirit

    4, Woman

    5, Another gender not listed (Please specify)

    6, Unsure

    55, I do not wish to answer this question

    Please specify:[open text field]

11. Do you identify as trans or transgender?

    1, Yes

    2, No

    3, Unsure

    55, I do not wish to answer this question

12. What is your sexual orientation? Please choose all that apply:

    1, Bisexual

2, Gay

3, Heterosexual

4, Lesbian

5, Pansexual

6, Queer

7, Two-Spirit

8, Another sexual orientation not listed (Please specify):

9, Unsure

55, I do not wish to answer this question

Please specify:[open text field]

13. Do you self-identify as First Nations, Metis or Inuk/Inuit? Please check all that apply

1, Yes, First Nations

2, Yes, Metis

3, Yes, Inuk/Inuit

4, No

55, I do not wish to answer this question

14. Do you identify as racialized?

The term racialized is defined by the Government of Canada in the Employment Equity Act as persons, other than Indigenous peoples, who do not identify as Caucasian, European, and/or White in race, ethnicity, origin, and/or colour, regardless of birthplace or citizenship.

1, Yes

0, No

55, I do not wish to answer this question

15. Which of the following best describes your racial and/or ethnic group(s)? Check ALL that apply.

1, Asian – East (e.g., Chinese, Japanese, Korean)

2, Asian – South (e.g., Indian, Pakistani, Sri Lankan)

3, Asian – South East (e.g., Malaysian, Filipino, Vietnamese)

4, Black – African (e.g., Ghanaian, Kenyan, Somali)

5, Black – Caribbean (e.g., Bajan, Trinidadian, Jamaican)

6, Black – North American (e.g., Canadian, American)

7, Indo – Caribbean (e.g., Guyanese with origins in India)

8, Jewish

9, Latin, Central, or South American (e.g., Argentinean, Chilean, Salvadorian, Mexican)

10, Indigenous (e.g., First Nations, Metis, Inuk/Inuit)

11, Middle Eastern (e.g., Afghani, Armenian, Egyptian, Iranian, Iraqi, Jordanian, Algerian, Lebanese, Palestinian, Syrian, Yemeni)

12, Pacific Islander or Polynesian/Melanesian/Micronesian (e.g., Cook Island Maori, Hawaiian Maori, Fijian, Marquesan, Marshallese, Niuean, Samoans, Tahitian, Maori, Tongan, New Zealand Maori)

13, White (including European, White-Canadian/American/Australian/South African)

14, Another identity not listed (Please specify below)

15, Do not know

55, I do not wish to answer this question

Please specify:[open text field]

16. Whether or not it affects your day-to-day life, are you a person with a disability?

A person with a disability is someone who has a long-term or recurring physical, mental, sensory, psychiatric, or learning disability and considers oneself to be disadvantaged by reason of that disability or believes that society is likely to consider them to be disadvantaged by reason of that disability. A person with a disability may also be someone whose functional limitations owing to their disability have been accommodated in their environment.

1, Yes

0, No

55, I do not wish to answer this question

[If yes to disability] What type of disability do you have? Please check ALL that apply

1, Chronic illness

2, Chronic pain

3, Developmental disability
4, Drug or alcohol dependence
5, Learning disability
6, Mental illness and/or psychiatric disability
7, Physical, functional, or mobility disability
8, Sensory disability (i.e. hearing or vision loss)
9, Speech disability
10, Another disability not listed
Please specify:[open text field]
11, Do not know
55, I do not wish to answer this question

11. Reason for visiting the expanded midwifery care model? Check ALL that apply.

1, Prenatal visit
2, Medication abortion
3, Abortion referral
4, PAP test
5, Sexual health screening
6, STI treatment
7, IUD insertion/removal
8, Nexplanon insertion/removal
9, Contraception
10, Infant feeding consultation
11, Menopause counseling
12, Well baby care
13, mental health
14, Postpartum visit
15, Immunization
16, Another reason not listed (Please specify:)

Please specify:[open text field]

55, I do not wish to answer this question

11. How did you hear about the expanded midwifery care model?

1, Physician

2, Midwife/Midwifery practice group

3, Nurse Practitioner

4, Nurse

5, Health Unit referral

6, Social media

7, Friend or family member

8, Poster

9, Referral from anther health centre

10, Other

Please specify:[open text field]

55, I do not wish to answer this question

Appendix J: Midwife interview guide

Midwife participant interview guide

For three specific EMCM sites (Norwest CHC, South Riverdale CHC, Crown Point FHT) offering MAB care

Research Question

What are the experiences of clients, midwives, and other primary healthcare professionals of medication abortion care when provided through Ontario's Expanded Midwifery Care Models?

Do you have any questions for me before proceeding to the interview?

As part of our study on midwifery integration, we are researching medication abortion experiences within Expanded Midwifery Care Models (EMCMs). I am a Registered Midwife providing medication abortion care. Because of my practical knowledge, I will ask general and specific questions about your experience providing medication abortion care. You may decline to answer any of the questions asked at any time.

Please explain why and how interprofessional medical care is delivered at your facility.

- What brought you to collaborate with other primary care providers to offer medication abortion care?
    - Was there a call for abortion care within your organization or community?
    - Who initiated the collaboration?
- What is the clinical pathway? How was this established?
- Through what channels do clients present for medication abortion care?
- How many medication abortion clients do you typically connect with over a week?
- How many visits do clients commonly attend for their care?
- How is follow-up care delivered?
- What are other reproductive health services offered with medication abortion care?

Please describe your experience providing MAB care.

- How do you think your professional model influences abortion care?
- What do you feel are the strengths of midwives offering MAB care?
- In what ways has offering medication abortion influenced your clinical practice?
- Are there ways you would like to see abortion care improve or be done differently?

What is your experience working with other providers to deliver abortion care?

- With whom do you collaborate?
- How does collaborating under a medical directive influence your experience providing abortion care?
- What do you value in offering care in this way?

- What do you think are the strengths of interprofessional abortion care?
- What are the limitations?

Given what we discussed today, is there anyone you think we should speak to?

Are there any documents you can share related to what we discussed today?

Here, speak to recruiting clients and collaborators to the study and the process.

Appendix K: Healthcare provider interview guide

Provider participant interview guide

For three specific EMCM sites (Northern, Southern 1, Southern 2) offering abortion services

Research Question

What are the experiences of clients, midwives, and other primary healthcare professionals of medication abortion care when provided through Ontario's Expanded Midwifery Care Models?

Do you have any questions for me before proceeding to the interview?

As part of our study on midwifery integration, we are researching medication abortion experiences within Expanded Midwifery Care Models (EMCMs). I am a Registered Midwife with experience providing medication abortion services. Because of my practical knowledge, I will ask general and specific questions about your experience providing medication abortion care. You may decline to answer any of the questions asked at any time.

Please explain why and how interprofessional MAB care is delivered at your facility.

- What brought your organization to offer medication abortion care?
    - Was there a call for abortion care within your organization or community?
    - Who initiated the collaboration?
- What is the clinical pathway? How was this established?
- Through what channels do clients present for abortion care?
- How many medication abortion clients do you typically connect with over a week?
- How many visits do clients commonly attend for their medication abortion care?
- How is follow-up care delivered?
- What are other reproductive health services offered with medication abortion care?

What is your opinion of midwives providing MAB care?

- How do you think the midwifery model influences abortion care?
- What do you feel are the strengths of midwives offering abortion services? What are the limitations?
- How do you think collaborating with a medical directive influences care provision?

Please describe your experience of working with midwives to offer MAB care.

- How do you think professional models of care influence abortion care?
- In what ways has offering interprofessional medication abortion care influenced your clinical practice?
- What do you value in providing medication abortion in this way?
- In what ways has offering collaborative medication abortion care influenced clinical practice?

- Are there ways you would like to see abortion care improve or be done differently?

Given what we discussed today, is there anyone you think we should speak to?

Are there any documents you can share related to what we discussed today? (If these aren't publicly available documents, ensure appropriate permission is obtained to share them.)

Appendix L: Client interview guide

Client participant interview guide

For three specific EMCM sites (Northern, Southern 1, Southern 2) offering medication abortion care

Research Question

What are the experiences of clients, midwives, and primary care providers of medication abortion care when provided through Ontario's Expanded Midwifery Care Models?

Do you have any questions for me before proceeding to the interview?

As part of researching how midwives work within health care settings, we are exploring peoples' [medication abortion/SRHC] experiences in Ontario's Expanded Midwifery Care Models (EMCMs).

I am an EMCM midwife providing sexual and reproductive health care (SRHC) along with physicians and nurse practitioners. Because of my experience, I am asking clients about their care experiences. You may choose not to answer any of the questions I ask at any time.

I want to share how we view midwives' working in health care as a starting point for today's interview.

We see midwives helping the most in health care systems when:
1. patients and providers know about the care midwives can provide,
2. midwives and other providers work together to support the best care for patients and,
3. midwives feel included and valued working within the health care system.

Do you have any questions for me before proceeding to the interview?

- Denotes probes

Ontario midwives offer expanded SRHC in collaboration with other care providers.

Can you tell me about your experience receiving [abortion/SRH] care from midwives?

Prompts:

Person-centred care:

- How did you hear that midwives were offering [abortion/SRH] care?
- Were you referred by someone, or did you seek care? If so, who referred you?
- How easy was it for you to contact a midwife?
- How long did you wait to see a midwife?

- Can you tell me about the time and opportunity you had in your appointments to ask questions and explore your choices?
- Did you contact a midwife with questions or concerns between your appointments? If so, how did you get a hold of them? How did this go for you?

Continuity of care/relationship building:

- How many midwives did you see for your care? How did this go for you? How did you feel meeting one/several midwives?
- What other care providers in addition to a midwife did you see for your care? How do you feel the providers seem to work together?

Informed choice/choice of birthplace:

- What kind of visits were you offered? In-person, phone, home, virtual visits?
- How do you think the location of the healthcare clinic and the choice of location of visits affected your access to care?
- How did talking with a midwife about your options helped you make a choice that was right for you?
- What "take home" information was shared with you? How was the information shared with you (paper, email, text)? How did you feel about the amount of information you received?

Health promotion:

- What supplies were you offered to support your care? How did they help?
- What was your experience with follow-up care? How many visits did you have? Were they in person, at home, over the phone?
- What other [contraception/SRHC] services in addition to your original care needs? How did [having contraception, LARC insertion, PAP testing, STI screening, etc.] go for you?

Can you tell me what you valued most about having your [abortion/SRH] care with midwives?

What do you think is unique or special about midwives providing this care?

Can you explain why you do or don't feel that midwives were the right provider for your needs?

Did you have any needs that were not addressed?

What do you think, if anything, could have been done differently?

Is there anything else you would like to add regarding your experience with midwifery care?