

Access to Abortion: What Women Want From Abortion Services

Ellen R. Wiebe, MD, Supna Sandhu

Department of Family Practice, University of British Columbia, Vancouver BC

Abstract

Objective: Whether Canadian physicians can refuse to refer women for abortion and whether private clinics can charge for abortions are matters of controversy. We sought to identify barriers to access for women seeking therapeutic abortion and to have them identify what they considered to be most important about access to abortion services.

Methods: Women presenting for abortion over a two-month period at two free-standing abortion clinics, one publicly funded and the other private, were invited to participate in the study. Phase I of the study involved administration of a questionnaire seeking information about demographics, perceived barriers to access to abortion, and what the women wanted from abortion services. Phase II involved semi-structured interviews of a convenience sample of women to record their responses to questions about access. Responses from Phase I questionnaires were compared between the two clinics, and qualitative analysis was performed on the interview responses.

Results: Of 423 eligible women, 402 completed questionnaires, and of 45 women approached, 39 completed interviews satisfactorily. Women received information about abortion services from their physicians (60.0%), the Internet (14.8%), a telephone directory (7.8%), friends or family (5.3%), or other sources (12.3%). Many had negative experiences in gaining access. The most important issue regarding access was the long wait time; the second most important issue was difficulty in making appointments. In the private clinic, 85% of the women said they were willing to pay for shorter wait times, compared with 43.5% in the public clinic.

Conclusion: Physicians who failed to refer patients for abortion or provide information about obtaining an abortion caused distress and impeded access for a significant minority of women requesting an abortion. Management of abortion services should be prioritized to reflect what women want: particularly decreased wait times for abortion and greater ease and convenience in booking appointments. Since many women are willing to pay for services in order to have an abortion within one week, this option should be considered by policy makers.

Résumé

Objectif : La question de savoir si les médecins canadiens peuvent refuser d'orienter leurs patientes vers des services d'avortement et celle de savoir si les cliniques privées peuvent percevoir des frais pour les avortements qu'elles pratiquent sont des sujets

controversés. Nous avons cherché à identifier les obstacles qui empêchent les femmes d'avoir accès à des services d'avortement thérapeutique; nous avons également demandé aux femmes d'identifier ce qui leur semblait le plus important en ce qui a trait à l'accès à des services d'avortement.

Méthodes : Aux fins de cette étude, nous avons sollicité la participation des femmes qui se sont présentées à deux cliniques d'avortement autonomes (l'une bénéficiant d'un financement public et l'autre étant privée) au cours d'une période de deux mois. La phase I de l'étude mettait en jeu l'administration d'un questionnaire visant à recueillir des renseignements quant aux caractéristiques démographiques, aux obstacles perçus en matière d'accès à l'avortement et aux souhaits des femmes en ce qui concerne les services d'avortement. La phase II de l'étude mettait en jeu des entrevues semi-structurées menées auprès d'un échantillon de commodité de femmes, le tout ayant pour but de consigner leurs réponses à des questions au sujet de l'accessibilité. Les réponses obtenues dans chacune des cliniques au moyen des questionnaires de la phase I ont fait l'objet d'une comparaison; les réponses obtenues dans le cadre des entrevues ont fait l'objet d'une analyse qualitative.

Résultats : Quatre cent deux des 423 femmes admissibles ont rempli un questionnaire et 39 des 45 femmes sollicitées ont consenti à donner une interview. Les femmes ont obtenu des renseignements au sujet des services d'avortement auprès de leurs médecins (60,0 %), sur Internet (14,8 %), dans un annuaire téléphonique (7,8 %), auprès d'amis ou de membres de la famille (5,3 %) ou au moyen d'autres sources (12,3 %). Bon nombre d'entre elles ont vécu des expériences négatives en matière d'accès. À ce sujet, le problème le plus important s'est avéré être le temps d'attente prolongé; tandis que le deuxième problème en importance s'est avéré être la difficulté de prendre rendez-vous. En ce qui concerne la clinique privée, 85 % des femmes ont affirmé qu'elles étaient disposées à payer pour obtenir des temps d'attente plus courts, par comparaison avec 43,5 % en ce qui concerne la clinique publique.

Conclusion : Les médecins qui ne se sont pas montrés disposés à orienter leurs patientes vers des services d'avortement ou à leur fournir des renseignements à ce sujet ont causé de la détresse à une minorité significative des femmes exigeant un avortement et ont nuit à l'accès à ces services. La gestion des services d'avortement devrait faire en sorte d'accorder la priorité aux souhaits des femmes, particulièrement en ce qui concerne le raccourcissement du temps d'attente pour l'obtention d'un avortement et la simplification du processus de prise de rendez-vous. Puisque de nombreuses femmes sont disposées à payer pour obtenir un avortement dans un délai d'une semaine, cette option devrait être envisagée par les décideurs.

Key Words: Abortion, access, waiting list

Competing Interests: None declared.

Received on July 10, 2007

Accepted on September 25, 2007

J Obstet Gynaecol Can 2008;30(4):327-331

INTRODUCTION

There has been much recent discussion about access to therapeutic abortion in Canada, and in particular whether it is acceptable for a physician to refuse to refer a patient to abortion services if the physician is opposed to abortion.¹⁻⁶ The National Abortion Federation sent a letter to the Canadian Medical Association on May 9, 2007, asking for the policy to be changed so that physicians could not refuse to give women information on obtaining abortions.⁷ The CMA recently restated their position on referring for abortion, as follows:

CMA policy states that "a physician should not be compelled to participate in the termination of a pregnancy." In addition, "a physician whose moral or religious beliefs prevent him or her from recommending or performing an abortion should inform the patient of this so that she may consult another physician." You should therefore advise the patient that you do not provide abortion services. You should also indicate that because of your moral beliefs, you will not initiate a referral to another physician who is willing to provide this service (unless there is an emergency). However, you should not interfere in any way with this patient's right to obtain the abortion. At the patient's request, you should also indicate alternative sources where she might obtain a referral. This is in keeping with the obligation spelled out in the CMA policy: "There should be no delay in the provision of abortion services."⁸

According to Statistics Canada, 103 768 women had abortions in Canada in 2003.⁹ A report by Canadians for Choice indicated that in 2006, 15.9% of Canadian hospitals provided abortions, a decline of almost 2% since 2003.¹⁰

A study in the United Kingdom found that of 132 women having abortions, 107 were referred by a GP, but 15% had to make an appointment with a second GP because the first would not make a referral. Of 140 GPs surveyed, 33 (24%) considered themselves "broadly anti-abortion."¹¹ An American study of family physicians and GPs found that 23% would not refer patients for abortion.¹² In a Medical Post survey of Canadian physicians in 2007, 46% of respondents believed that physicians should be allowed to refuse referral for abortion.¹³

In light of the uncertainty about how a physician's beliefs and actions might impede access to abortion, it is important to understand what women experience and what they value when they seek therapeutic abortion. More than one half of the abortions performed in Canada are carried out in clinics that do not require referrals, but the remainder are performed in hospitals, which do require referrals; therefore, the physician's role in access is important. Most abortions performed in hospitals and government-funded clinics are free for women, but an increasing number of procedures are being performed in unfunded clinics that charge fees (personal communication, Dawn Fowler, Canadian Director, NAF).

The purpose of this study was to gain insight into the barriers that women face when they seek abortion services and what women consider to be the most important features of access to abortion services. In order to understand more about financial barriers, two clinics were included in this study: a private clinic at which abortions can be performed within one week for a fee, and a government-funded clinic at which abortions are funded by provincial medical insurance but with longer wait times.

METHODS

This was a mixed method study with use of questionnaires and semi-structured interviews. The participants were women presenting for abortion at two free-standing abortion clinics in Vancouver, BC, between May 1 and June 30, 2006. Ethics approval was obtained from the Clinical Research Ethics Board of the University of British Columbia.

Clinic 1 has no provincial funding. It provides medical and early surgical abortions and charges patients \$100 for medications not covered by provincial medical insurance. Clinic 2 is a fully provincially funded clinic that provides only surgical abortions up to 15 weeks' gestation. Both clinics are accredited by the College of Physicians and Surgeons of British Columbia and by the NAF. Women can go to either of these clinics directly without being referred by a family physician.

In Phase I of the study, women who agreed to participate completed a questionnaire that asked for demographic information including ethnicity, perceived barriers to access to abortion, and what the women wanted from abortion services. The questionnaires were available in both English and Chinese and were distributed by clinic staff. Punjabi-speaking patients who were not able to complete the questionnaire themselves completed it with the assistance of a Punjabi-speaking investigator. All of the questionnaires were completed at the clinic before the abortion was performed.

ABBREVIATIONS

CMA	Canadian Medical Association
NAF	National Abortion Federation

Table 1. Demographic information for women accessing abortion services

	Phase I questionnaire n = 402	Phase II interviews n = 39
Mean age (years)	27.8	29.4
Mean education (years)	13.9	14.2
Married (%)	128 (31.8)	13 (33.3)
Ethnicity (%)		
White Caucasian	184 (45.8)	17 (43.6)
East Asian	96 (23.9)	5 (12.8)
South Asian	65 (16.2)	8 (20.5)
Other	56 (13.9)	9 (23.1)

Table 2. Information about access to abortion services for women

	Clinic 1 (n = 226) (medical and surgical, unfunded)	Clinic 2 (n = 175) (surgical only, fully funded)
Access through physician (%)	138 (61.1)	102 (58.6)
Waiting period (days)	3.1*	12.6*
Less than 30 min to make appointment (%)	151 (75.1)	121 (74.7)
Less than one hour travel time to clinic (%)	183 (81.3)	129 (73.7)

* $P < 0.001$

In Phase II of the study, a convenience sample of 39 women were asked to expand on their answers to the questionnaire in semi-structured interviews. All interviews were conducted by the same investigator, and all interviews were in English. Some interviews were carried out in the clinic and some were conducted later by telephone, depending on the patient's preference.

The taped interviews were transcribed and forwarded to the second investigator. Transcribed interviews were analyzed to identify salient themes. Data collection and data analysis occurred concurrently, so that insights from earlier interviews informed and focused subsequent ones. Interview transcriptions were reviewed by both investigators, and recurring themes in the women's accounts of their experiences were identified. The investigators then discussed these emerging themes until no new themes were noted. Demographic information was entered into SPSS version 13.0 (SPSS Inc., Chicago IL) and frequency statistics were obtained. Data from Phase I questionnaires were compared between the two clinics.

RESULTS

Four hundred twenty-three women were eligible to participate in Phase I, and 402 completed the questionnaire. The mean age of participants was 27.8 years (range 14–48 years). One hundred twenty-eight (31.8%) were married and 56 (13.9%) were living in a common-law relationship. Almost

one half (45.8%) of the participants were white Caucasian and 40.1% were East Asian or South Asian. Of 45 women who were approached for interviews, four declined and two were excluded because of inadequate data, leaving 39 interviews for analysis. The 39 women who were interviewed were demographically similar to the 402 who completed the questionnaire (Table 1).

The majority of women (61.1%) were referred to the abortion clinics by a physician. The remainder acquired information via the Internet (14.7%), from a telephone directory (7.7%), friends or family (5.2%) or from other sources, such as the BC NurseLine (12.2%). White Caucasian women were more likely to find information via the Internet (20.2%) than South Asian women (7.7%) or East Asian women (13.7%) ($P = 0.015$). The waiting times were significantly shorter in the private clinic (Clinic 1) than in the public clinic (Clinic 2) (3.1 days vs. 12.6 days, $P < 0.001$). Other aspects of access (how the women found information, how much time was required to make an appointment, how much time was required to travel to the clinic) were similar between the clinics (Table 2).

Women were asked to rate how important various aspects of access to abortion were to them on a 10-point scale (Table 3). The most important issue was the time they were required to wait before undergoing the abortion. Other important issues were how quickly they could make an

Table 3. Importance of various aspects of access to abortion (on a scale of 0–10, 0 = not important, 10 = very important)

Ranking	Clinic 1 (n = 226) (providing medical and surgical abortions, unfunded)	Clinic 2 (n = 175) (providing surgical abortions to 15 weeks' gestation only, fully funded)
First	Abortion as soon as possible (mean score 9.5)	Abortion as soon as possible (mean score 9.4)
Second	Appointment within 10 minutes (mean score 8.6)	Talking to a live person on the telephone (mean score 8.8)
Third	Dealing with a female physician (mean score 8.6)	No charge for abortion (mean score 8.6)
Fourth	Talking to a live person on the telephone (mean score 8.5)	Appointment within 10 minutes (mean score 8.5)

Table 4. Responses from women in Phase II concerning three main themes

Theme I: Family physicians—helping or harming	Theme II: An abortion as soon as possible	Theme III: Difficulties making an appointment
Went to family physician/GP as first resource for information on abortion services: 29 (74.4%)	Expressed anxiety about waiting too long: 22 (56.4%)	Experienced telephone difficulties (e.g., being put on hold, receiving a busy signal): 20 (51.3%)
Went to family physician and had negative experience: 6 (15.4%)	Expressed concern about the physical discomfort of pregnancy: 20 (51.3%)	Expressed emotional stress and difficulty about booking an appointment: 12 (30.8%)
Did not go to family physician because of feeling uncomfortable: 8 (20.0%)	Concern about difficulty paying to reduce wait time: 30 (76.9%)	Prefers to speak to someone in order to ask questions: 10 (34.5%)

appointment and whether or not they were able to speak to someone in person. Although they preferred to see female physicians, this was less important than the preceding issues. The women were asked “If you could have one of the two choices below, which would you choose: (1) A \$100 abortion within one week? or (2) a free abortion after waiting for two weeks?” In Clinic 1, 170 women (85%) preferred to pay to have an abortion within one week, but in Clinic 2 only 70 women (43.5%) preferred to pay ($P < 0.001$). There were no significant differences in these responses between the different ethnic groups.

In Phase II, three main themes emerged from the women's responses (Table 4).

Theme I: Family Physicians—Helping or Harming

The responses to the questionnaire indicated that most women obtained information about abortion from their physicians, and in the interviews the participants described how that experience was for them. For many it was distressing:

“He didn't let me give him my story. He just said that you shouldn't go through it.”

“So I went to the family physician and he said ‘OK, it's your choice but I'm Catholic. I'm not allowed to give you any information.’”

Other women found their physicians very helpful:

“I go to my family physician, and she does everything for me. She's always been there. I didn't even know that it was

legal to have an abortion in Canada. She said ‘Oh no, what are you talking about? It's allowed. There is nothing wrong with it. Women have the choice to do it.’ That was just a relief.”

Theme II: An abortion as Soon as Possible

The issue women identified as most important in the questionnaires was to undergo the abortion as soon as possible. In the interviews, women described how distressing it was to wait for a procedure:

“The longer you go, the procedure is more invasive, and you can't do the pills.”

“I think if I've made the decision that this is something that I want to do, there is a little bit of anxiety in prolonging it. I know what is going on, right. I have this life growing inside of me. There is a little bit of agony going on and there is a bit of mourning and a sense of loss. It's, like, why prolong that if you don't have to.”

Theme III: Making an Appointment

The issue women identified as second most important in the questionnaires was the difficulty they had when actually making an appointment for an abortion.

“When you are anxious and so worried, you want to get an appointment. You just want to make your appointment and come in as soon as possible. You get a shock, like me, finding out that you are pregnant. So it's important.”

“I wouldn’t feel comfortable. If I called here and got a machine, I would try somewhere else. You feel so alone throughout the process that you just want a person to talk to.”

DISCUSSION

Women were able to find abortion services by using information from the Internet, a telephone directory, and other sources, but the majority sought a GP, even though a referral was not required for the clinics studied. The women said that physicians who refused to support their decision to seek abortion presented a barrier that caused them distress. In many places in Canada, the only abortion services available are in hospitals requiring a referral (personal communication, Dawn Fowler, Canadian Director, NAF), so a physician who refused to give information about abortion or provide a referral would constitute a barrier to access. A recent report indicated that if a woman telephoned a hospital for information, she would be likely to have difficulty getting the information she needed to find abortion services, even if they were available in that hospital.⁸ None of the women in our study said they had telephoned a hospital, but women living in small towns might be more likely to do so. A study of 1022 women seeking abortion in Canada found that 73.5% travelled more than one hour to obtain abortion services, and many rated the trip as “very difficult.”¹⁴

For a number of medical services in Canada, it is possible to shorten wait times by paying a facility fee.¹⁵ The length of time spent waiting to have an abortion was the most important issue for the women in this study, and many were willing to pay to have the procedure performed more quickly. It is logical that the women who had paid facility fees in Clinic 1 were more likely to say that they were willing to pay than those seen in Clinic 2.

It has been common throughout Canadian medical systems to have user-unfriendly appointment systems associated with long wait times.¹⁶ The women in this study expressed distress at the extra anxiety this caused them when making appointments for an abortion.

CONCLUSION

We found that physicians who refused to make a referral or give information about obtaining an abortion to women seeking their help to do so caused distress and interfered with access for a significant minority of women requesting an abortion. Some women did not ask their physicians, because they expected problems. Others received the help they wanted from their physicians.

Management of abortion services should be prioritized to reflect what women want. In particular, wait times to undergo an abortion should decrease, and the process of booking an appointment by telephone should be as convenient as possible.

Since many women are willing to pay for services in order to have an abortion within one week, this should be considered an option for policy makers.

ACKNOWLEDGEMENTS

We thank the Child and Family Institute 2006 Summer Student Research Program and the Community-Based Clinical Investigator Program of the University of British Columbia, Department of Family Practice for their support. We are grateful to the staff and patients of Willow Women’s Clinic and Everywoman’s Health Centre for participating in this study.

REFERENCES

1. Blackmer J. Clarification of CMA policy [Letter to the Editor]. *CMAJ* 2007;176:494. Available at: <http://www.cmaj.ca/cgi/letters/176/4/494#7430>. Accessed December 28, 2007.
2. Côté A. Access to abortion [Letter to the Editor]. *CMAJ* 2007;176:493–4. Available at: <http://www.cmaj.ca/cgi/content/full/176/4/493-a>. Accessed December 28, 2007.
3. Buckingham JE. Access to abortion [Letter to the Editor]. *CMAJ* 2007;176:492. Available at: <http://www.cmaj.ca/cgi/content/full/176/4/492-a>. Accessed December 28, 2007.
4. Read JE, Smith BJ. Access to abortion [Letter to the Editor]. *CMAJ* 2007;176:492. Available at: <http://www.cmaj.ca/cgi/content/full/176/4/492-a>. Accessed December 28, 2007.
5. Rodgers S, Downie J. Access to abortion [Letter to the Editor]. *CMAJ* 2007;176:494. Available at: <http://www.cmaj.ca/cgi/content/full/176/4/492-a>. Accessed December 28, 2007.
6. Kotalik JF. Access to abortion [Letter to the Editor]. *CMAJ* 2007;176:492. Available at: <http://www.cmaj.ca/cgi/content/full/176/4/492-a>. Accessed December 28, 2007.
7. National Post May 9, 2007 Physicians asked to change national abortion policy. Available at: <http://www.canada.com/nationalpost/news/story.html?id=ace96d87-b5c4-4dce-9ad0-0314c1e000bc&k=0>. Accessed January 4, 2008.
8. Blackmer J. Clarification of the CMA’s position concerning induced abortion [Letter to the Editor]. *CMAJ* 2007;176:1310.
9. Statistics Canada. Induced abortions. Ottawa: Statistics Canada; March 15, 2006. Available at: <http://www.statcan.ca/Daily/English/060315/d060315c.htm>. Accessed July 4, 2007.
10. Shaw J. Reality check: a close look at accessing abortion services in Canadian hospitals. Ottawa: Canadians for Choice; 2006. Available at: http://www.canadiansforchoice.ca/report_english.pdf. Accessed January 4, 2008.
11. Finnie S, Foy R, Mather J. The pathway to induced abortion: women’s experiences and general practitioner attitudes. *J Fam Plann Reprod Health Care* 2006;32:15–8.
12. Westfall JM, Kallail KJ, Walling AD. Abortion attitudes and practices of family and general practice physicians. *J Fam Pract* 1991;33:47.
13. Should physicians be allowed to refuse to refer patients for induced abortions? *Medical Post* June 22, 2007.
14. Sethna C, Doull M. Far from home? A pilot study tracking women’s journeys to a Canadian abortion clinic. *J Obstet Gynaecol Can* 2007;29:640–7.
15. False Creek Surgical Centre. Surgical procedures [web page]. Available at: <http://www.nationalsurgery.com/FCSC/procedures.php>. Accessed January 4, 2008.
16. Sibbald B. Clement: set wait-times or the courts will. *CMAJ* 2006;175:567.