A DOULA'S GUIDE
TO ABORTION IN CANADA

Illustrations throughout this guide by Julia Hutt

This resource was created with the Contraception and Abortion Research Team (CART) as part of *the CART-Access project: Advancing access to abortion for under-served populations through tools for health professionals and people seeking care*. It was designed in an effort to bridge the gaps in information for non-clinical support people providing services to people seeking abortion in Canada.

CART, founded in 2011, is located in the Department of Family Practice at the University of British Columbia (UBC). CART is an interdisciplinary, cross-sectoral research team created to support health services and policies to ensure equitable access to abortion and contraception throughout Canada.

Funded by Health Canada, the project addresses intersectionality, power and the compounding of historic, systemic and sustained barriers to seeking care for underserved populations.

Thank you to our contributors and collaborators!

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INTRODUCTION

Abortion is completely decriminalized in Canada and publicly funded as healthcare. However, many people face complex logistical, geographical, financial, and social barriers when seeking abortion access. Doulas and other support people may play a critical role in helping people navigate these barriers.

This guide provides general information on abortion in Canada for doulas and people who may support someone accessing an abortion. While not all who provide this support may call themselves "abortion doulas," in this document the term is used to refer to a non-clinical support person who provides emotional and practical support before, during, and/or after an abortion. The specific supports provided typically depend on each individual doula, where they are located, and their own unique skills and boundaries.

This guide is not meant to replace an abortion doula training. Doulas interested in providing **abortion** support are encouraged to seek further training and resources on topics including: **reproductive justice**, **values clarification**, **anti-oppressive and trauma-informed practice**, and **abortion stigma**.

Abortion doulas are also encouraged to locate **regionally specific information** about services within their communities and to seek additional evidence-based, non-clinical, and up-to-date resources to share with their clients.

This resource was created with the understanding of the following[1]:

- Abortion is common, legal, and safe in Canada
- Everyone should have the right to make decisions about their own body
- No one should be forced to continue a pregnancy
- Pregnant people should have access to a supportive individual of their choice when accessing abortion services

Everyone should have the right to make decisions about their own body

1 Rebic et al. (2021)

A NOTE ON LANGUAGE

Following language recommendations by the Society of Family Planning.

Procedural Abortion is used rather than surgical or aspirational abortion to avoid the false impression that the procedure is a surgery involving incisions. This term includes various techniques depending on the trimester, tools, setting, or resources available to the clinician. Some providers may also use the terms MVA (manual vacuum aspiration), D&C (dilation & curettage), dilation and aspiration, and D&E (dilation & extraction), to refer to procedural abortions.

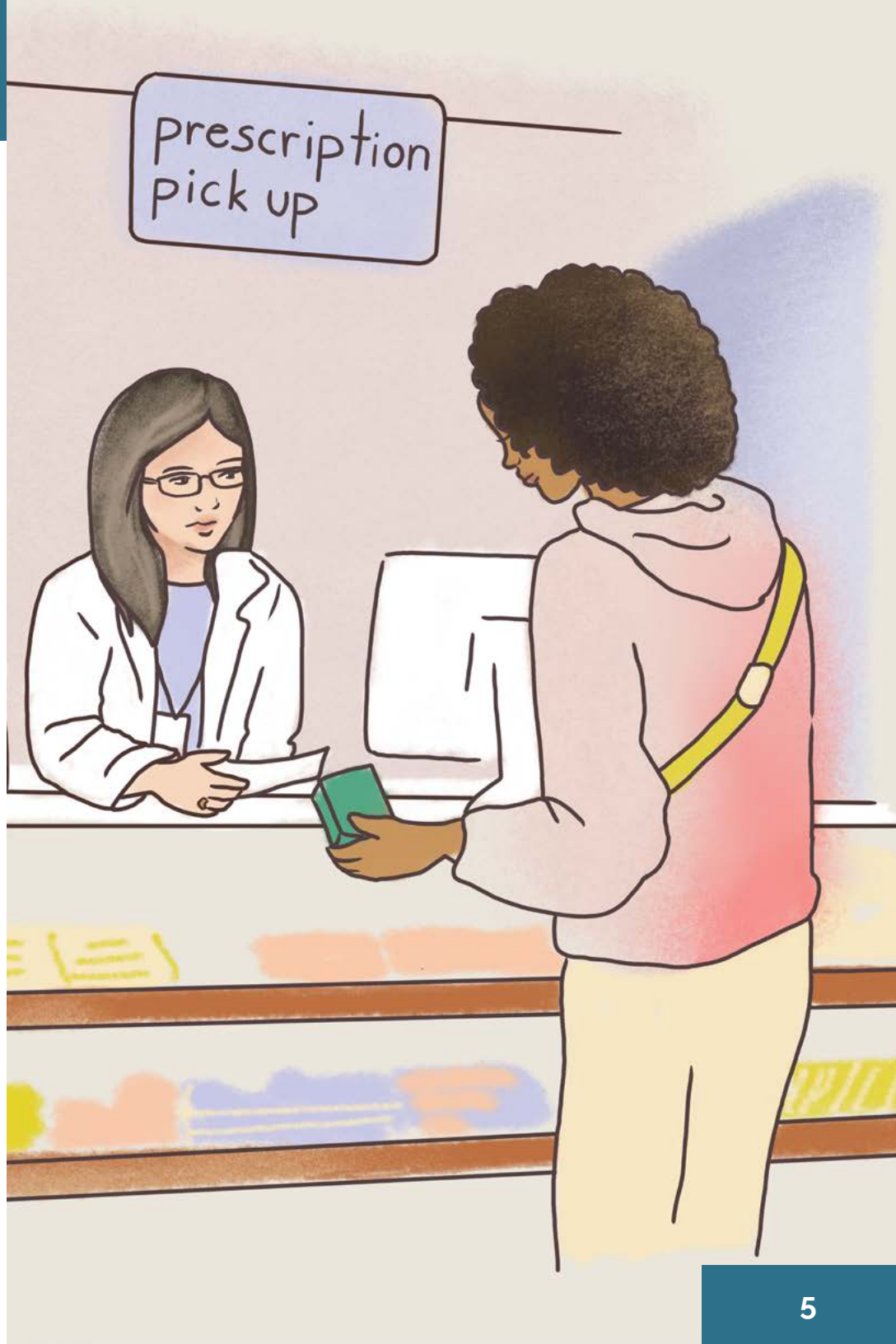
Medication Abortion is used in place of medical abortion or chemical abortion to counter portrayals of medication abortion as medically necessary, overly clinical, or dangerous, and to facilitate public knowledge that an abortion with pills exists as an option. Medication abortion is not the same as emergency contraception and does not use the same medications (*Plan B* contains levonorgestrel and *ella* contains ulipristal acetate).

Abortions in the second and third trimester are referred to as such. "Late" or "early" are inappropriate terms to describe abortion care because it can be a form of judgement and may impact how someone is viewed based on when they are accessing care.

Gestational duration is used in place of gestational age to not personify the fetus.

Client is used when referring to a person a doula may support in seeking abortion.

Gender-neutral language is used to be inclusive of all individuals who may seek abortion care and address a broad audience. When supporting individual clients, it is recommended that doulas ask them about the language they use to describe themselves (e.g. their pronouns).



ABORTION OPTIONS IN CANADA

MEDICATION ABORTION

In Canada, medication abortion involves a regimen of two medications, Mifepristone and Misoprostol, taken 24 hours apart. Health Canada has approved medication abortion for use outside of a clinical setting up to 9 weeks (63 days), though some prescribers may use it beyond that in first trimester abortions up to 11 weeks. It can be prescribed by primary care providers and is publicly funded. Medication abortion involves bleeding, cramping and expelling the tissue outside of a clinical setting. These medications may also be used in hospital contexts for abortions in the second and third trimesters.

PROCEDURAL ABORTION

Procedural abortion happens in a clinic or hospital. There are various ways to have a procedural abortion, depending on the client's preferences, the training of the care provider, the hospital or clinic resources and the gestational duration of the pregnancy. Generally speaking, procedures involve using instruments to remove the pregnancy tissue from the uterus.

ABORTION EFFICACY AND SAFETY

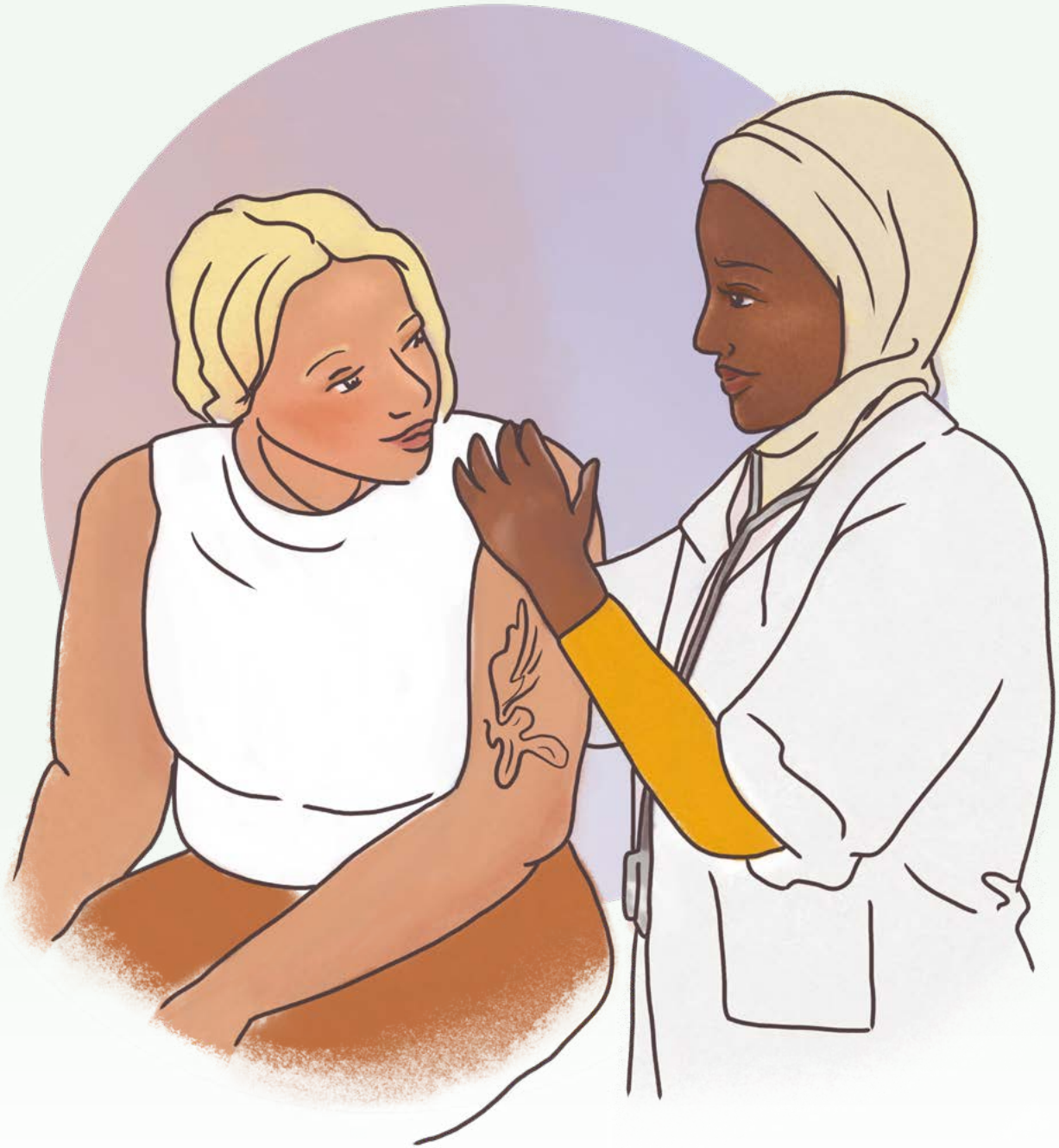
All abortion methods described in this guide are highly effective and very safe

Abortion is safer than many other minor procedures (e.g. colonoscopy, tonsillectomy, and plastic surgery)

There are no long-term physical or mental health issues associated with abortion

Fertility will not be affected following an uncomplicated abortion

Abortion does not cause, and is not linked to, any form of cancer



ABORTION IN THE FIRST TRIMESTER

Over 90% of abortions in Canada occur in the first trimester. During the first trimester, clients may experience a medication abortion at home or a procedural abortion in a clinic or hospital setting.

PROCEDURAL ABORTION

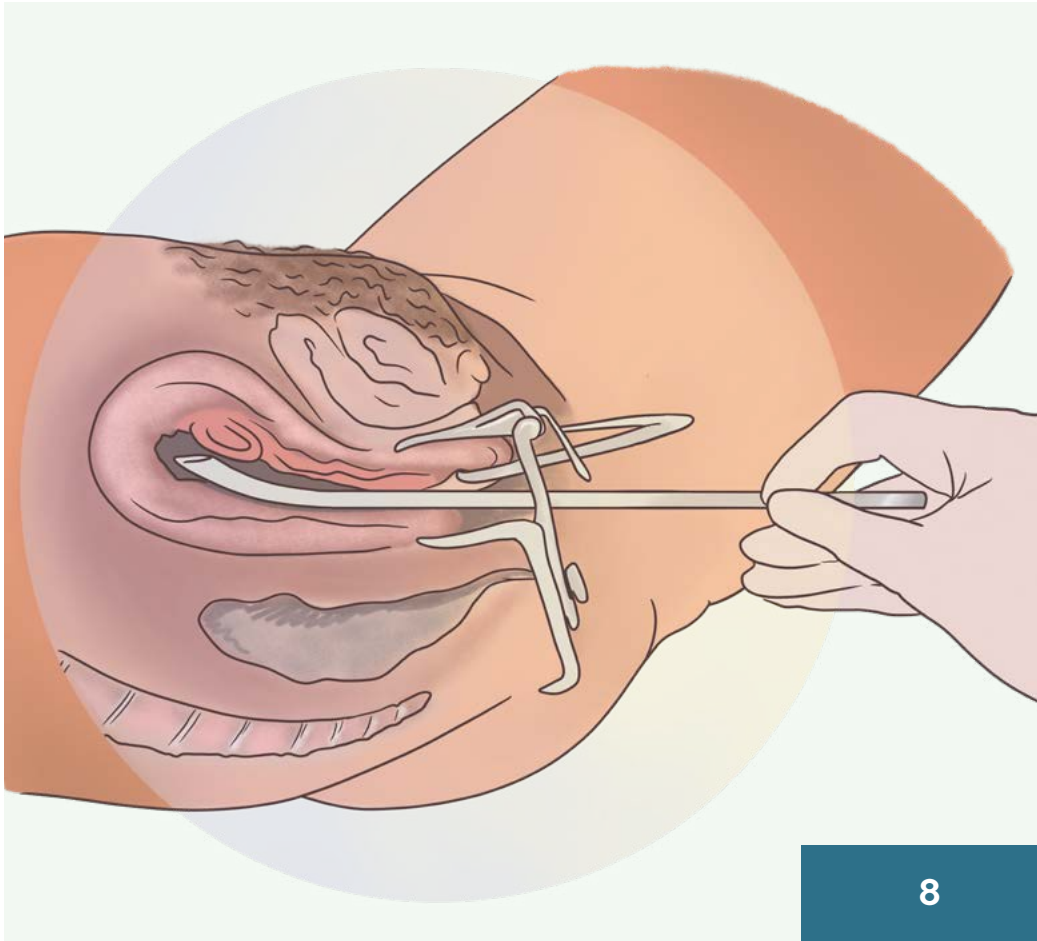
In the first trimester, procedural abortion can be performed by family physicians or obstetrician-gynecologists. The exact process followed will vary depending on clinician training and the capacities of facilities or equipment available, but generally includes these steps:

1. Medications are offered for pain, anxiety, and to prevent infection
2. The cervix may be frozen with an injection of local anesthetic
3. Dilators may be used to open the cervix
4. A small tube is inserted through the cervix into the uterus and attached to a syringe or machine
5. Suction is used to empty the uterus

A DOULA'S ROLE

A doula may support clients having a procedural abortion in considering their options, preparing for appointments, and advocating for their choices. Some providers may allow support people in procedure rooms during procedural abortion if requested by a client in advance, but in most cases doulas will need to wait in the waiting room or outside the clinic.

Many abortion clinics do not allow any support people. These rules are in place because of security and patient privacy concerns, and often have zero exceptions. Doulas can still support the patient by accompanying them as far as is allowed, texting them while they are in the waiting room, and meeting them afterwards.



MEDICATION ABORTION

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Mifepristone was first developed in France and approved there for use in 1988. It is available in over 60 countries worldwide and has a very strong safety record. It became widely available in Canada in 2017 under the brand name Mifegymiso. Primary care providers (family doctors and nurse practitioners) can prescribe medication abortion and the cost is covered by provincial/territorial health insurance. Clients without a provincial/territorial health card are required to pay out of pocket.

MIFEGYMISO CONTAINS TWO BOXES:

Green box: Mifepristone (1 pill)

Blocks progesterone, which:

- Helps detach the pregnancy tissue from the uterine walls
- Softens the cervix
- Induces contractions of the uterus
- Increases sensitivity of uterine and cervical muscles to Misoprostol

Orange box: Misoprostol (4 pills)

A synthetic prostaglandin, which induces strong uterine contractions

Medication abortion involves heavy bleeding, cramping, and expelling of tissue from the uterus. Bleeding starts approximately 4 hours after Misoprostol, the second medication, is taken. The duration and intensity of pain and bleeding experienced can vary considerably. Clients are typically offered pain management options and advised by providers to keep track of bleeding. A pregnancy test (blood or urine test) several weeks later can be helpful to confirm the abortion is complete.

A DOULA'S ROLE

A doula may provide emotional and practical support to clients having a medication abortion once misoprostol is taken. Clients may be more likely to ask a doula to assess symptoms during a medication abortion, or for clinical information and advice on pain relief and management options because a provider is not present. It can be helpful to prepare for this possibility beforehand by suggesting a client asks their provider about pharmacological pain management options, how much bleeding is considered normal, and what number they have been given to call with medical concerns. **See p.14** for suggestions on how doulas can refer clients to their medical care providers when asked to provide care outside their scope.

In addition to information and guidance from abortion providers, clients may find the MIFEGYMISO Monograph useful for detailed information about the medications, including contraindications.

CHOOSING BETWEEN ABORTION TYPES

MEDICATION ABORTION

POSSIBLE ADVANTAGES

- May be faster to get an appointment
- May feel more control over timing of the abortion
- May feel the experience is less invasive
- Likely to involve less time in a clinical setting
    - Many prescribers offer "low/no-touch" & telemedicine options
    - Can be experienced outside of clinic setting
    - No restrictions on choice of support person
    - May feel more privacy at home
- More control over tissue disposal (e.g. ritual, flushing)
- Can look like a miscarriage or painful period

POSSIBLE DISADVANTAGES

- Could take longer and be more painful
- Bleeding can be heavy with tissue discharge
- Some providers require follow-up appointment
- Less time in a clinical setting
    - May mean less time with their provider
    - The clinical setting can be comforting to some
    - Home may not be a safe or private place
- Although low, there is a risk of requiring emergency care and proximity to an ER

PROCEDURAL ABORTION

POSSIBLE ADVANTAGES

- Can be done beyond 9 weeks
- Quick procedure, over in a few minutes
- High likelihood of completion
- Less bleeding
- Support of clinical team during abortion
- Most common side effects are bleeding, pain from cramping, and nausea
- Range of anesthesia options may be available, including general

POSSIBLE DISADVANTAGES

- Procedure involves insertion of instruments in vagina and uterus
- Clinical setting and pain management options can be upsetting for some
- Support person may be restricted from entering clinic
- Escort policies may require a confirmed drive home
- Minor risks of complications such as infection
- May require travel arrangements to/from clinic

ABORTION IN THE SECOND AND THIRD TRIMESTERS

In Canada, abortion is less common and less available in the second and third trimesters. Different techniques, equipment, and supplies are involved and different training is required of providers. Informed choice surrounding options for abortion in the second and third trimesters is paramount, as in all reproductive experiences and decisions.

Both procedural (dilation and evacuation) and medication (induction) techniques are used. Additional considerations for clients may include:

- Care typically requires several appointments over several days
- A detailed intake, assessment, and informed consent process to ensure complete understanding of the procedures
- Cervical preparation, to soften and dilate the cervix, may be done in advance using medication and/or manual dilators
- A procedure may be done to stop the fetal heartbeat

Though difficult to access with few providers, medication abortion is used in abortion after the first trimester to induce labour in a hospital setting. Pain management options for these abortions include epidural anesthesia. In these cases, clients typically have more options for contact with the fetus. Some will want to see, hold, and spend time with the fetus after delivery, while others may want no contact at all. There is no wrong choice but the ability to choose and have those choices supported can deeply impact a clients' experience. Doulas can help clients explore, advocate for, and access their choices.

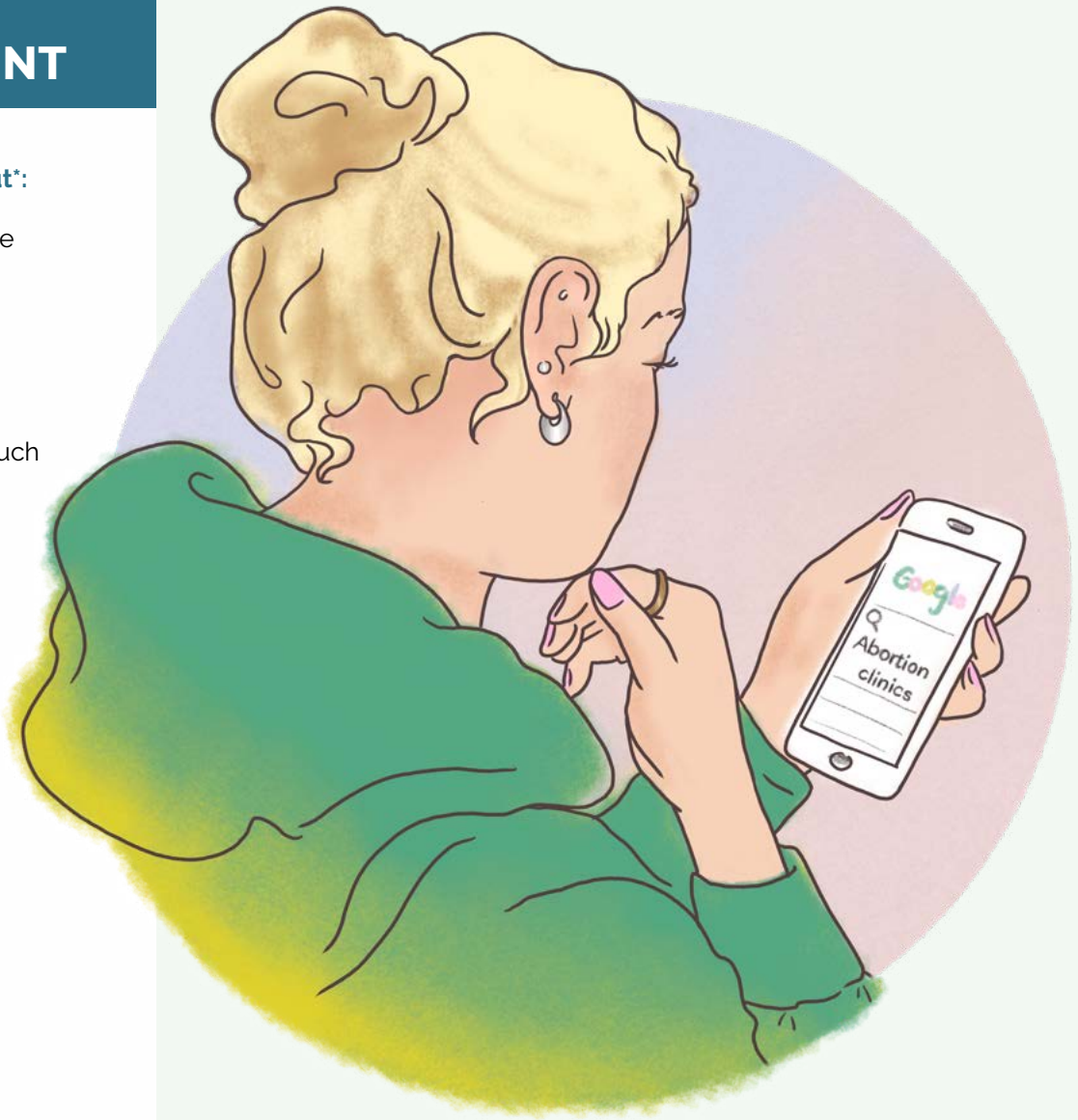
Doula support for second and third trimester abortions may involve helping a client seek care in another city, province, or even in the United States. Depending on an individual's needs, this may include supporting clients as they complete paperwork, secure identification/travel documents, book travel, etc. It can be helpful for doulas to know what abortion options are available in their region, gestational duration limitations, and resources for financial support if clients need to travel or pay out of pocket for care. Supporting a client through induction can also be similar to providing labour doula support or support following a stillbirth. Additional training in pregnancy loss and labour support may be helpful.

PREPARING FOR AN APPOINTMENT

As part of an intake process, a provider may ask a client about*:

- The first day of their last menstrual period (LMP) to confirm the pregnancy and gestational duration
- Number of previous pregnancies and their outcomes
- Types of contraception currently or previously used
- Date of last Pap test and other relevant gynecologic history such as previous cervical surgeries (LEEP, cone biopsy) or known uterine anomaly
- Rh status if known (blood type)
- History of relevant health conditions such as anemia and allergies
- Prescription medications
- Mental and physical health conditions and symptoms
- Client's feelings and autonomous decision-making about the abortion
- If they want to speak to a counsellor
- Preferences and questions about available abortion options
- Their emotional and practical supports in place
- Interest in and choice of contraceptive method after their abortion

A provider may recommend or require* that a client complete an ultrasound to determine gestational duration and the position of the pregnancy. Doulas may or may not be able to accompany patients for ultrasonography. Ultrasounds come in two types: external and transvaginal (internal).



A provider may recommend or require* that a client completes bloodwork to determine hCG levels (pregnancy hormone), hemoglobin levels, blood type, complete blood count (CBC), and Rh status.

**Clients can always ask why certain information testing is needed. They can discuss clinical questions with their provider.*

EMOTIONAL RESPONSES TO ABORTION

As with all reproductive experiences, there is a wide range of possible emotions and reactions someone having an abortion in any trimester may have. These may include relief, joy, sadness, guilt, and regret, with relief reported as the most common one[2]. These emotions can be nuanced and present together, even when they may seem to contradict. For example, some people feel relief and sadness, relief and guilt, grief and gratitude.

It is important for doulas not to assume a client will have difficult emotions about their abortion, but to be prepared to hold space for a range of experiences. Developing emotional support skills and a list of trusted resources for ongoing support can be very helpful.

Unfortunately, many organizations that claim to offer after abortion support are anti-abortion or "anti-choice" and use these services as an opportunity to reinforce abortion stigma. **Refer to p. 14 for trusted resources for emotional support**.

2 Foster et al, (2018)

ABORTION DOULA TOOLKIT: INFORMATION AND RESOURCES

An abortion doula's toolkit is full of **information** to support their clients in making their own decisions. This information may include resources for:

EVIDENCE-BASED INFORMATION ON ABORTION

- CART-Access resources (including this document)
- Society of Obstetricians and Gynaecologists of Canada (SOGC),
- Society of Family Planning (SFP)
- National Abortion Federation (NAF)
- Google scholar

HOW TO FIND A PROVIDER

- Choice Connect Abortion Referral App
- Action Canada's Access Line (call 1-888-642-2725 or text 613-800-6757)
- Provincial/territorial phone lines to self-refer for abortion services
- Fédération du Québec pour le planning des naissances (FQPN) (Quebec)

LOGISTICAL AND FINANCIAL ASSISTANCE

- Action Canada's Access Line
- NAF's hotline
- FQPN Emergency Access Fund (Quebec)
- Hope Air

EMOTIONAL SUPPORT

- Abortion Resolution Workbook, pregnancyoptions.info (EN & SPA)
- Action Canada's Access Line (EN & FR)
- All-Options Talk Line
- Faith Aloud Clergy Counselling line
- Connect & Breathe: After-abortion non-judgemental talkline

INFORMATION SPECIFIC TO A REGION

- Fake clinics/crisis pregnancy centres in the area (see How to Identify Fake Clinics; List of Anti-Choice Centres)
- Local providers and requirements;
  - Gestational duration limits
  - Escort policies requiring clients to have a ride home after procedural abortion
  - Any private fees not covered by insurance
  - Costs for uninsured clients
  - Exact location and travel logistics
  - Pain and anxiety management options
  - Pharmacies that reliably stock Mifegymiso

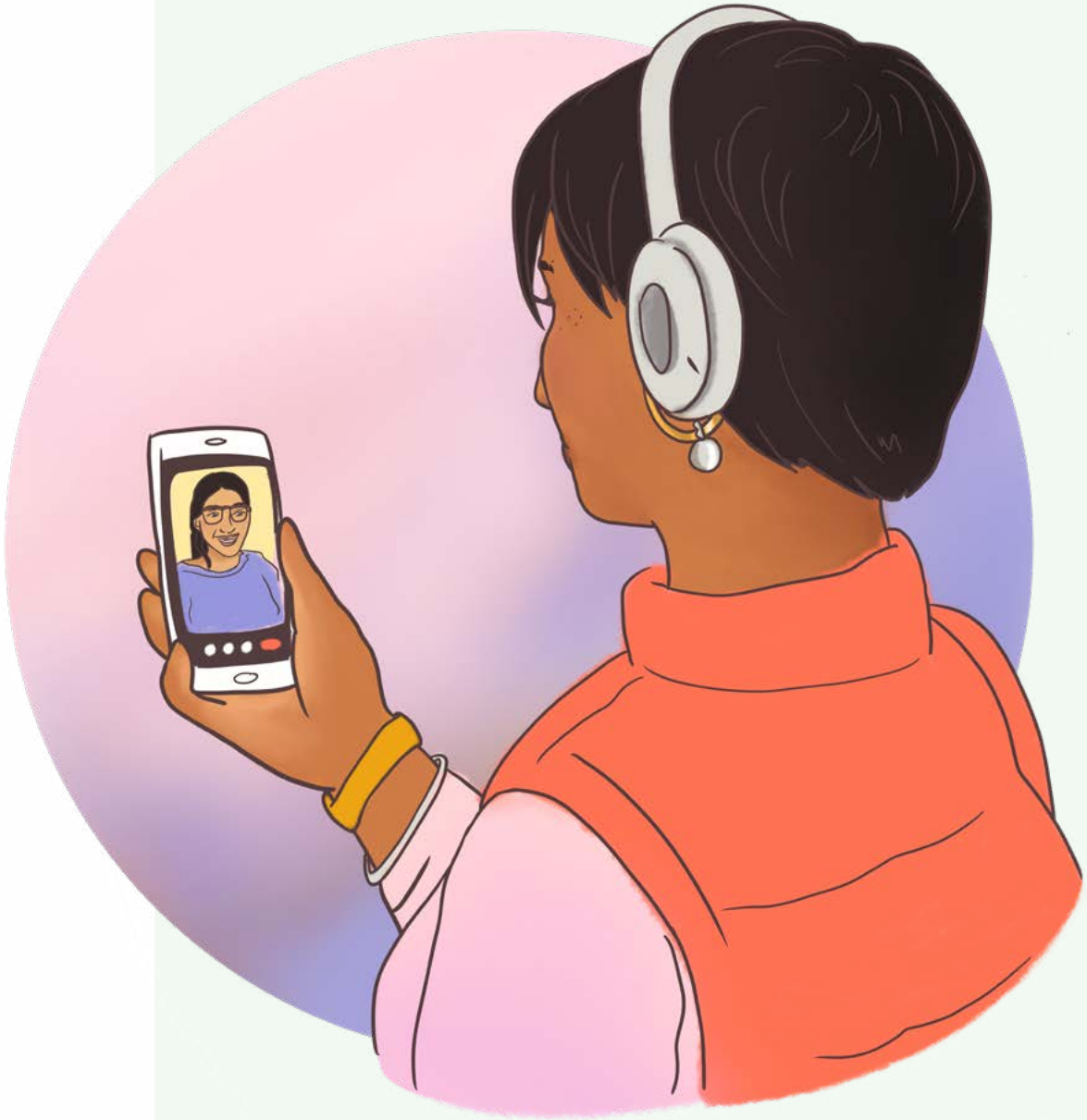
OTHER SUPPORTS

- Other doulas for referrals and peer support
- Trusted community organizations and resources focused on supporting specific needs and populations

CONSIDERATIONS BEFORE PROVIDING SUPPORT

Before providing abortion support, doulas may want to:

- **Reflect on what** support they do and do not offer to clients (individual boundaries and limits)
- **Consider if** they want to provide support as a volunteer or for specific rates, and the sustainability of doing each
- **Explore** professional liability insurance for protection from potential risks when providing support
- **Explore** car insurance that allows for transportation of clients if providing rides
- **Work to become** visible in their community by letting local clinics and other organizations know they offer support
- **Reflect on their** own physical and emotional safety in different settings and situations they may navigate while supporting clients
- **Consider how** they might prepare to support each client's individual needs
- **Consider how** they might take care of themselves before and after each client (e.g. developing practices for self-care and reflection)
- **Establish who** they can contact if *they* need support



UNDERSTANDING AND RECOGNIZING ONE'S OWN LIMITS

Everyone has their own personal values, beliefs, and biases that they bring to everything they do. These are often a mix of implicit and explicit messages received from families of origin, society, culture, and personal experiences. They have also been shaped by our proximity to power in ways that risk causing harm if not intentionally examined.

In this section, an introduction to how to recognize oppression is provided, followed by an exercise that doulas can use to reflect on their own limits through this lens.

Unpacking power and privilege, and actively fighting against oppression in all of its forms, is a lifelong journey. Doulas are encouraged to seek additional resources on anti-oppression and to engage in regular self-reflection beyond what is possible in this brief guide.

RECOGNIZING OPPRESSION

The four I's of Oppression[3]

The following forms of oppression do not exist in isolation, they influence and support each other.

1. **Ideological**: The idea that one group of people is somehow better (privileged) than another (oppressed) and therefore has the right to control them. Involves a process of "othering" and creating an "us vs. them" mentality.
2. **Institutional**: Refers to how institutions and systems reinforce and manifest the idea by embedding it into laws, media, public policy, etc.
3. **Interpersonal**: The ways we play violence out on each other. Ideology structured into institutions gives permission and reinforces mistreatment of individuals who are oppressed.
4. **Internalized**: Individuals internalize the ideology of oppression. The oppressed group internalizes negative messages about themselves and comes to believe they are somehow lesser, while the privileged group internalizes the ideology as their worldview and believes they are somehow superior.

RECOGNIZING LIMITS AND BOUNDARIES

Awareness and reflection on one's own relationships to power and privilege can help abortion doulas recognize their own limits when it comes to supporting others to avoid causing harm.

This activity provides a non-exhaustive list of examples of support situations. As a doula, you're invited to reflect on how you might feel and what you could do if asked to support someone who:

- has strong beliefs that differ from yours
- is from a different cultural or social background
- does not speak the same language
- is facing significant financial barriers
- is in a situation that makes you uncomfortable
- has experienced forms of oppression that you do not experience or have not experienced
- is being pressured or coerced
- has needs beyond your current skills or training

It is important for all doulas to continuously reflect on what would be a hard limit or boundary for them to remain accountable to themselves and the people they work with. Exploring these further may include seeking additional information, connecting with community members for resources, ideas, and support, and figuring out who to refer a client to when different situations arise. Some of these may change over time, but in the meantime a thoughtful referral is sometimes the best support that can be provided.

3 Based on materials from the Chinook Fund (n.d.)

REDIRECTING QUESTIONS TO A PROVIDER

Sometimes clients ask doulas for clinical information and advice. In these cases, it is important that clients are redirected to their provider with kindness and compassion. Transparency about the limits of doula support early on can make this easier to do in the moment.

Here are some examples of common scenarios and how a doula could respond:

SCENARIO: 1

Client asks a question about risks, details about the type of procedure they are having, or what pain medications they can take.

SUGGESTION:

"That is a great question and I want to make sure you get the right information. Since I'm not clinically trained, what do you think about a) calling the clinic right now b) writing down this and any other questions you have to bring to your appointment?"

SCENARIO: 2

A virtual client tells you they are bleeding
a lot during their medication abortion.

SUGGESTIONS:

"Do you remember what the clinic said about how much bleeding is normal? It might be time to give them a call to check in."

"I want to make sure it is okay but I am not qualified to assess if this amount of bleeding is normal. How do you feel about calling the clinic to ask? I will be right here to support you no matter what they say."

SCENARIO: 3

You see that the client is bleeding more than expected while providing in-person support during a medication abortion.

SUGGESTION:

"I am seeing you have gone through X number of pads in X hours and I remember the clinic saying to reach out if that happens. How do you feel about calling them together to check in? I will be right here with you."

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