Clinic 554 and Abortion Access in New Brunswick – Final Report

2023

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This research has been reviewed by the UNB Research Ethics Board and is on file as REB 2021-090.

Financial contribution from

Health Canada Santé Canada

The views expressed herein do not necessarily represent the views of Health Canada.

Avec le financement de

Santé Canada Health Canada

Les opinions exprimées dans ce document ne sont pas nécessairement celles de Santé Canada.

Acknowledgements

The authors would like to thank the following:

- Members of the Community Advisory Panel, research participants, and staff members at UNB who helped the project team achieve its goals.
- New Brunswick Provincial Archives
- Our research assistants: Courtney Pyrke, Indigo Komiwonuhke Poirier, Marina Kwak, Mandi Parsons, Kalum Ng, Cady Dredger, and Anna McDermid

Land Acknowledgement

The Reproductive Justice Access NB Project would like to respectfully acknowledge that UNB and our researchers are working on unsurrendered and unceded traditional Wolastoqey land. As treaty people under the Peace and Friendship Treaties, we acknowledge the nationhood, title, and sovereignty of the Wəlastəkwewiyik (Wolastoqiyik), Mi'kmaq and Peskotomuhkati (Passamaquoddy) peoples.

This acknowledgement is part of our obligations as treaty peoples. This obligation takes on special significance in light of reproductive histories. Canadian governments and the stigma that settlers, including many of the authors of this report, have generated and continue to advance have contributed to substantial loss of knowledge and practices around reproductive health including abortion and midwifery. This loss of knowledge and tradition resonates with the empty spaces that remain in our archival work and whose documents and information were recorded, in what way, were deemed important, and were able to be recovered to date.

Reproductive Justice is a model for analyzing, critiquing, and building stronger communities that emerged from the work of Black activists in the United States, and in Canada, we are particularly indebted to Indigenous activists for its proliferation on these lands. This land acknowledgement seeks not only acknowledges the lands that have been stolen and the sovereignty of these nations, but also makes clear the ways that settlers continue to benefit from the reproductive knowledge, activism, and teachings of Indigenous communities.

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Recommendation 1: The Government of New Brunswick should repeal paragraph 2.01(b) a.1 of Schedule 2 of the General Regulation under the Medical Services Payment Act NB Reg 1989-84-20. 50

Recommendation 2: The Government of Canada should direct CIHI and Statistics Canada to develop and implement a national strategy for addressing data gaps in abortion care. 51

Recommendation 3: The Government of Canada should work with provincial and territorial governments to develop and implement a rural abortion access strategy. 52

Recommendation 4: Governments at all levels should collaborate on strategies for meeting the needs of members of equity-seeking groups requiring reproductive healthcare, including striking an inter-ministerial committee. 53

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1.0 Introduction

Abortion access in New Brunswick (NB), Canada is complex and contested. The decriminalization of abortion by the federal government in 1969[1] precipitated a 50-year-old tradition of the Government of New Brunswick to develop policies that restrict access to this constitutionally protected, common place health care service. These restrictions include the now amended regulation in the *Medical Services Payment Act, 1989*[2] that limited Medicare coverage for abortions to those deemed "medically required" by two doctors and performed in a hospital as well as the ongoing prohibition on Medicare funding for abortions performed in clinics.

The Government of New Brunswick (GNB) maintains tight control over where, when, and how procedural abortions are provided, excluding clinics from Medicare coverage. Currently, Medicare-covered procedural abortions in NB are only provided in three hospitals in two cities. Clinic 554, the only fee-for-service abortion clinic in the province, operates in Fredericton, NB, currently at reduced capacity. These abortion policies have been regularly met with legal challenges, some successful (e.g., *Morgentaler v New Brunswick*, 1989)[3] and others in progress (e.g., *CCLA v New Brunswick*).[4] At the centre of the current landscape of restriction is Regulation 84-20 of the *Medical Services Payment Act, 1989* which limits Medicare coverage for several services to hospitals, including procedural abortions, and blood work.

It was in this context of restricted access to abortion care that the Morgentaler Clinic provided fee-for-service procedural abortions to New Brunswickers for 20 years in the capital of Fredericton. When the Morgentaler Clinic closed in 2015 due to the financial strain of providing abortions without Medicare funding,[5] local activists, advocates, and health care providers, led by the grassroots pro-choice group Reproductive Justice New Brunswick, crowdfunded for a queer-positive family practice that also provided abortion care. The plan was for this clinic to provide Medicare-covered primary care and fee-for-service abortion care at the site of the former Morgentaler Clinic. That practice, Clinic 554, faced similar challenges as the Morgentaler Clinic. It has since closed the family practice and sold the building and is only providing abortions on site at a reduced capacity.

From 2015 to the present, New Brunswick residents have continued to access procedural abortions at Clinic 554 and paid out of pocket for the procedure and related expenses. Despite the ongoing use of Clinic 554 and considerable advocacy and activism on the part of service providers, patients, and community members, GNB continues to assert that there are no access barriers to procedural abortion in New Brunswick and therefore no reason to repeal 84-20. For example, the Minister of Health recently argued that the

[1] *Criminal Law Amendment Act, 1968-69* SC 1968-69, c 38, s18.
[2] General Regulation - *Medical Services Payment Act*, NB Reg 1989-84-20.
[3] *Morgentaler v New Brunswick* (AG) 1989 CanLII 8086 (NB QB).
[4] *CCLA v PNB*, 2021 NBQB 119.
[5] "Morgentaler Clinic in N.B. to Close, Citing No Provincial Funding," April 10th, 2014, https://www.cbc.ca/news/canada/new-brunswick/morgentaler-abortion-clinic-in-fredericton-to-close-1.2604535.

absence of an abortion waitlist suggests no need for policy change[6] and the Premier has asserted that abortions are "very accessible here in the province."[7]

Questions of access and barriers to procedural abortion services animate the research shared in this report. Specifically, the research team asked: What does abortion access in New Brunswick look like after 2015? And what, if any, barriers exist to this health care service? We found that people in New Brunswick continue to access costly fee-for-service abortions, which suggests that funded abortion care is not "very accessible" and the option of having a clinic-based abortion is something New Brunswickers need and want. This report shares the research findings to provide readers with an improved understanding of the landscape of procedural abortion (also called surgical abortion) in New Brunswick since 2015, and to contextualize the current state of this reproductive health care service within the political history of the region.

This report provides extensive quantitative data of procedural abortions performed in New Brunswick's Clinic 554 as well as more in-depth qualitative data on the barriers to procedural abortions in the province. The report draws on anonymous clinic data, insights from three focus groups (15 participants total), 28 semi-structured interviews, and 41 surveys completed by providers, activists, advocates, subject matter experts and people who have had abortions, as well as archival data from more than 500 archival files. Readers will be left with an improved understanding of the implications of enduring limitations on this safe, legal health care service and with recommendations shared by a variety of pro-choice stakeholders.

This work is a timely intervention as the province recently passed the *Health Facilities Act, 2023*[8] to allow other simple procedures, such as cataract surgeries, to be performed outside of hospitals in so-called surgical facilities while still being covered by Medicare. The rationale for this new legislation is that it can "improve service to patients and alleviate pressure on our hospital system."[9] The same benefits can be observed for clinic-based abortion care. However, despite legislative changes and ongoing pressure from community leaders, activists, politicians and legal experts, New Brunswick will remain the only province where procedural abortions are not funded in clinics.

Moreover, this research found that the assertion that there are no access barriers to procedural abortions in NB remains unsubstantiated. GNB does not track procedural abortions provided outside of publicly funded hospitals and, therefore, does not know the number of abortions provided by Clinic 554. At the same time, abortion is not mentioned in the most recent Community Health Needs Assessments (CHNAs) by either the Vitalité

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[6] Jacques Poitras, "Bill Would Pave Way for Doing Some Surgeries in N.B. Outside Hospitals," *CBC News,* October 26, 2022. https://www.cbc.ca/news/canada/new-brunswick/surgeries-medicare-bill-1.6630371.

[7] Silas Brown, "Health Authorities Are Responsible for Abortion Access, Not the Government," *Global News,* June 2nd, 2021, https://globalnews.ca/news/7915697/n-b-abortion-access-responsibility-debate/.

[8] *Health Facilities Act*, SNB 2023, c 13 (not yet in force).

[9] "New Legislation to Allow Some Surgical Procedures to Be Performed Outside Hospitals," Government of New Brunswick, accessed October 24, 2023, https://www2.gnb.ca/content/gnb/en/news/news_release.2023.05.0231.html.

or Horizon Health Networks. The absence of abortion from CHNAs is significant in a province where, as noted above, policy renders some service data unavailable to the province. Quite simply, the province is making reproductive health care policy that is not based on a complete set of procedural abortion statistics, nor a comprehensive assessment of community reproductive health needs. Despite a commitment to adopting a Gender Based Analysis+ (GBA) framework in policymaking, information about procedural abortion, which is very much a gendered matter impacting women and gender minorities, is largely absent in official government discourse. There is little information on the government's website and no mention of reproductive health care at all in the most recent health care strategy *Stabilizing Health Care: An Urgent Call to Action*.[10] We are witnessing an erasure of the need for procedural abortions, which are safe, legal and unremarkable health care procedures, from the official public conversation. This erasure contributes to maintaining a status quo characterized by policies and practices that frustrate access to reproductive freedom.

The decision to focus on the period since 2015 is threefold.

- Firstly, 2015 to present represents the period after the infamous two-doctor rule was removed from the province under the leadership of Liberal Premier Brian Gallant.
- Secondly, the period selected captures the life of the embattled Clinic 554 to provide a careful analysis of the ongoing demands on fee-for-service abortion providers following the closure of Morgentaler and the repeal of the two-doctor rule.
- Thirdly, this period captures the approval of Mifegymiso (also referred to as Mifepristone) by Health Canada (2015)[11] and the extension of Medicare coverage[12] in New Brunswick for this medical[13] abortion option (2017)[14], which changed where and how New Brunswickers can end a pregnancy.

Certainly, there have been many important, and in some cases positive, changes to abortion care in New Brunswick in the last eight years. It is the question of access in this more recent context that this project takes up. What follows builds on the tireless work of health care providers, academics, activists, lawyers, and community members who have

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[10] New Brunswick Department of Health Government of New Brunswick, *Stabilizing Health Care: An Urgent Call to Action* (Fredericton, 2022), https://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/Stabilizing-health-care.pdf.

[11] Health *Canada, Health Canada New Drug Authorizations: 2015 Highlights. New Active Substances, Subsequent Entry Biologics, and Generic Pharmaceuticals* (Ottawa: Health Canada, 2015).

[12] Bobbi-Jean MacKinnon, "Abortion Pill Now Available for Free to Women in New Brunswick | CBC News," *Canadian Broadcasting Corporation*, July 7, 2017, https://www.cbc.ca/news/canada/new-brunswick/abortion-pill-mifegymiso-new-brunswick-free-1.4194436.

[13] The term medical abortion is used by many healthcare providers and reproductive healthcare scholars to refer to an abortion that is induced via medication, such as Mifegymiso. Therefore, we use the term medical abortion in this report, however, medication or pharmaceutical abortion is noted as the preferred term by community partners in this work.

[14] Adrienne K. South, "New Brunswick Makes Medical Abortion Pill Free to Patients with Medicare Card," *Global News*, July 7, 2017, https://globalnews.ca/news/3581697/new-brunswick-makes-medical-abortion-pill-free-to-patients-with-medicare-card/.

been involved in the more than five-decade struggle for abortion care in the province. This report, and the broader project, are offered in the spirit of contributing to the ongoing collective work of ensuring all New Brunswickers who can become pregnant have access to comprehensive reproductive health care services.

Access barriers are not experienced equally, of course. New Brunswick is a province with high rates of poverty among lone female parents and people with disabilities,[15] and in the northern part of the province,[16] a population that is largely Francophone, where Black people, Indigenous people and people of colour experience racism within the medical system,[17] where racialized and Indigenous children are more likely to live in poverty,[18] and where anti-LGBTQ+ discourse is once again on the rise. These multiple dynamics of oppression and discrimination mean, quite simply, that the burdens of abortions barriers are more profound for equity-deserving groups. While this research reports quantitative data that treats those in need of abortion as a monolithic group, we recognize that in and between the numbers are experiences where poverty, racism, colonialism, ableism, and trans and homophobia are also part of the (in)access story. When these dynamics arose in the qualitative data they are reported and reflected upon, but there is work to be done.

2.0 Relevant Literature

There is a large, diverse, and interdisciplinary body of literature on abortion in Canada. Dominant analytical frameworks in the sociolegal abortion literature are constitutional legal analysis, legal history, qualitative and archival historical analysis, and reproductive justice. Most of the literature approaches abortion from a patient or service seeker perspective, with fewer contributions taking an institutional, provider or systems approach.

Very little literature published between 1970 and 2023 in sociology, political science, history or gender and women's studies focuses on abortion in New Brunswick specifically. Of the small handful that does exist, most focuses on the history of Dr. Morgentaler and his involvement with the province. One study focuses on the experience of patients in New Brunswick before and after the change to Reg. 84-20 in 2014.[19] Some studies also focus

[15] Dan Dutton and Herb Emery, *Deep Poverty in New Brunswick* (Fredericton: NBIRDT, 2019), www2.gnb.ca/content/dam/gnb/Departments/esic/pdf/DeepPoverty.pdf

[16] Heather Atcheson, Chelsea Driscoll, and the Human Development Council, *New Brunswick's 2022 Child Poverty Report Card*, (Saint John: Human Development Council, 2023), https://sjhdc.ca/report/new-brunswicks-2022-child-poverty-report-card/.

[17] Manju Varma, *Systemic Racism Commissioner's Final Report*, (New Brunswick: Province of New Brunswick, 2022). www2.gnb.ca/content/dam/gnb/Corporate/Promo/systemicracism-racismesystemique/SystemicRacismCommissionerFinalReport.pdf

[18] Atcheson, Driscoll, and the Human Development Council, *New Brunswick's 2022 Child Poverty Report Card*.

[19] Angel M. Foster et al., "If I Ever Did Have a Daughter, I Wouldn't Raise Her in New Brunswick:' Exploring Women's Experiences Obtaining Abortion Care before and after Policy Reform," *Contraception* 95, no. 5 (2017): 477–84.

their efforts on the Maritimes broadly, comparing the experiences and history of New Brunswick to that of PEI and Nova Scotia.[20]

The Canadian literature is broader. Much of the work focuses on the legal history of the Morgentaler decision (leading up to, the case itself, and its aftermath). The other focus, led largely by Christabelle Sethna et al.,[21] explores the history of lack of local access and resulting abortion tourism in Canada, both in hospitals and freestanding clinics.[22]

In addition to the Canadian Institute for Health Information (CIHI) and Statistics Canada, civil society organizations, including CARAL archival documents and ARCC reports, are a significant source of quantitative data. Works by Ackerman,[23] [24] Backhouse,[25] McTavish[26] [27] and others on abortion history and abortion access in New Brunswick and the Maritime provinces point to social conservatism, often motivated by religious affiliation, as a reason for the persistence of legislative, regulatory, administrative and provider barriers to abortion. A very recent study of politicians and policymakers finds that religious affiliation and perceptions of religiously motivated voter preferences continue to shape New Brunswick abortion politics.[28] Similar observations have been made about the Province of Alberta.[29]

[20] Katrina Ackerman, "In Defence of Reason: Religion, Science, and the Prince Edward Island Anti-Abortion Movement, 1969–1988," *Canadian Bulletin of Medical History* 31, no. 2 (2014): 117–38, https://doi.org/10.3138/cbmh.31.2.117.

[21] Christabelle Sethna and Marion Doull, "Accidental Tourists: Canadian Women, Abortion Tourism, and Travel.," *Women's Studies* 41, no. 4 (2012): 457–75.

[22] Christabelle Sethna and Gayle Davis, eds., *Abortion across Borders: Transnational Travel and Access to Abortion Services* (Baltimore: John's Hopkins University Press, 2019).

[23] Katrina Ackerman, "A Region at Odds: Abortion Politics in the Maritime Provinces, 1969-1988." (PhD Thesis, Waterloo, University of Waterloo, 2015).

[24] Katrina Ackerman, "After Morgentaler: The Politics of Abortion in Canada," *Canadian Historical Review* 100, no. 2 (2019): 312–14, https://doi.org/10.3138/chr.100.2.br14.en.

[25] Constance B. Backhouse, "Involuntary Motherhood: Abortion, Birth Control and the Law in Nineteenth Century Canada," *Windsor Yearbook Of Access to Justice* 3 (1983): 61-130.

[26] Lianne McTavish, "The Cultural Production of Pregnancy: Bodies and Embodiment at a New Brunswick Abortion Clinic," *TOPIA: Canadian Journal of Cultural Studies* 20 (2008): 23–42, https://doi.org/10.3138/topia.20.23.

[27] Lianne McTavish, "Abortion in New Brunswick," *Acadiensis* 44, no. 2 (2015): 107–30.

[28] Claire Johnson and Sara Naam, "Political Barriers to Abortion Access in New Brunswick: A Qualitative Exploration of a Political Hot Potato," *Journal of Canadian Studies* (2023), 57, no. 2, 181-204.

[29] Carol Williams, "'Reproductive Self-Determination and the Persistence of "Family Values" in Alberta from the 1960s to the 1990s,'" in *Compelled to Act: Histories of Women's Activism in Western Canada,* edited by Sarah Carter and Nanci Langford (Winnipeg: University of Manitoba Press, 2001), 253-290.

Many legal scholars draw on the *Canadian Charter of Rights and Freedoms* including equality rights,[30] [31] [32] [33] life, liberty and security of the person,[34] [35] [36] Canadian federalism,[37] [38] [39] [40] architectural/structural constitutionalism,[41] and the *Canada Health Act*[42] [43] [44] to argue for rights-based improvements to abortion access.

Scholarship identifies legal and regulatory, policy and provider-centred access barriers. These include both historical and contemporary legal and regulatory restrictions on funded abortions such as New Brunswick's Regulation 84-20 which currently restricts Medicare to hospital abortions, and formerly included two-doctor certification and specialist care, as well as restrictions on reciprocal billing. The legal literature includes a number of titles that deal with New Brunswick or include the province in the analysis.

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[30] Emmett Macfarlane and Rachael Johnstone, "Equality Rights, Abortion Access, and New Brunswick's Regulation 84-20," *University of New Brunswick Law Journal* 72 (2021): 302–24.

[31] Kerri A. Froc, "New Brunswick Women's Rights and the Legal Imagination," *Journal of New Brunswick Studies / Revue d'études Sur Le Nouveau-Brunswick* 13, no. 2 (2021): 27-35, https://journals.lib.unb.ca/index.php/JNBS/article/view/32610.

[32] Daphne Gilbert, "Attesting to Fundamental Human Rights: The Backlash to the Active Promotion of Equality in Canada," *Journal of Law & Equality* 16 (2020): 1–36, https://heinonline.org/HOL/P?h=hein.journals/jleq16&i=26.

[33] Martha Jackman, "Health Care and Equality: Is There a Cure," *Health Law Journal* 15 (2007): 87–142, https://heinonline.org/HOL/P?h=hein.journals/hthlj15&i=95.

[34] Sonia Lawrence, "2013: Constitutional Cases in Review," *The Supreme Court Law Review: Osgoode's Annual Constitutional Cases Conference* 67, no. 1 (2014), https://doi.org/10.60082/2563-8505.1283.

[35]Jocelyn Downie and Carla Nassar, "Barriers to Access to Abortion Through a Legal Lens," *Health Law Journal* 15 (2008): 143-73, https://ssrn.com/abstract=2071284.

[36] Gwen C. Mathewson, "Security of the Person, Equality and Abortion in Canada Comment," *University of Chicago Legal Forum* 1989 (1989): 251–80, https://heinonline.org/HOL/P?h=hein.journals/uchclf1989&i=255.

[37] Sarah Burningham, "Provincial Jurisdiction over Abortion," *Queen's Law Journal* 45, no. 1 (2019): 37–80, https://journal.queenslaw.ca/sites/qljwww/files/Issues/Vol%2045%20i1/3.%20Burningham%20-%20Final.pdf.

[38] Donley Studlar and Raymond Tatalovich, "Abortion Policy in the United States and Canada: Do Institutions Matter?" in *Abortion Politics: Public Policy in Cross- Cultural Perspective*, eds. Marianne Githens and Dorothy McBride Stetson (New York: Routlegde, 197), 75–95.

[39] Beverley Baines, "Abortion, Judicial Activism and Constitutional Crossroads," *University of New Brunswick Law Journal* 53, no. 2004 (2019): 157–83, https://journals.lib.unb.ca/index.php/unblj/article/view/29427.

[40] Howard A. Palley, "Canadian Abortion Policy: National Policy and the Impact of Federalism and Political Implementation on Access to Services," *Publius: The Journal of Federalism* 36, no. 4 (2006): 565–86, https://doi.org/10.1093/publius/pjl002.

[41] Joanna N. Erdman, "Constitutionalizing Abortion Rights in Canada," *Ottawa Law Review* 49, no. 1 (2018): 221, https://rdo-olr.org/wp-content/uploads/2018/09/OLR-49-1-11-Erdman-Final.pdf.

[42] Chris Kaposy, "Improving Abortion Access in Canada," *Health Care Analysis: An International Journal of Health Philosophy and Policy* 18, no. 1 (2010): 17–34, https://doi.org/10.1007/s10728-008-0101-0.

[43] Sujit Choudhry, "The Enforcement of the Canada Health Act," *McGill Law Journal* 41, no. 2 (1996): 461-508, https://ssrn.com/abstract=1137723.

[44] Martha Jackman, "The Regulation of Private Health Care under the Canada Health Act and the Canadian Charter Note," *Constitutional Forum* 6, no. 2 (1995): 54–60.

The New Brunswick-specific literature is sparse with respect to other types of barriers, but certainly includes work on Canada more broadly. Policy barriers include informational barriers like a lack of reliable information about how to access abortion.[45] The literature also speaks to the barriers arising from broad conscientious objection claims by physician and health care providers, ranging from the refusal to provide abortion care to the refusal to refer punitive treatment of patients seeking abortion care or requiring abortion aftercare.[46] [47] [48] [49] [50] An additional barrier that has been documented across health care professions and over time is the lack of abortion care training in health care curricula.[51] [52] [53]

Differential impact of abortion barriers on vulnerable populations has also been noted by scholars. Poverty and single motherhood,[54] [55] [56] Indigeneity,[57] [58] rurality,[59] and youth[60] have been explored. The experience of Black and other racialized communities with

[45] Laura Dodge et al., "Just Google It: Quality of Information Available Online for Abortion Self-Referral," *Contraception* 96, no. 4 (2017): 274, https://doi.org/10.1016/j.contraception.2017.07.049.

[46] Jocelyn Downie, Jacquelyn Shaw, and Carolyn McLeod, "Moving Forward with a Clear Conscience: A Model Conscientious Objection Policy for Canadian Colleges of Physicians and Surgeons," *Health Law Review* 21, no. 3 (2013): 28–32.

[47] Foster et al., "If I Ever Did Have a Daughter, I Wouldn't Raise Her in New Brunswick:' Exploring Women's Experiences Obtaining Abortion Care before and after Policy Reform."

[48] Kaposy, "Improving Abortion Access in Canada."

[49] Downie and Nassar, "Barriers to Access to Abortion through a Legal Lens."

[50] Sanda Rodgers and Jocelyn Downie, "Abortion: Ensuring Access," *CMAJ* 175, no. 1 (2006): 9–9, https://doi.org/10.1503/cmaj.060548.

[51] Martha Paynter, Wendy V. Norman, and Ruth Martin-Misener, "Nurses Are Key Members of the Abortion Care Team: Why Aren't Schools of Nursing Teaching Abortion Care?," *Witness: The Canadian Journal of Critical Nursing Discourse* 1, no. 2 (2019): 17–29, https://doi.org/10.25071/2291-5796.30.

[52] Daniel T. Myran et al., "Abortion Education in Canadian Family Medicine Residency Programs," *BMC Medical Education* 18, no. 1 (2018): 121, https://doi.org/10.1186/s12909-018-1237-8.

[53] Atsuko Koyama and Robin Williams, "Abortion in Medical School Curricula," *McGill Journal of Medicine* 8, no. 2 (2005): 157–60, https://doi.org/10.26443/mjm.v8i2.551.

[54] Jessica Shaw, "Full-Spectrum Reproductive Justice: The Affinity of Abortion Rights and Birth Activism," *Studies in Social Justice* 7, no. 1 (2013): 143–59, https://login.proxy.hil.unb.ca/login?

[55] Kaposy, "Improving Abortion Access in Canada."

[56] Martha Bailey and Nicholas Bala, "Canada: Abortion, Divorce, and Poverty, and Recognition of Nontraditional Families," *Journal of Family Law* 30, no. 2 (1992 1991): 279–88. https://heinonline.org/HOL/P?h=hein.journals/branlaj30&i=289.

[57] Renée Monchalin, "Novel Coronavirus, Access to Abortion Services, and Bridging Western and Indigenous Knowledges in a Postpandemic World," *Women's Health Issues* 31, no. 1 (2021): 5–8, https://doi.org/10.1016/j.whi.2020.10.004.

[58] Danielle Miller, "Beyond Legal: A Feminist Intersectional Analysis of the Policy Landscape Shaping Indigenous Women's Access to Abortion Services in Canada" (Thesis, 2023), https://dspace.library.uvic.ca/handle/1828/15107.

[59] Christabelle Sethna and Marion Doull, "Spatial Disparities and Travel to Freestanding Abortion Clinics in Canada," *Women's Studies International Forum* 38 (2013): 52–62, https://doi.org/10.1016/j.wsif.2013.02.001.

[60] Stephanie Begun et al., "'I Know They Would Kill Me': Abortion Attitudes and Experiences Among Youth Experiencing Homelessness," *Youth & Society* 52, no. 8 (2020): 1457–78, https://doi.org/10.1177/0044118X18820661.

respect to abortion has been researched in the United States[61] and warrants further attention in the Canadian context.

3.0 Methods

The New Brunswick government does not collect information on procedural abortions provided outside of the three designated hospitals, nor do the health authorities include abortion care in their annual CHNAs. This means that the number of procedural abortions performed in New Brunswick, the abortion needs of New Brunswickers, and the barriers to accessing this safe and legal health care service are all data that is missing from the official, public conversation about abortion in NB. At the same time, abortion remains a highly stigmatized health care service in this region, making it difficult for patients to come forward and talk about their experiences in the public arena.

To address these obstacles, the research team developed a mixed-method approach that included the following: 1) a review of anonymized data from Clinic 554 from the 1,007 procedural abortions performed since 2015; 2) three focus groups; 3) twenty-eight semi-structured interviews with people who have accessed and/or been involved in advocacy for abortion care in the province; 4) an anonymous online survey; and 5) archival research to provide a robust historical background on the legal and policy context in which abortion restrictions operate. This research project was reviewed and approved by the Research Ethics Board at the University of New Brunswick (REB #2021-090). A circle of experts, made up of key stakeholders such as medical practitioners, lawyers, scholars and non-profit leaders, offered guidance to the research team around the development of research tools, participant recruitment, and knowledge translation activities. This circle of experts did not have access to raw data or any identifying information about participants.

This section of the report will explain the methods employed for each piece of this project.

3.1 Anonymized Clinic Data

The research team worked collaboratively with Clinic 554 to build a database tool that allowed the clinic staff to share anonymized data about their procedural abortion practice with the research team. Throughout this process, the research team was able to reliably ascertain novel information such as the number of procedural abortions performed at Clinic 554, gestational age, payment process (e.g., out of pocket, pro bono, donation to the clinic, etc.), age, and health zone (if available). No member of the research team saw or had access to clinical documents or deanonymized patient information. The data was analyzed using the Statistical Package for the Social Sciences program (SPSS).

[61] Katherine Brown et al., "Black Women's Lived Experiences of Abortion," *Qualitative Health Research* 32, no. 7 (2022): 1099–1113, https://doi.org/10.1177/10497323221097622.

3.2 Interviews and Focus Groups

The research team conducted a total of 28 semi-structured interviews and three focus groups (15 people in total) with health care providers, activists, advocates, subject matter experts and people who have had abortions for a total of 43 distinct participants. All participants were 19 years of age or older and were able to take part in either English or French. The targets for focus groups and interviews were exceeded. To maintain confidentiality in a small province, and because these categories overlap, the report does not further break down interview and focus group participant numbers by categories such as health care providers, activists, advocates, subject matter experts, people who have had abortions, etc.

The interviews and focus groups were transcribed and identifying information was removed. The primary investigators (PIs), project coordinator, and a research assistant inductively developed a codebook from the interview and focus group guides, which was then further refined by reading through a small selection of the transcripts and completing some initial coding. The transcripts were coded using NVIVO. Intercoder reliability was achieved through double coding of at least 25% of the transcripts with coders meeting and sharing their coding process and discussing convergences and divergences in their processes and findings. One PI organized coded data into initial themes after reading through a selection of NVIVO reports, and these themes were finalized through a collective process of deliberation among PIs and the project coordinator.

Seven final themes were identified, and data summaries for each were then produced by the coders. These themes included policies and practices, payment, access to information, myths, anti-choice activism, and recommendations. Theoretical saturation was achieved for each theme. Some quotes have been slightly altered to protect the confidentiality of participants.

3.3 Survey

Because abortion is a highly stigmatized health care procedure in New Brunswick, the research team developed an online survey in French and English to allow prospective participants (19 years of age and older) to share their experiences and insights anonymously in lieu of, or in addition to, participating in an interview or focus group. This survey was made up of both fixed responses and open-ended write-in questions about accessing or attempting to access an abortion. At the end of the survey, participants could self-refer for an interview (< 5 selected this option). In total, 41 people completed the survey. While a relatively small number, the target was 20 and the survey was a research tool designed to capture the experiences of people who wanted to remain anonymous and ***not*** an attempt to gather statistical data for the purpose of generalization. The quantitative survey data was aggregated, and the qualitative responses were coded using the same codebook as the interview and focus group data. Where relevant, the survey responses are reported alongside focus group and interview data in the results section.

3.4 Archival Data

A comprehensive analysis of the current landscape of abortion access in New Brunswick necessitates a robust understanding of the history of abortion care both provincially and nationally. To effectively situate the ethnographic data, survey responses and clinic data within the landscape of abortion care in NB, the research team not only conducted a review of existing literature (see literature review), but also substantial archival research in the Provincial Archives of New Brunswick. Working with the provincial archivists, the researchers reviewed more than 500 documents that included memos, letters, petitions, newspaper articles, newsletters, magazines, policy papers, drafts, minutes from organizational meetings, legal records, hospital statistics, internal communications, membership lists, board meeting communications and conference summaries from relevant fonds. These fonds included Everett Chalmers, the Moncton Hospital, the New Brunswick Nursing Association, Knights of Columbus Pro-Life Canada, Carol Fergusson Fonds, Greg Milton Fonds, York-Sunbury-Queens Medical Society and the Morgentaler case. In addition to informing the historical overview in this report, this archival work is presented in a detailed online timeline available at https://timeline.rjaccessprojectnb.ca

4.0 Results

4.1 Introduction

Abortions have been legal in New Brunswick since 1969. However, successive provincial governments have used their legislative and regulatory powers over health care as a mechanism for restricting access to funded abortions. It is only in the last decade that New Brunswick has moved to liberalize its approach. This has translated into a substantial change in governmental discourse. Gone are the days when the provincial government vowed to give Dr. Morgentaler the fight of his life. Instead, the Liberal government under Premier Gallant committed to removing regulatory restrictions and made New Brunswick the first jurisdiction to fund medical abortions.

> *Your government has eliminated barriers to reproductive health that were in place for nearly three decades and is committed to doing more.* (Victor Boudreau, Health Minister, 2017)[62]

The current Conservative government has not reversed these changes. Instead, Premier Higgs has asserted that abortion care in New Brunswick is adequate and that the issue is not one to be judged by politicians.[63] Our study sought to determine whether the discursive reorientation across partisan lines was matched by comprehensive improvements to access. For the reasons that follow, we conclude that the answer to this question is no. Some barriers to abortion access experienced by patients in New

[62] MacKinnon, "Abortion Pill Now Available for Free to Women in New Brunswick"
[63] Brown, "Health Authorities Are Responsible for Abortion Access, Not the Government: Higgs."

Brunswick have been removed or lessened, but others remain, and not all improvements can be credited to the provincial government.

This finding does not take away from the impact of changes made by the province. The regulatory changes regarding the specialist, two-doctor and reciprocal billing requirements all resulted in somewhat better access, as did the expansion of abortion care in Moncton and the funding for medical abortions. However, while our participants acknowledged these valuable changes, many of the concerns held by most research participants about ongoing barriers to abortion care remain. Importantly, neither the previous Liberal nor the current Conservative government has persuaded New Brunswickers that they are trustworthy on the abortion issue. Members of each participant group attributed the responsibility for ongoing barriers to policies designed and implemented by both Liberal and Conservative governments. Despite recent changes, participants articulated the view that barriers to abortion care still exist for many people and that recent governments are perpetuating a long tradition of obstinate, illogical, and discriminatory opposition to abortion care.

> *I think there's no question that the barriers come from our own government. There is just no question about that. They are literally just trying to gaslight us, that there's still no barriers left. They fixed it. They opened the hospitals, there's no lack of service. It's just a blatant lie. There is a lack in service, there are huge barriers. They are just making this stigma and what can be a difficult situation for vulnerable people more difficult and more stigmatized. Definitely, one hundred percent I put the blame with the government for not supporting the Morgentaler Clinic in the first place and Clinic 554 after that.*

Additionally, our study shows that some barriers, as well as some improvements in access, do not originate from the provincial level. Rather, they are attributable to actions at the federal level, or originate in grassroots advocacy, professional self-regulation, or clinical guidelines. For example, it was Health Canada that held up the necessary approvals for medical abortions for decades before finally approving Mifegymiso in 2015. In 2019, Health Canada additionally removed the requirement that an ultrasound[64] be performed before prescribing Mifegymiso.[65] This last step amounted to the removal of a significant barrier in New Brunswick because there is a shortage of ultrasound technicians.[66]

Our data shows that three types of barriers continue to dominate: 1) legal and regulatory barriers resulting in a lack of funded, locally accessible clinic-based abortion care, 2)

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[64] Amanda Connolly, "Ultrasound No Longer Required before Patients Can Access Abortion Pill: Health Canada," *Global News*, April 16, 2019, https://globalnews.ca/news/5173789/how-to-get-abortion-pill-canada-ultrasound/.

[65] The College of Family Physicians of Canada (CFPC), "Abortion Resources for Family Physicians," accessed October 24th, 2023, https://www.cfpc.ca/en/education-professional-development/practice-tools-guidelines/abortion-resources-for-family-physicians.

[66] Raechel Huizinga, "New Brunswick Medical Imaging Technologists Suffering from Pandemic Burnout," *CBC News*, March 10, 2022, https://www.cbc.ca/news/canada/new-brunswick/new-brunswick-medical-imaging-technologists-burnout-1.6379322.

information deficits and an associated culture of stigma and misinformation, and 3) practical or logistical challenges faced both by people seeking an abortion and those providing the service. These barriers were identified by participants across modes of participation in our research, including those who shared their abortion experiences in a survey, focus group, or interview, to activists and providers, in both English and French language groups.

The results section of the report is divided into five sections. We begin by outlining the legal, regulatory and policy context of abortion care in New Brunswick and illustrate the history and continuity of barriers to abortion access. Next, we analyze medical abortion care and its impact on access. We then consider the information landscape. Here, we explore the availability and accessibility of reliable public health information on abortion, describe limitations and barriers, and consider the implications of informational barriers introduced by anti-choice activists, health care providers, and government officials. This leads to a discussion of how the lack of reliable public information on abortion care fuels stigma and myths and makes it difficult for the provincial government, hospitals and other health care providers to ensure that patients receive timely and accurate information. In the final section, we identify practical barriers to abortion access and the provision of abortion care.

In short, what we have found is that in a context where the *Medical Services Payment Act* still limits funded procedural abortions and related blood tests to hospitals, there are only three hospitals in two cities that offer abortion services. This means that people need money for travel and support, and there is little to no support for people accessing the procedure, which amounts to barriers to health care. There is still a lack of reliable information and a prevalence of stigma and misinformation. The situation has not improved enough to warrant any claim of "barriers removed", and people continue to pay out of pocket to access abortions at Clinic 554. Despite considerable change, our data shows that there are continuities in the barriers to abortion access.

4.2 Legal, Regulatory and Policy Contexts and Barriers

Canada largely decriminalized abortion in 1969 and has not had a federal abortion law since 1988. Despite this, Canada lacks a straightforward articulation of a *Charter* right to abortion and a readily enforceable statutory right to funded abortion care. This means that abortion, while always lawful, remains inaccessible to many Canadians, including those in New Brunswick. Unlike in other parts of Canada, however, where the lack of access is frequently the result of government inaction, New Brunswick has taken positive steps to make abortion more difficult to access.

The history of abortion in New Brunswick demonstrates that there can be a large gap between the legality of a procedure and meaningful access to it. In this study, based on the literature and contributions from participants, we define meaningful access as requiring abortion care that is free, certain, inclusive and local. Free access requires comprehensive coverage by Medicare or other forms of insurance, regardless of the method used to provide abortion care, any personal characteristics of the person seeking an abortion, or the gestational age. Certain access requires that the outcome that abortion

care will be provided is clearly predictable by the person seeking an abortion. Access is certain when a patient knows that they will be able to access an abortion through an available access point. Inclusive access requires abortion care to be available in a manner that is safe, confidential, and supportive, and is free from discrimination and punitive treatment. Finally, we define access as local when transportation needs are minimal or transportation to access points is well supported.

New Brunswick governments acted to restrict access to abortion beginning in 1985. In April of that year, Dr. Morgentaler wrote to the provincial health minister to propose that they cooperate to open a Medicare-funded abortion clinic in the province.[67] The proposal was rejected. Instead, in June of the same year, the government, led by Richard Hatfield, made it an offence for a doctor to provide an abortion outside of a hospital, punishable by a loss or suspension of their license to practice in the province.[68]

Dr. Morgentaler's challenge to the Therapeutic Action Committee (TAC) system in the Criminal Code was successful in the Supreme Court of Canada. The justices were divided in their reasons, but at minimum, it was clear that using an administrative regime that causes delays to abortion access was unconstitutional because it violated the rights of patients to security of the person. The decision recognized that delaying abortions carried medical risks that were not justified.

In 1988, shortly after the abortion provisions in the Criminal Code were struck down by the Supreme Court, Premier Frank McKenna called a press conference and described a policy in which two doctors would be required to approve an abortion for it to be covered by Medicare at one of four approved hospitals.[69] The New Brunswick Advisory Council on the Status of Women (NBACSW) responded a week later, arguing that McKenna's policy would maintain access restrictions similar to those that had been struck down by the Supreme Court.[70] Abortion access and politics in the province continued to be uncertain and volatile for some time. Hospitals were not sure whether their TACs could continue to operate,[71] and the registrar of the College of Physicians and Surgeons wrote to its members advising them of "the importance of being very conscious to avoid becoming the test case which is being sought by both ends of the spectrum of public opinion."[72] Right to Life groups held rallies and a letter-writing campaign, and Choix NB Choice, an organization with about ninety members in Saint John, Moncton, and Fredericton, held a forum on abortion at UNB Saint John.[73]

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[67] Provincial Archives of New Brunswick, RS417: Records of the Office of Premier Richard B. Hatfield, *6720-A (1985)*. Letter to Charles Gallagher from Henry Morgentaler, April 24, 1985.

[68] *An Act to Amend An Act Respecting the New Brunswick Medical Society and the College of Physicians and Surgeons of New Brunswick*, SNB 1985, c 76

[69] "Abortion Policy Comes Under Fire from Both Sides," *Telegraph Journal*, February 13, 1988.

[70] "Abortion Policy Concerns Women's Council," *Daily Gleaner*, February 18, 1988.

[71] "Chalmers Abortion Panel Put in Limbo," *Telegraph Journal*, February 10, 1988.

[72] Provincial Archives of New Brunswick, Carol Fergusson Fonds MS 3848, File MS 2A1. Memorandum from Victor D. McLaughlin to the members of the College of Physicians and Surgeons, "Re: The Abortion Controversy," February 22, 1988.

[73] Provincial Archives of New Brunswick, Carol Fergusson Fonds MS 3848, File MS 2A1.

Dr. Morgentaler sued for reimbursement for three abortions performed on New Brunswick residents at his Quebec clinic. The province argued that the provincial policy was that abortions were covered in New Brunswick only if performed in an accredited hospital and approved by two doctors. In April 1989, the court held that no such policy had been formally adopted, and that the only provincial legislation governing abortion, passed in 1985 under Premier Hatfield, did not apply to out-of-province doctors.[74] Following this loss, Premier McKenna moved to formalize the policy he had announced in February 1988. On May 5, 1989, his government added abortion to the services not covered by Medicare that are listed in Reg. 84-20, Sched 2. The amendment read:

> 2.01(b) The following are deemed not to be entitled services:
>
> (a.1) abortion, unless the abortion is performed by a specialist in the field of obstetrics and gynaecology in a hospital facility approved by the jurisdiction in which the hospital facility is located and two medical practitioners certify in writing that the abortion was medically required;[75]

In March of 1989, the Nova Scotia government passed legislation prohibiting the provision of, and denying funding for, abortions performed outside of approved hospitals. Dr. Morgentaler opened a clinic in Halifax and was soon charged under the legislation. He was acquitted at trial. The Court of Appeal agreed, and, in September 1993, the Supreme Court of Canada found in Dr. Morgentaler's favour, holding that Nova Scotia's prohibition on performing abortions outside of an approved hospital was "aimed primarily at suppressing the perceived public harm or evil of abortion clinics.[76]

Dr. Morgentaler obtained his New Brunswick medical license on March 11, 1994. He opened a clinic in Fredericton in June, and the Minister of Health quickly complained to the College of Physicians and Surgeons asking the College to restrict Dr. Morgentaler from performing abortions at the Fredericton clinic. This complaint was filed pursuant to the 1985 New Brunswick statute. A similar Nova Scotia statute was struck down by the Supreme Court in 1993. Applying the Supreme Court decision, the New Brunswick Court of Queen's Bench in 1994[77] struck down the law and a majority of the New Brunswick Court of Appeal[78] upheld the decision in 1995. This decision dealt with the prohibition, but not with the other component found unconstitutional in the Nova Scotia case, the exclusion of abortion from insured services. In 1997, the McKenna government removed the 1985 sanctions against doctors performing abortions outside of approved hospitals but let Reg. 84-20 stand.

Reg. 84-20 continued unchanged through both Liberal and Progressive Conservative governments. In 2003, Dr. Morgentaler sued the provincial government on the grounds that Reg. 84-20 violated both the *Charter* and the *Canada Health Act*. The province

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[74] *Morgentaler v New Brunswick (Attorney General)*, 1989 NBJ No 311.
[75] *General Regulation - Medical Services Payment Act,* NB Reg 1989-84-20, sched 2, s. 2.01(b) (a.1).
[76] *R v Morgentaler,* [1993] 3 SCR 463.
[77] *Morgentaler v New Brunswick,* 1994 CanLII 10960 (QB)
[78] *Morgentaler v New Brunswick (AG)*, 1995 CanLII 16625 (NB CA).], leave to appeal denied, [1995] SCCA No. 126.

adopted a litigation strategy of delay. It challenged the standing of Dr. Morgentaler and when it lost,[79] proceeded to appeal that decision. Anti-choice organizations sought intervener status and when they lost,[80] sought to appeal.[81] Seven years later, in 2009, the New Brunswick Court of Appeal ruled[82] that Dr. Morgentaler did indeed have standing to challenge the legislation. Ironically, the court relied on Dr. Morgentaler's extensive experience as a litigant and his financial wherewithal to support the notion that he was in the best position to bring the challenge:

> *It is, as well, worth bearing in mind that Dr. Morgentaler brings to the judicial arena financial resources and legal expertise which will undoubtedly help level the playing field and greatly improve the chances that any judicial decision on the merits is fully informed both factually and legally.*[83]

The province did not appeal the decision that time, but it did not need to. By the time the Court of Appeal ruled, Dr. Morgentaler had spent roughly one million dollars on the litigation. In 2008, the clinic had been damaged by a flood, causing an additional cost of $100,000 in repairs. While other downtown businesses were reimbursed, no such compensation was granted to the clinic. By 2009, Dr. Morgentaler had been worn down financially. He continued to make contributions to ensure that no woman would have to be turned away. After his death in 2013, his estate could no longer support these payments.

After campaigning with the promise that, if elected, his party would "…act swiftly to ensure that we find any barriers to a woman's right to choose and eliminate them,"[84] Brian Gallant's provincial Liberal government amended Regulation 84-20 of the *Medical Services Act*. The amendment removed the requirements for a specialist to perform the procedure, as well as the need for referrals from two doctors.[85]Funded abortions became available at the Family Planning Clinics at Chaleur Regional Hospital in Bathurst, the Moncton City Hospital and the Dr. Georges-L. Dumont University Hospital Centre, both in Moncton.

Despite the provincial government claim that all barriers have been removed, the data tells us that not only did several well-documented and longstanding access barriers survive the regulatory changes of 2014 and the introduction of Mifegymiso, they continue to prevent abortion access from being local, certain, inclusive, and free. A recurring theme

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[79] *Morgentaler v New Brunswick*, 2008 NBQB 258. (CanLII)
[80] *Morgentaler v NB*, 2004 NBQB 139. (CanLII)
[81] *Coalition for Life and Health v Dr. Henry Morgentaler and the Province of New Brunswick*, 2005 NBCA 3. (CanLII)
[82] *New Brunswick v Morgentaler*, 2009 NBCA 26. (CanLII)
[83] *Ibid* at para 59.
[84] Sarah Boesveld, "Abortion Thrust into Spotlight in New Brunswick Election after 'Strategic' Blitz by Activists," *National Post*, September 17, 2014, https://nationalpost.com/news/politics/abortion-thrust-into-spotlight-in-new-brunswick-election-after-strategic-blitz-by-activists.
[85] Government of New Brunswick, Office of the Premier, "Provincial Government Removes Barriers to a Woman's Right to Choose", November 26, 2014, https://www2.gnb.ca/content/gnb/en/news/news_release.2014.11.1334.html

in our data was that Regulation 84-20 of the *Medical Services Payment Act*, which denies Medicare coverage for procedural abortions and other types of pregnancy-related care performed outside a hospital, imposes financial barriers on individuals seeking abortion services.

Unlike anywhere else in the country, procedural abortions performed in a clinic are not covered by New Brunswick Medicare because of Regulation 84-20 of the *Medical Services Payment Act*.[86] As discussed, beginning in 1989, in Schedule 2, any abortion performed outside a hospital setting was listed as one of several services that are not entitled for payment by Medicare. We have reproduced it again in full for ease of reference:

> (a.1) abortion, unless the abortion is performed by a specialist in the field of obstetrics and gynaecology in a hospital facility approved by the jurisdiction in which the hospital facility is located and two medical practitioners certify in writing that the abortion was medically required;

Paragraph a.1 has been amended and now reads:

> (a.1) abortion, unless the abortion is performed in a hospital facility approved by the jurisdiction in which the hospital facility is located; (…)

The amendment removed two important barriers: the procedure no longer has to be performed by an OB/GYN and it no longer requires certification of medical necessity by two doctors. Previously, both requirements conspired to create nearly insurmountable hurdles as many New Brunswickers lack access to primary health care providers, many doctors held conscientious objections to certification or worried about legal liability as the legal standard of medical necessity was highly uncertain, and access to specialists is even more difficult.

Participants agreed that these measures were significant improvements to access, but argued that they were not sufficient. These efforts appeared to at least one participant as a way to avoid repealing 84-20:

> *… they (the government) tried to seem like they were getting rid of the gaps without getting rid of the regulation that we know is the main problem. And so they tinkered at the edges without changing access very much. …. So I felt that the government, after 2015, liked to pretend they fixed things without actually fixing anything.*

The primary, and ongoing, financial barrier resulting from Regulation 84-20 identified by participants is the lack of government funding for abortions provided at the Morgentaler Clinics and Clinic 554. At the time of its closure in 2014, the Morgentaler Clinic charged $700 to $850 for each abortion depending on the gestational age, albeit with the commitment that no one who needed an abortion was turned away, even if they

[86] *General Regulation - Medical Services Payment Act,* NB Reg 1989-84-20, sched 2, s. 2.01(b) (a.1).

could not pay for it. As a result, the Morgentaler Clinic operated at a loss of about $10,000 per year, which the Toronto and Montreal Morgentaler Clinics subsidized. Despite the subsidies, many patients paid out of pocket.

When Dr. Edgar bought the Morgentaler Clinic building and set up a family practice that also offers abortions in 2015, he charged the same fees as the Morgentaler practice despite rising costs. Clinic 554 also continued the practice of the Morgentaler Clinic of not turning patients away based on their ability to pay. Staff at the clinic helped patients who lacked the full fee at no charge, with the required paperwork to apply for subsidies. Staff at the clinic were also known to volunteer their time in some cases where the patient could not pay and the clinic was already incurring costs. As a result of Regulation 84-20, clinic abortions at Clinic 554 do not meet our definition of meaningful access, as they are only free to some patients and only as a result of extraordinary and ultimately unsustainable efforts. However, Regulation 84-20 also means that abortion care is not necessarily free at the designated hospitals. This is because Regulation 84-20 also disentitles other relevant ancillary services including the following:

> (b) medicines, drugs, materials, surgical supplies or prosthetic devices; (…)
>
> (m) laboratory procedures not included as part of an examination or consultation fee; (…)
>
> (y) venipuncture for the purposes of taking the blood when performed as a standalone procedure in a facility that is not an approved hospital facility; (…).

The effect of Regulation 84-20 is not only the exclusion of clinic abortions from Medicare coverage, but it also means that there may be costs to patients associated with accessing procedural abortion services, whether they go to a hospital or Clinic 554.

Additionally, in the case of procedural abortions offered at the designated hospitals, anyone who does not have a Medicare card is required to pay a fee, and any related blood tests and ultrasounds performed at a clinic are not funded. The fee for a hospital abortion for anyone without Medicare coverage is significantly higher than the cost of a clinic abortion. The Moncton Family Planning Clinic's fee is $2,770, $180 of which has to be paid on the day of the procedure to cover the doctor's fee.

Ironically, participants also identified that raising the necessary funds for an abortion can compete with the ability to pay for the cost of contraceptive care.

Looking at the payment issue from another perspective, one of the most obvious indicators that access barriers still exist is the amount of money spent by individuals on their abortion at the clinics over the years. That said, the gap is invisible in the official data. Because clinic abortions are not covered by Medicare, the government does not include either procedural or medical abortions performed at Clinic 554 in its data.

From 2015 to 2021, more than 93% of people contributed financially to their procedural abortion at Clinic 554. Together, these full and partial out-of-pocket payments add up to $640,430. Of this number, $549,530 is known to have been paid by people who reported living New Brunswick. This excluded 132 people who did not disclose an address to Clinic 554, which means that these abortions could have been provided to people living within or outside of New Brunswick. Close to 12% of people relied on some pro bono work to access their abortion. Clinic 554 provided $52,245 of pro bono work between 2015 and 2022 to ensure access to abortion was maintained. For each person who needed pro bono assistance, the clinic provided on average $439.03.

And we haven't even touched on the issue of people who don't have a health card. What are we doing for people who don't have a health card? And why don't they deserve so much of our breath? Why is this not front and centre? In our work as reproductive advocates, it really needs to be. Because those people are getting publicly funded services and they're paying for them out of pocket and it's not ethical, and it's not fiscally responsible.

Then Clinic 554 really is their only hope because they're quoted thousands and thousands and thousands of dollars to have it done at the hospital. That's a big barrier. I guess to Higgs' it's a small percentage of people but it's still a person's life, you know?

One might wonder why patients would choose to access abortion care in a clinic setting where they have to pay rather than accessing a funded service in a hospital. The answer lies in the certainty and timeliness of clinic abortion care access. A comparison between Badgley Report data in 1975 and health data from 2017 shows that most hospital abortions are performed between nine and twelve weeks. Shockingly, the timing of hospital-based abortion procedures is fundamentally unchanged despite the striking down of the TAC regime on the basis of unconstitutional delay.[87] [88]

[87] Committee on the Operation of the Abortion Law, "Canada. Report of the Committee on the Operation of the Abortion Law, (Ottawa: Ministry of Supplies and Services, 1977) (Chair: Robin Badgley)" (Ottawa: Ministry of Supplies and Services, January 1977), Bora Laskin Law Library, University of Toronto, 147, https://library.law.utoronto.ca/whrr/Badgley_Report.

[88] Canadian Institute for Health Information (CIHI), "Induced Abortions Reported in Canada in 2017," Access Data and Report, n.d., https://www.cihi.ca/en/search?query=induced+abortions. n.b. The 2017 data have been adjusted to distribute "unknown" gestational age abortions proportionately.

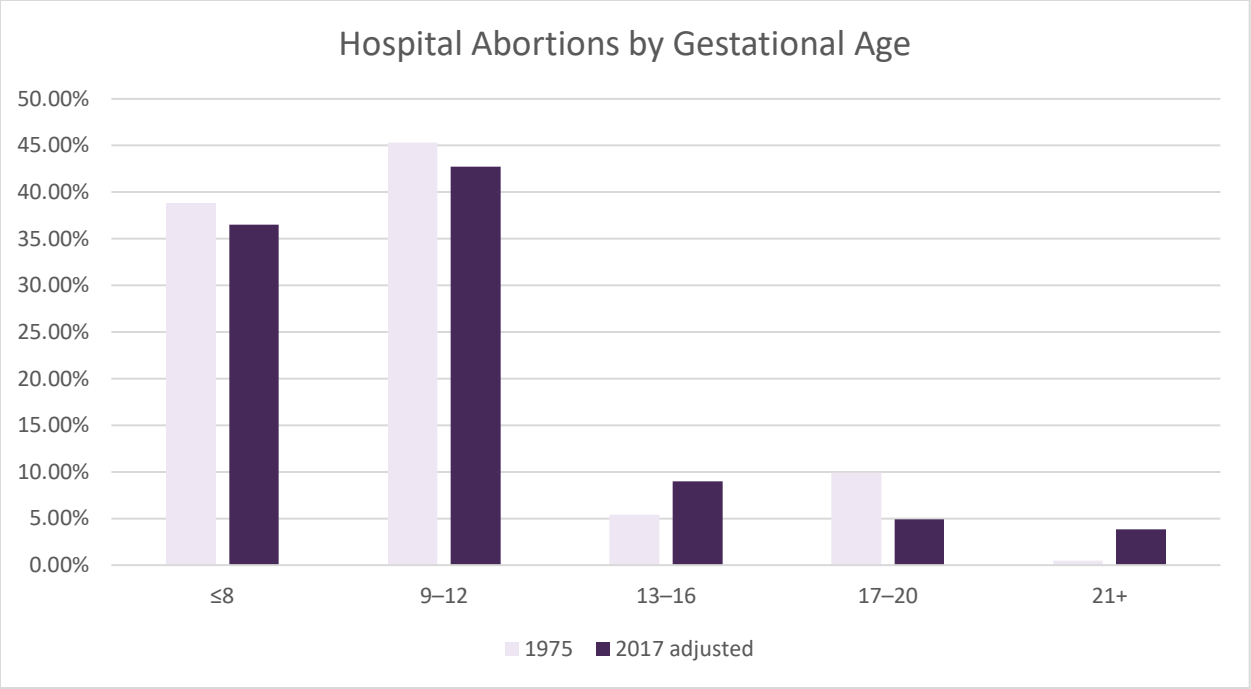

FIGURE 1

Surprisingly, striking down the TAC system did not result in fewer delays in hospital abortion care. Importantly, the situation of patients with respect to health risks arising from delay has not changed, but neither the medical nor the legal system is motivated to consider the problem.

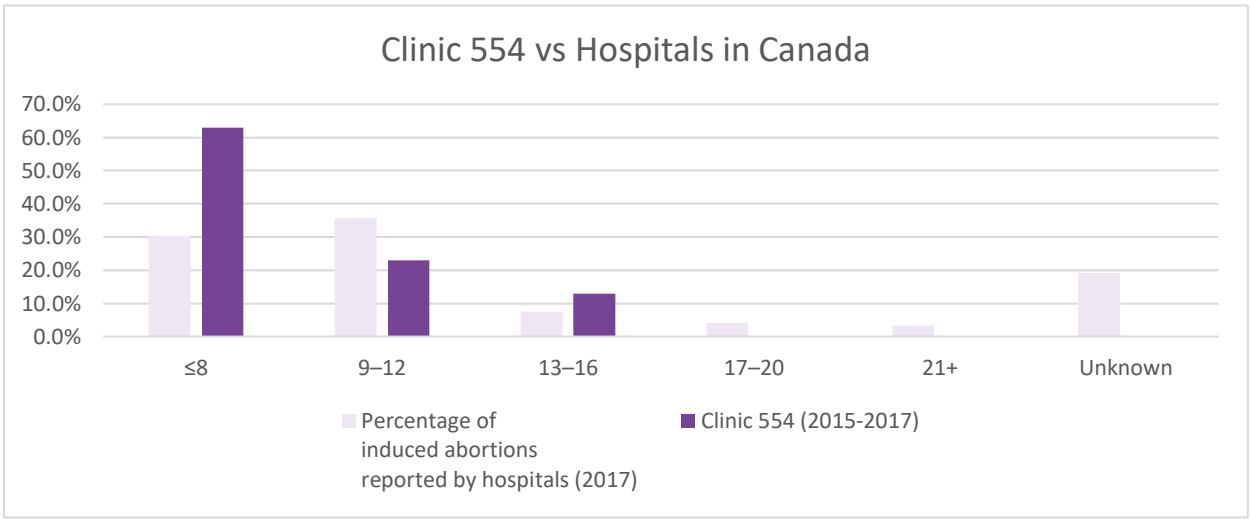

FIGURE 2

By contrast, our data show that abortions at Clinic 554 occur significantly earlier in the pregnancy than abortions in the Canadian hospital system. Over sixty percent of procedures are carried out before 9 weeks, compared to around 30% in Canadian hospitals. We conclude that Regulation 84-20 suffers from the same constitutional defect

that led to the striking down of the TAC regime: it causes administrative delay. Avoiding this delay and the inevitable health and psychological consequences of delay is a key motivator for accessing clinic abortions. Individual New Brunswick patients and clinic providers have been footing the bill for timely and certain abortion access.

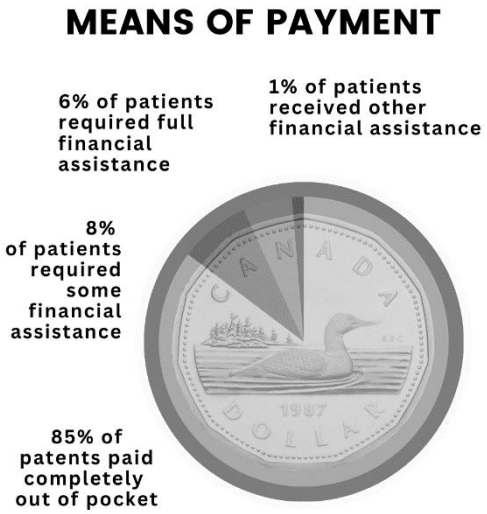

FIGURE 3

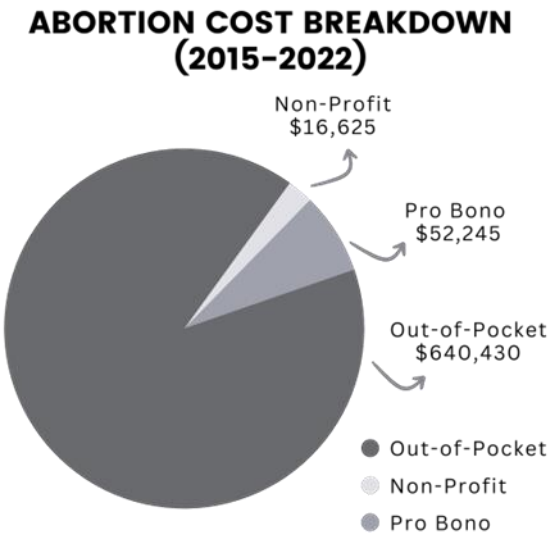

FIGURE 4

As discussed, barriers can arise from government inaction as well as government action. For many years, unregulated protest created access barriers to abortion care. Participants were aware that other jurisdictions took more steps to protect the privacy and freedom from harassment for people accessing abortion care. One participant explained that while there are protesters in Nova Scotia, there is provincial legislation that governs how far away the protesters have to be from hospitals and clinics that provide abortion care. The New Brunswick government declined to institute a similar protective safe zone[89] around either the Morgentaler Clinic or Clinic 554. Instead, New Brunswick Right to Life was able to establish a "Women's Care Center" at 562 Brunswick Street, right next door to the Morgentaler Clinic in Fredericton. Without a bubble zone, there was a regular group of anti-abortion protesters who was affiliated with the Women's Care Center and who had free rein to harass patients, their support people, and providers on days when abortions were being performed at the Morgentaler Clinic.

[There were patients] who went there by mistake, and that's really horrible, because they'll lock you in a room and show you nasty videos.

[89] Abortion Rights Coalition of Canada (ARCC), "Safe Access Zone Laws and Court Injunctions in Canada (to Protect Abortion Access)," Abortion Rights Coalition of Canada, August 22, 2022, https://www.arcc-cdac.ca/media/2020/06/Bubble-Zones-Court-Injunctions-in-Canada.pdf.

There have been some protections instituted, but not by the provincial government. A judge issued a permanent court injunction in 2017 to prevent anti-choice protests outside the hospital in Bathurst.[90] During the COVID-19 pandemic, Parliament passed Bill C-3[91] to prevent protesters from interfering with vaccination efforts. The new offences of intimidation, interference or obstruction of health care facilities effectively made it illegal to protest outside Clinic 554 in a manner that intimidates, interferes or obstructs. The federal assistance arguably came too late. By the time C-3 was enacted, protests at the clinic site had ceased.

Anti-abortion protest is enabled in part by the federal government. New Brunswick Right to Life is a CRA-registered charity and, therefore, in accordance with federal law, pays no tax but is able to issue charitable receipts for donations.[92] This amounts to public financial support for protests that are now criminalized. As indicated, at the current time the issue seems moot, but this may, of course, change again.

For some people, access barriers to a funded abortion arise from the administration of Medicare rather than laws and regulations. Participants pointed to issues of documentation for portions of the population and argued that that tying the service to the

> *Patients that have applied for Medicare cards and haven't gotten them yet, from out of the country, newcomers that are waiting for their Medicare cards.*

hospitals was challenging for people, particularly given that there is a minimum four- to six-week processing period for Medicare applications.[93]

Participants noted the precariousness of abortion care as a result of the overall shortage of health services in the province that lead to delays in an area of health care that is very time-sensitive. Sixteen participants pointed out that there is a general health care crisis in the province due to a shortage of doctors and nurses, which increases delays for all medical procedures. This is particularly problematic when it comes to meeting the gestational age limits of both medical and procedural abortions. One participant noted that New Brunswick provides abortions at a very limited gestational age compared with elsewhere in Canada. Gestational age limits are not the result of regulatory restrictions but are instead implemented through hospital policies. These barriers highlight the importance of going beyond legal and regulatory review to consider policies and practices.

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[90] *Regional Health Authority A (Vitalité Health Network) v Godin*, 2017 NBQB 93 (CanLII).
[91] *Ibid.*
[92] Abortion Rights Coalition of Canada (ARCC), "Position Paper #80. Why Anti-Choice Groups Should Not Have Charitable Tax Status," 2023, https://www.arcc-cdac.ca/media/position-papers/80-Charitable-Tax-Status.pdf.
[93] Government of New Brunswick, "Medicare," Health, accessed October 24, 2023, https://www2.gnb.ca/content/gnb/en/departments/health/Medicare.html.

4.3 Medical Abortions

During the time of operation of Clinic 554 as a family practice and abortion clinic, a long-awaited change occurred at the federal level. Health Canada approved medical abortion by Mifegymiso in July of 2015 after a three-year review process and the rollout for dispensation started in January of 2017. It will be recalled that this medication was developed in France and approved there in 1988, but remained unavailable in North America until the FDA approved it in the United States in 2000. Canadians had to wait another 15 years for approval, and clinical standards in Canada continue to evolve.

In July of 2017,[94] New Brunswick was the first province in the country to announce that the Medical Abortion program[95] would cover the full cost of Mifegymiso for any New Brunswick resident with a valid Medicare card and a prescription.[96] [97] There is no copayment or fee, and community pharmacies either in or outside New Brunswick that register can fill the script. These pharmacies then bill the Department of Health directly for reimbursement.

Medical abortion has been anticipated widely as a key component of addressing access gaps in Canada, particularly in rural and remote areas. Early studies support the notion that medical abortion indeed has the potential to improve access, but also note that it is far from a cure-all. Our review of available quantitative data did not provide conclusive answers on some key questions: How many medical abortions are carried out annually in the province? What is their success rate? What has the impact of the availability of medical abortions been on the number of procedural abortions? How have changing Health Canada requirements and evolving clinical protocols affected the provision and accessibility of medical abortions? Has the overall number of abortions in New Brunswick changed? How has the pandemic affected abortion care needs?

There is also a need to understand why patients would have a medical or a procedural abortion. The answer to this question will not come from statistics. Our study provides insight into some of the reasons and constraints. They are discussed below after a discussion of the quantitative data.

Here is what the available data show: the Department of Health has been tracking the number of claims submitted for Mifegymiso on its website.[98]

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[94] MacKinnon, "Abortion Pill Now Available for Free to Women in New Brunswick."

[95] Government of New Brunswick: Department of Health, Pharmaceutical Services, "Medical Abortion Program Policy (Plan J)" (Government of New Brunswick, November 19, 2019), https://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/policymanual-manuelpolitiques/Medical-Abortion-Program_Plan-J.pdf.

[96] Canadian Press, "N.B. to Provide Abortion Pill Mifegymiso Free of Charge," *Atlantic*, April 4, 2017, https://atlantic.ctvnews.ca/n-b-to-provide-abortion-pill-mifegymiso-free-of-charge-1.3354427?cache=yes%3FautoPlay%3Dtrue%3FclipId%3D89530%3Fot%3DAjaxLayout.

[97] South, "New Brunswick Makes Medical Abortion Pill Free to Patients with Medicare Card."

[98] Government of New Brunswick, "New Brunswick Medical Abortion Program Mifegymiso Claims: 2019-20 to 2022-23," 2023, https://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/abortion/mifegymiso_claims.pdf.

New Brunswick Medical Abortion Program
Mifegymiso Claims

	2019-20	2020-21	2021-22	2022-23
# of Claims	736	724	828	448
Total Paid	$246,327.02	$242,201.03	$277,315.06	$150,070.31

Note: Current year data is updated 90 days after the end of the previous quarter.

FIGURE 5

The provincial data come with some limitations. The data are presented by fiscal year rather than following the national standard reporting by calendar year, which makes comparisons difficult. CIHI data includes medical abortions, but does not publish provincial data by method. There is some inevitable data delay as well. Also, it is not clear how many of the dispensed doses were administered in hospital emergency rooms or at the family planning clinic(s) in hospitals, versus the number filled by regular prescription.

Further, Mifegymiso is also prescribed for patients who have an incomplete spontaneous miscarriage. It is not clear whether the provincial data include these prescriptions, and if they do not, by what mechanism the Department of Health distinguishes between prescriptions for these different purposes. Finally, this table does not show how many patients used their prescription or what the efficacy rate was for New Brunswick patients. The latter two points are related. Because medical abortions are indicated in the first trimester, there may be a substantial number of people who obtain a prescription for a medical abortion who will not end up having a medical abortion. This is because a small number of patients will have a procedural abortion after attempting a medical abortion,[99] some will have spontaneous miscarriages, and some patients may change their minds. In short, while we know from the provincial data how many prescriptions are filled and paid for by the province, this is a very imperfect proxy for the rate of medical abortions in the province.

The federal data is provided by CIHI. For the relevant years, the currently available data provides two sets of information that can help inform an analysis of medical abortion in New Brunswick.

[99] Sheila Dunn and Rebecca Cook, "Medical Abortion in Canada: Behind the Times," *CMAJ* 186, no. 1 (2014): 13–14, https://doi.org/10.1503/cmaj.131320.

TABLE 1

Year	Number of induced abortions reported by hospitals	Number of induced abortions reported by clinics (beginning in 2021: by non-hospital settings) by clinics	Total
2014	528	0	**528**
2015	676	0	**676**
2016	827	0	**827**
2017	699	0	**699**
2018	507	99	**606**
2019	431	98	**529**
2020	495	0	**495**
2021	754	141	**895**

Note that this table includes all abortions in the reporting years including all methods for providing abortions available at the time. The clinic data for 2014 to 2020 are non-existent or incomplete. In other words, the zeros do not represent a report that no abortions were provided in a clinic. Rather, it represents that no clinic abortions were reported to CIHI from 2014 to 2017 as well as in 2020. Also, our data show that only some clinic abortions were reported to CIHI in 2018 and 2019.

Our research can fill some of the federal data gaps by adding or correcting information derived from our review of client data from Clinic 554. It should be noted that the data from Clinic 554 only represents procedural abortions.

TABLE 2

Year	Number of induced abortions reported by hospitals	Number of procedural abortions in current study of Clinic 554	Previous total	Corrected total
2014	528	n/a	528	**528**
2015	676	217	676	**893**
2016	827	233	827	**1,060**
2017	699	218	699	**917**
2018	507	112	606	**619**
2019	431	111	529	**542**
2020	495	81	495	**576**

The second relevant CIHI data relates to the number and distribution ratio between medical and procedural abortions. It is only published at the national level without breakdown by province and there is only one year of data as the first year of reporting medical abortions using Mifegymiso is 2021.

TABLE 3

Method of abortion		Number of induced abortions	Percentage of induced abortions
Surgical		55,073	63.1%
Medical		32,234	36.9%
Total		**87,307**	**100.0%**

According to the source notes for this data table, the numbers include clinics providing abortion services in New Brunswick. We were not able to obtain segregated provincial data for New Brunswick.

During the years of operation of the Morgentaler Clinic, the combined hospital and clinic reported abortions in New Brunswick were quite stable, between 1,036 and 1,104 abortions per year. In the year of its closure, the Morgentaler Clinic did not report 2014 procedures to CIHI. Our research has not identified any reason why the need for abortions would have been less between 2014 through the first six months of 2017, i.e., the period after the closure of the Morgentaler Clinic and the arrival of Mifegymiso in New Brunswick. The 2014 numbers must be treated as an anomaly.

Beginning with the opening of Clinic 554, the numbers returned to the expected range with 2016 appearing as a "normal" year in the history of abortion care in the province. 2018 marks the first year with a decline in reported abortions. This is likely attributable to an increase in medical abortions which do not appear to show up in the New Brunswick CIHI data until 2021. Note, however, that the 2018 numbers reported through the hospitals could have included some medical abortions, according to the CIHI methodology.

For 2020 and 2021, it is possible to use the numbers provided by the province to estimate the number of prescriptions filled for Mifegymiso in New Brunswick, assuming an even distribution over the calendar year. This would suggest about 727 filled prescriptions in 2020 and 802 in 2021. For the reasons discussed, these numbers likely overestimate the number of medical abortions in New Brunswick. The total of reported hospital abortions and prescriptions filled in 2020 would be 1,303. In 2021, the total would be 1,697.

We are not convinced that the available data about Mifegymiso is sufficiently clear or sturdy enough to support conclusions about the number of individual, completed medical abortions in New Brunswick and therefore the overall number of abortions in New Brunswick. One researcher has provided some figures to the media which appear to

suggest a much higher uptake of Mifegymiso in New Brunswick than the Canadian average. We have not been able to independently verify the data provided by the researcher. If accurate, this would raise questions about the reasons for the difference. Why would New Brunswickers access medical abortions at twice the national average? We conclude that it is not possible to be certain of the rate of medical abortions in New Brunswick. More data about how many New Brunswickers access medical abortions is needed. If it indeed proves that New Brunswickers have a much higher uptake rate, it would be important to understand whether this is an indicator of barriers to procedural abortion access, reflects patient choice, or has other reasons.

To better understand medical abortion access, we inquired into the availability and accessibility of Mifegymiso in a sample of twenty pharmacies, ranging from large to small and including franchises as well as independent pharmacies. Only 1/5 of the sample (4/20) had Mifegymiso in stock. One pharmacy indicated that they usually stock it but they were out. Larger pharmacies and those that serve a younger demographic, for example on a postsecondary campus, will typically have it in stock. Smaller stores may not. Most pharmacies indicated that they could order it and have it in for the next day. A few pharmacies responded unhelpfully to our inquiry, stating that they did not have the medication and did not offer to look it up or offer suggestions. In contrast, several other pharmacies were forthcoming and helpful. We also inquired about the price of the medication for someone without a Medicare card or insurance. The quoted price ranged from "a couple hundred dollars" up to $400 to $500 in some estimates, and narrowed to $325 to $340 for pharmacists who looked up the price in response to our inquiry. All pharmacies either knew or looked up that it had to be prescribed by a physician, although there was inconsistent information provided about the necessity of ultrasounds and blood work to access Mifepristone. We conclude that Mifegymiso is available in New Brunswick, but that more could be done to improve access to a medication that has, without question, expanded access to abortion across the province, and the country.

Despite the increased access to abortion care offered by Mifegymiso, more than one participant believed that medical abortion had been overpromised as a solution to access issues. Eleven interviewees discussed barriers to medical abortions in response to the idea that the provincial coverage of Mifegymiso adequately addressed delays in access, and we heard that there can be some challenges associated with both accessing medical abortions, and with the experience of a medical abortion.

Access concerns included the need for multiple medical appointments, the ancillary costs of medical abortions (such as the cost of pain management medication), as well as inadequate information about the process of going through a medical abortion.

Medication abortions, according to the information provided by New Brunswick's health authorities, may require several appointments both prior to and following the prescription. Such appointments could include blood work, an appointment to access a prescription, and additional blood work after the medication course is complete to ensure that the pregnancy is terminated. These extra appointments can be a strain on an already overtaxed health care system. There is research being conducted on the use of pregnancy

tests instead to assess the completeness of a medical abortion;[100] however, pregnancy tests do represent another ancillary cost to abortion care and if used in this way would need to be provided free of charge with a Mifegymiso prescription.

On the issue of ancillary costs and Mifegymiso, one participant noted that patients will need additional supplies during the process that are not covered by Medicare.

> *Medication abortion … the only thing that the government pays for is the abortion pill. … if you need Gravol, you have to buy it. If you need Advil and Tylenol, which every human will, you have to buy it. If you're anxious and need … Ativan or something, you have to buy it. If your pain is really bad, and you need fentanyl and T3s (Tylenol 3), you have to buy it. So all of the symptom management of the abortion is not included with the government's "funding," funding in air quotes, of a medication abortion.*

According to the government's webpage, patients can get information about medical abortions from their primary health provider, any of the three Family Planning Clinics in Moncton and Bathurst, by calling Tele-Care 8-1-1,[101] or from the Vitalité "Abortion" webpage.[102] The health authority sites provide the contact number and website for Clinic 554 as sources of information about a prescription, but none of these web sources list the prescribers or pharmacies that stock the medication. People taking the medication might not know that the abortion process may take multiple days to complete, and that blood work may be required to ensure that it has been effective.

People can also be insufficiently well prepared for the effects of a medical abortion, which, according to our participants, can be a very bloody and painful process depending on how advanced the pregnancy is. People may end up at a hospital because they think something has gone wrong. One particularly harrowing story told to us recounted how the patient had been prescribed Mifegymiso three times rather than being referred for a procedural abortion, and ended up with a more serious infection.

One participant told us that there have been a significant number of cases where people have sought procedural abortions because of a "failed abortion." Other people have sought help at Clinic 554 specifically because they had a negative experience with a medical abortion in the past or presented at the hospital emergency ward because of the level of pain and bleeding.

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[100] Allison Gilbert et al., "At-Home Urine Pregnancy Test Assessment after Mifepristone and misoprostol for Undesired Pregnancy of Unknown Location," *Contraception* 120 (2023): 109955, https://doi.org/10.1016/j.contraception.2023.109955.

[101] Government of New Brunswick, "Medical Abortion Program - Q&A," June 20, 2017, https://www2.gnb.ca/content/gnb/en/departments/health/MedicarePrescriptionDrugPlan/NBDrugPlan/ForHealthCareProfessionals/medical_abortion_program_qa.html.

[102] Vitalité Health Network, "Abortion," accessed September 18, 2023, https://www.vitalitenb.ca/en/points-service/sexual-health/pregnancy/unplanned-pregnancy/abortion.

Covering medical abortion is not a substitute for covering surgical abortion.

Our participants concluded that there will always be a need for procedural abortions because not everyone will realize that they have an unwanted pregnancy within nine weeks, and a medical abortion is not always a viable option for people who have other medical conditions.

Finally, participants noted that in the absence of access to procedural abortions, the decision to have a medical abortion is not entirely voluntary. Limiting access for funded procedural abortions to a few designated hospitals prevents people from accessing the kind of care they want and need when they want it. When people cannot overcome the barriers to access for a procedural abortion, medical abortion cannot be considered a genuine "choice." According to our participants, this affects low-income patients more. Participants expressed the concern that a medication abortion may be the only viable option for some people who lack economic means to travel and take time off work, not because it is the most suitable, but because it is the only affordable option.

Although access to medical abortion can address some of the issues related to confidentiality, time off work, organizing childcare, travel costs and time, it also has the effect of privatizing the burden of abortion care to the patient and further removing the conversation about abortion from the public sphere.

4.4 Informational Gaps

A recurring theme among our participants was that lack of reliable and trusted information about abortion care. Participants pointed out that this is not new, referencing that the scarcity of reliable information, combined with the efforts of anti-abortion movements to intimidate abortion seekers and providers, spread misinformation, and perpetuate stigma, were seen as longstanding barriers to access in the province. Our participants expressed the view that one consequence of suppressing information about abortion is that people are not able to access the care they need. When patients do not have a primary care provider or are not able to get useful advice from their health care provider, they are left to do their own research, usually online. This can be difficult, because as one respondent explained, people may not know where to look, who to call, or what to ask for. When people are panicked about their situation, it can be difficult for them to conduct research and process information about where to go, what to do, and how many appointments are required.

When asked where to find information, participants most commonly recommended calling Clinic 554 for non-judgmental, accurate and complete information about all options. Some participants mentioned calling the hospitals where abortion services are provided, their physicians if they have one, or local walk-in clinics. Several participants identified online research as the most valuable approach, and that information about both medical and procedural abortions is available on the Clinic 554 FAQ page and RJNB.org. This data suggests that patients are required to rely on their own capacity to research and comprehend information about the landscape of abortion care in the province in order to

access this service. While grassroots groups such as MyChoiceNB and Reproductive Justice New Brunswick are engaged in continuous efforts to improve knowledge about where, how, and when to access abortion care in New Brunswick, the lack of public health information creates a considerable burden on pregnant people to have to learn about and navigate different points of access on their own, especially if they do not have a primary care provider or one who patients feel it is safe to speak with about abortion.

The burden of navigating information among patients raises the issue of health literacy in New Brunswick. A 2008 report by the Canadian Public Health Association demonstrated that health literacy in Canada was low, with New Brunswick facing some of the lower rates of health literacy in the country.[103] While an older study, this report highlighted lower health literacy among structurally marginalized communities including newcomers, people with disabilities and older adults. Given the relationship between health literacy and health outcomes, access to reliable and easily understood information is essential. Furthermore, as discussed below, the information about abortion provided by the Government of New Brunswick is not written in clear language creating additional barriers to comprehension, especially in a province where 1/5 adults has a literacy rate below the national average. Beyond health literacy, language is a barrier to access, with Francophone participants reporting a need to choose between timely care or care in French. One participant stated:

> *It's very difficult to get care in your own language. We hear that a lot… Either they have to choose to have an abortion or other sexual and reproductive health service in their language or in English, or, well, they have to wait. But you can't wait for an abortion, for example, or you can't wait for childbirth.*

Another raised concerns about access to equal levels of care when the ability to exercise language rights is not available.

> *Numerous studies show that when you are treated in a language that is not your own, you are exposed to risks of medical errors, complications, pain or inadequate follow-up. There really are a lot of problems. It's not just an inconvenience because it's not in our language. These are real medical problems, which then have to be managed.*

The issue of language rights in medical care is not new to New Brunswick. It was an arbitral decision, later overturned in court, that allowed for the hiring of unilingual paramedics and brought the issue of language in health care access to the forefront. Our research suggests that access to inclusive and certain care may be further mediated by disparities in bilingual services.

[103] Irving Rootman and Deborah Gordon El-Bibbety, *A Vision for a Health Literate Canada: Report of the Expert Panel on Health Literacy* (Ottawa, Ontario: Canadian Public Health Association, 2008), https://www.cpha.ca/vision-health-literate-canada-report-expert-panel-health-literacy.

Our research also confirmed that people tend to seek information about abortion care at the time that they need it rather than learn about it through public information or in educational settings. This is not surprising. Participants pointed out that there are few public sources of information and there is no public health advertising about the services available. Further, information about abortion has not been included in the school health curriculum.

In the short term at least, information about abortion care must therefore be responsive to information seekers who are experiencing an unintended pregnancy. Since this is a stressful situation, it is important that the information is easy to find, accessible and trustworthy. Unfortunately, that is not currently the case. When it comes to online research, many participants noted that in their experience, so-called pregnancy centres often come up in information searches before services that provide accurate information about pregnancy options and offer abortion services. Crisis pregnancy centres are widespread, even in cities like Saint John where there are no abortion providers.

At the time of writing, there are two websites with information and contact numbers for the hospital-based family planning clinics available through the Horizon[104] and Vitalité[105] Health Networks.

The Horizon website lists available services at the Moncton City Hospital as assistance in pregnancy decision-making, procedural abortions for pregnancies of less than 14 weeks, and up to 16 weeks depending on physician availability, medical abortions for pregnancies less than nine weeks gestational age, emergency contraception and counselling, as well as services related to intrauterine devices and contraception implants. The website provides links to the family-planning clinics in the Vitalité network, Clinic 554, and a Horizon site regarding Women's and Children's Health. The site states that people can self-refer. It also provides a toll-free number and recommends leaving a voicemail due to high call volume. One participant reported calling a few times to arrange abortion care at the Moncton City Hospital, and when they could not get an answer, they were prompted to leave a voice mail. To our participants, it seemed unreasonable to expect everyone who calls to be comfortable leaving a voicemail when seeking information about a time-sensitive procedure, particularly in situations where people are marginalized or vulnerable. These concerns were exacerbated by the fact that the prompt to leave a message does not provide a time frame for the return call.

The site is available in English and French, and the French version of the site does not indicate the language of service at the hospital. The Horizon website also has a chart of answers to frequently asked questions (FAQ) about medical and procedural abortions. The FAQ section provides a chart of short answers to commonly asked questions about both medical and procedural abortions. On the positive side, the site is easy to find, particularly if the search includes "Moncton" as a search term. It also provides accurate, up-to-date information about the services offered at the Moncton Hospital. The site is

[104] Horizon Health Network, "Family Planning Clinic - Abortion Clinic," accessed September 18, 2023, https://horizonnb.ca/services/clinics/family-planning-clinic-abortion-clinic/.
[105] Vitalité Health Network, "Abortion."

mostly written in neutral language. However, the information on the site has a Flesch-Kincaid Score of 46, which brings it into the "difficult to read" category. It is easy to see why. It uses long words and technical language such as "uterine aspiration" and "pregnancy tissue." It also requires knowledge of how medical professionals describe the stages of pregnancy. There is no explanation for the calculation of gestational age. It would be difficult for many people to successfully interact with the information provided on the website, particularly while experiencing a high level of stress. The information is also incomplete, as it does not provide information about costs for people without a health card. Finally, the site makes no reference to abortion care services for trans people.

Matters are much more concerning on the French side. The Vitalité site offers "go through with the pregnancy" as the first option under the "unplanned pregnancy" tab, which then links back to "planned pregnancy." Next, it discusses "adoption" and provides phone directions and a "useful link." It requires scrolling to the bottom of the page for a mention of abortion and another click on "to learn more" to access even the minimal information that people can self-refer, the contact numbers for the Family Planning Clinics at Chaleur Regional Hospital (Bathurst) and the Dr. Georges-L. Dumont University Hospital Centre (Moncton), and additional links for information about adoption and medical abortion. It does not provide a link to the Horizon site, even in the English-language version of the site, and it does not appear to provide any of the information that is available on the Horizon FAQ site. It also indicates a gestational limit of 13 weeks and six days for all hospitals, which is at variance with the information provided by Horizon for the Moncton City Hospital. Clinic 554 is not linked for procedural abortions, but is linked for medical abortions. Like the Horizon site, the Vitalité site provides no information about the cost of the procedure for a person who does not have Medicare coverage.

Access to information is made more complicated by the lack of reliable internet access in rural parts of the province, specifically in the northern part of the province. While the New Brunswick government has taken steps to improve access, there are still large portions of the provinces without reliable internet access. Given the lack of materials about abortion in public spaces, such as doctors' offices and public health offices, as noted by some participants, virtual information is an important resource.

Neither the Horizon nor the Vitalité site permits the booking of appointments online.

We next considered information access over the phone. Participants told us that accurate information about abortion access was not always available from health care providers or the staff answering the public health information number (811), either because they were ill informed or anti-choice. Participants expressed concern that while people have been able to self-refer for procedural abortions since 2017, doctors can still influence how easily and quickly their patients can access the abortion services they need, and some have been known to attempt to dissuade their patients from having an abortion.

One participant who once worked in a nearby province reported that their office received many calls from New Brunswickers looking for information about how to access abortion care there because they did not know what services were available in their own province.

Indeed, the PEI website is not only easier to read, it also provides clear information about services at the Moncton Hospital.

We also tried to obtain information on the issue of costs for people without Medicare coverage. For this purpose, project staff contacted the (hospital) Family Planning Clinics to inquire. The only location where anyone answered the phone directly was in Bathurst. There, the person who answered said it would be "at least $1,000." The staffer left messages at Moncton City and Georges-L. Dumont hospitals, and only the call to Moncton City was returned the next day. The latter informed the caller that abortions not covered by Medicare and performed at Moncton City Hospital cost $2,770, of which $180 must be paid on the day of the procedure for the doctor's fee. Staff answering the phone also suggested that Clinic 554 was another option.

Another concern expressed by participants was that health care providers were not always a reliable source of information. Negotiating the health care system often requires overcoming a mixture of systemic issues, ignorance, and a lack of trained personnel, or dealing with health care providers who are not always supportive of the right to choose. In the event that a person has a primary care provider (PCP), they may seek advice regardless of whether they are required to do so in the hopes of receiving accurate information. Accurate information is not always available from general practitioners if they are either ill -informed or anti-choice. Another participant who works in health care finds it necessary to maintain a list of "safe" providers to whom patients in their care can be referred for reproductive health services.

> *… but our health care system is supposed to be … a separate agency from government. However, government controls it. So the people that are in control within the government -- and currently our government has very toxic views about abortion, they're very vocal about these toxic views … That is seeping down into the health care system because it's okay for … family doctors to not prescribe birth control. … There are no repercussions to that. … we're also guided in our services and our access to money and our access to services, by the government, who very strongly and very vocally does not believe in abortion access and doesn't see a problem there … Despite literally being told, "You have a problem."*

Nine participants described a lack of accurate knowledge among medical care providers, likely because, as three participants explained, nursing schools do not teach the subject at all, and medical schools devote very little time to it outside of a specialized OB/GYN residency. One participant who was a medical practitioner spoke of their peers being surprised that a general anesthetic was not required, and how there was a general lack of understanding among their colleagues about the simplicity and straightforwardness of the procedure.

> *I remember one of my colleagues being so surprised that women could go in and not even need anesthesia or anything like that, and just having a local anesthetic and some laughing gas. She was so shocked because she thought it was this big procedure that required general anesthesia and*

that everybody needed an IV, and so I really encountered a lot of people who just didn't understand and didn't know because they had never been exposed to it.

Thirteen participants mentioned challenges associated with having an unsupportive medical practitioner when accessing abortion care. Participants reported being judged, challenged or actively discouraged from having an abortion by their care provider, and of being afraid to talk to their care provider because of the provider's religious or personal beliefs. Twelve participants discussed a fear of reprisal, which meant patients did not disclose their reproductive history or felt the need to lie because they worried that either they or their families would lose access to their family doctor over the choice to have an abortion. Health care providers described supporting people whose primary health care provider had undermined their trust, made them feel judged or disrespected, and caused real harm.

The lack of information in publicly funded health care organizations such as clinics, hospitals, public health offices, etc., is particularly problematic since anti-abortion organizations use their public protest techniques and multiple media and advertising tools to spread misinformation. As one respondent described, people only see anti-abortion advertisements near pregnancy centres and Christian organizations, and never advertisements for abortion care access.

I've been out and about the city and I've seen posters which says, "Pregnant? Do you have questions?" None of them are ever for safe and accessible abortion, it's always for women's care centres that are like Christian fronts that are like, "Let's convince you to have your baby!"

Participants mentioned seeing anti-choice posters in urban areas and billboards in rural areas of the province.

I did notice just driving around rural New Brunswick, seeing the billboards that say it begins at conception, and every life matters. I don't know if it's where people are seeking information, but it is unsolicited opinions about abortion that you're just driving by. Those are all over Canada too, I don't think it's specific to New Brunswick, but I don't like them.

Given the abundance of anti-choice information and the inaccessibility and scarcity of public information about the available services, Clinic 554 and community groups have had to step up to fill in the gaps, but these tend to be of limited scope. With the closure of the practice and the sale of the building at 554 Brunswick St, as well as the voluntary nature of RJNB membership, it is not clear how long these unofficial resources can be sustained.

As one participant noted, people who live outside of Fredericton may not know they can get support from Clinic 554 and organizations like Action Canada. This was the situation one participant found themselves in when they discovered they were pregnant during the COVID-19 pandemic and travel was frequently restricted. They were not sure what options were available in the Fredericton region. Because they were not a good candidate for a medical abortion, and the pregnancy was causing them significant stress, it was more efficient for them to absorb the cost of PCR testing and travel to another province where they were eligible for a funded, clinic-based procedural abortion.

At least two different community-based groups have set up websites to provide accurate and accessible information for the public. Reproductive Justice New Brunswick (RJNB), an advocacy group made up of volunteers who first came together in response to the closure of the Morgentaler Clinic in 2014, maintains a website[106] with access information as well as archived content. Since data collection for this project was completed, a self-organized group of NB health professionals has set up a website called My Choice NB with information about sexual health, abortion methods, and contraception. Both of these sites also link to the Clinic 554 website, which provides information about the clinic, a deeper level of detail about medical and procedural abortion procedures, a list of resources, and a phone number.

Not advertising either procedural or medical abortion services in traditional or new media, and relying on volunteers to provide information about abortion, means that people do not have enough information to make the best decision for themselves. This information deficit disproportionately affects people who are already vulnerable or marginalized. People in the province who do not have a provincial health card may think, based on the information we have from the government, that they need one and perceive themselves to be ineligible to access care. There is a real shortage of information that is specifically directed at youth, leading to an over-reliance on poor quality or jurisdictionally inaccurate sources of information. Youth, who may feel more pressure to be secretive about an unintended pregnancy, are more likely to be impacted by the challenges of accessing funds for a clinic procedure or transportation to a hospital. They may also experience the fear of discovery when taking time off from school or work might result in a phone call home.

Closing informational gaps is key to improving access to abortion care in New Brunswick.

4.5 Practical Barriers

In a place where abortions are a lawful and generally available service to the public, access to abortion is unquestionably a human right which may not be denied or hindered based on prohibited grounds recognized in human rights legislation. In New Brunswick, the *Human Rights Act* recognizes in its preamble that "human rights must be guaranteed by the rule of law." In s. 6, the Act specifically does not permit discrimination against any

[106] Reproductive Justice New Brunswick – Justice Reproductive Nouveau-Brunswick, "Accessing Abortions in New Brunswick," accessed September 18, 2023, https://rjnb.org/accessing-abortions-in-new-brunswick/.

person or class of persons with respect to any accommodation, services, or facilities available to the public. Prohibited grounds in the Act are broad and include (a) race, (b) colour, (c) national origin, (d) ancestry, (e) place of origin, (f) creed or religion, (g) age, (h) physical disability, (i) mental disability, (j) marital status, (k) family status, (l) sex, (m) sexual orientation, (n) gender identity or expression, (o) social condition, and (p) political belief or activity.

4.5.1 Patients' Barriers to Accessing Funded Abortions

Abortion is a very common procedure. Since the late 1980s, "Canada has had a stable abortion rate of approximately 14.5 per 1,000 females aged 15 - 44 years".[107] Abortion is not specialist care; it is a safe and quick surgical procedure and now also a straightforward course of medication. Despite this, New Brunswick patients continue to experience significant barriers to accessing abortion. In this section, we address the longstanding logistical problems of accessing an abortion. Special attention will be given to those for whom pregnancy, childbirth, and child rearing are the most difficult and who face the most significant barriers to access, notably those who have lived in contexts related to prohibited grounds of discrimination, including race, disability, family status, sex, sexual orientation, gender identity or expression, and social condition.

The cost of an unfunded abortion is obviously a barrier for patients of limited means. Even a funded abortion has ancillary costs that can be difficult to accommodate. Many forms of employment do not have paid sick leave. For others, it can be difficult to get time off, particularly for multiple appointments. A shortage of childcare options may present another barrier for people who already have children. A deeply entrenched barrier is the enduring and crushing stigma associated with the procedure, which is its own burden, on top of a procedure that can be isolating. Travel is a barrier in a province where public transit is limited for anyone who does not live near one of the three hospitals.

Hospital appointments are usually spread over two days. This is not for reasons of medical necessity.

> *… when the clinic opened, I think the implications were a lot better access. 554 had a one-day visit where the hospital required two days. And when 554 asked the government, "Why the two days?" "It's because," they [allegedly] said, "women should need to think about it first before they do it." … it was there intentionally, as a barrier, to delay.*

While it is possible for patients to self-advocate to get all their appointments in one day, this is not widely known. When accessing a hospital abortion, depending on the time of day of the appointments or the distance patients are travelling, there may still be the need for overnight accommodation because public transportation options are limited.

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[107] Dorothy Shaw and Wendy V. Norman, "When There Are No Abortion Laws: A Case Study of Canada," *Best Practice & Research Clinical Obstetrics & Gynaecology* 62 (2020): 54. https://doi.org/10.1016/j.bpobgyn.2019.05.010.

When someone has the financial means, can afford it, or has health insurance that allows them to take time off from work, the resources to set up care for any other children, they can access the type of abortion they prefer and manage their own care. They may prefer a clinic abortion, despite the out-of-pocket cost, as some (3) of our participants did because they could get a timely procedure, it would require fewer appointments, they could be assured of the result, and they knew that clinic staff would be non-judgmental. Also, both the Morgentaler Clinic and Clinic 554 provided a space for childcare when people had to bring other children with them to their appointment, but no such service is available in the hospital system.

> *It depends how much money you have … If you have $1,000 lying around to be able to go to Clinic 554 next week, then, it's easy. If you don't, and you have no idea where to go or you're in a rural area, well, first you need to have access to the internet so that you can find phone numbers for these hospitals … then you need to have access to transportation to those places, so whether that means you have to disclose what's going on to a family member or a friend, you have to pay them gas money, maybe you have to save up money for a hotel stay, because who wants to drive home right after that, meals, that kind of thing. And so, I would say, if you have money, it's easy, if you don't have money, then it's hell. … sometimes weather, or the climate, can be a big barrier.*

> *If you're supposed to go to Clinic 554 on a Friday and there's a snowstorm, you've got another extra week to wait, that's so hard. So many things can happen in that time, and just adds an extra week of uncertainty, or trauma, or whatever that experience is like for that individual.*

Some people may need time to raise the money, and when they do, as one participant mentioned, some find it difficult to accept access donations or other non-governmental funds to help cover their costs. We recognize that requiring abortion care already threatens a person's feeling of autonomy, which may be aggravated by having to rely on financial aid. In any event, a resistance to aid could result in a delayed procedure that is more expensive and uncomfortable, or the person not seeking one at all.

Uncertainty about the abortion stance of their family doctor is another difficult area for many New Brunswickers to navigate. New Brunswick has a long waiting list for access to a family physician in New Brunswick. If people do have a family doctor, they may have to tread carefully because the physician may not be supportive of their patient's access to abortion care. We know that the interaction between anti-choice physicians and patients seeking abortion care has been difficult since the 1970s, when the Moncton Hospital established a clinic to help patients navigate the therapeutic abortion committee process.

Even after a patient has secured an appointment, barriers continue. The co-location of abortion services in Moncton was highlighted by participants. As one interviewee noted, it does not make much sense to have two abortion sites in Moncton but no clinic at the hospital in Saint John, where abortion access is very challenging:

… there was in the city of Fredericton a provision of service there wasn't in Saint John. Now that's third-hand information, I don't know that, having not lived through it. But … it seemed to be known that the most difficult place to access an abortion was in Saint John.

The people who do the booking at 554 and the advocacy for funding have told me that there are some people who are too proud to do that. … They'd rather put up with delays to get to the hospital, go out of province … if they're past the hospital gestational limits, do anything other than put their hand out.

> *If we don't have the service covered by Medicare, then we just further marginalize the people who are most vulnerable who need this service, women, people with uteruses who can't travel to Moncton or to Bathurst, or even to Fredericton from rural places in New Brunswick. That was a barrier that we saw back when I started, and it's a barrier that we're still seeing now, just because of the rurality of where we are.*

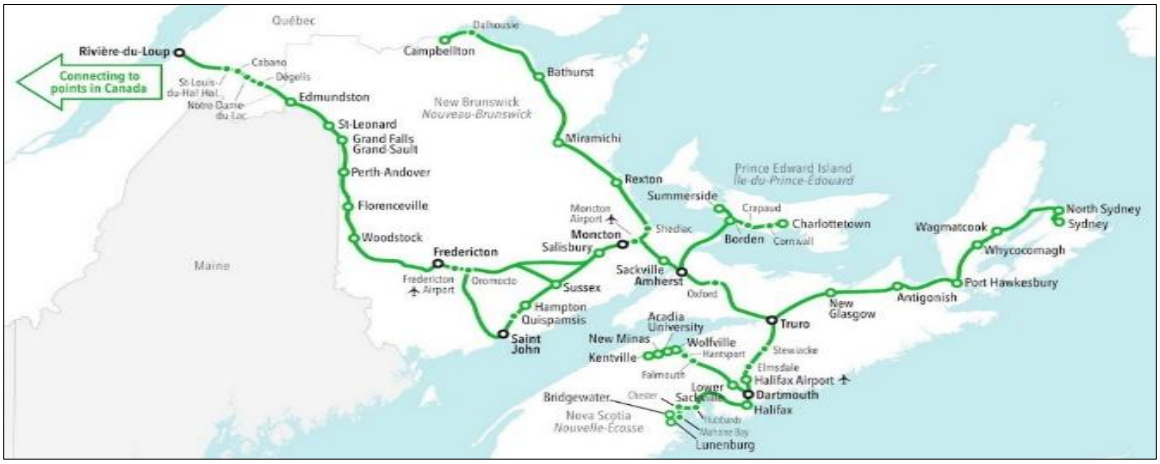
Transportation can be particularly challenging for anyone who lives in a rural area. New Brunswick is 73,440 square kilometres, spanning just over 240 km from east to west, and 320 km from north to south. [108] More than 18,000 km of highways and secondary roads, and 10 ferry routes,[109] with boats running either seasonally (4) or year-round (6), the majority of which are free of charge. Intra-provincial travel by rail is limited as there is only one passenger rail line in New Brunswick with stations in Campbellton, Bathurst, Miramichi, and Moncton.[110] The three largest cities, Saint John, Fredericton and Moncton, have urban transit systems that are struggling. In 2021, two rural transit projects were launched in the Acadian Peninsula and the Chaleur region with

[108] Government of New Brunswick, "Geography," accessed September 18, 2023, https://www2.gnb.ca/content/gnb/en/gateways/about_nb/geography.html.
[109] Government of New Brunswick, "Ferries," Transportation and Infrastructure - Bridges & Ferries, accessed September 18, 2023, https://www2.gnb.ca/content/gnb/en/departments/dti/bridges_ferries/content/ferries.html.
[110] VIA Rail Canada, "Explore New Brunswick by Train," accessed October 25, 2023, https://www.viarail.ca/en/explore-our-destinations/provinces/new-brunswick.

a combined budget of $1.14 million over five years provided by the Rural Transition Solutions Fund.[111]

Maritime Bus has stops in 24 locations, including Moncton and Bathurst, and stations are open six or seven days per week. (Fig. 6[112])

FIGURE 6



We note that during the pandemic, travel had dropped off so much that Maritime Bus was going to cancel routes to Edmundston and Campbellton, but the route was restored when the company received a subsidy of federal ($360,000) and provincial funds ($36,000).[113]

In addition to public transit, we identified a network of services listed on an online pdf where people can arrange rides to medical appointments.[114] A team member called each of the listed numbers three times and when someone answered, they asked if trips to Moncton were possible. When no one answered but there was the option to leave a message, they did. A full half of the services did not pick up or return messages. The following table summarizes the responses received.

[111] Mischa Wanek-Libman, "Canada Opens Rural Transit Grant Intake Process; Awards Projects in New Brunswick with Funds," *Mass Transit*, January 23, 2023, https://www.masstransitmag.com/bus/article/21293266/canada-opens-rural-transit-grant-intake-process-awards-projects-in-new-brunswick-with-funds.

[112] Image taken from Maritime Bus. Available at: https://www.maritimebus.com/en

[113] The Canadian Press, "Maritime Bus Gets $720,000 Subsidy to Operate Routes in Northern New Brunswick," *CTV News*, January 29, 2021, https://atlantic.ctvnews.ca/maritime-bus-gets-720-000-subsidy-to-operate-routes-in-northern-new-brunswick-1.5287970.

[114] Economic and Social Inclusion Corporation Government of New Brunswick, "Community Transportation Services," Social Supports NB, April 10, 2023, https://socialsupportsnb.ca/en/simple_page/community-transportation-services.

These responses illustrate the difficulties with relying on volunteer services. Some places have excellent offerings, but capacity may be very limited, and the service will tend to be less than reliable or accessible.

TABLE 4

Area	Organization	Response
Acadian Peninsula	Déplacement Péninsule	Yes, some people go to Moncton.
Restigouche	Restigouche Community Transportation	Yes, they go to Moncton, they require 48 hours' notice, there is a 25 cent/km fee, which is estimated at $175-200 for a return trip.
Kent County	KENT Community Transportation	Yes, they go to Moncton, they require 48 hours' notice. They operate on a first-come, first-serve basis. If someone is not a client, they need to register to become one. If someone wants to volunteer to be a driver, they need to pass a criminal record check and driver's abstract.
Miramichi/Northumberland	Northumberland Community Transportation	Yes, they go to Moncton, all over NB, and even NS.
Sussex region	Sussex Dial-A-Ride	Yes, they go to Moncton, it's $40, and they require 48 hours' notice.
York County	Urban/Rural Rides	They do travel to Moncton, SJ, and Halifax.
Fundy	Dial-A-Ride Fundy Regional	Not in service
Harvey	Harvey Regional Dial-A-Ride	Left message, no response
McAdam, Charlotte County, Chaleur, Westmorland - Albert	McAdam Transportation/Charlotte Dial-A-Ride/Community Transportation Chaleur, Urban/Rural Rides	No response

Another participant discussed the difficulty in accessing ultrasounds in New Brunswick and how that affects abortion access.

Getting an ultrasound is a huge issue everywhere, as far as I know. Because no matter where you come from, you have to get an ultrasound at the right time, and then you have to get what you need soon after that. So that's certainly a barrier/issue everywhere in the province.

The barriers discussed so far relate to challenges getting abortion care in the first place. However, we also heard about concerns that when accessed, services may be offered in a manner that is discriminatory or unsafe. For example, we heard that accessing a funded abortion at one of the hospitals may not be a safe place for marginalized people.

> *Hospitals are not safe settings for a lot of people, especially vulnerable people, like trans people or people who don't have Medicare, or people who use drugs…*

By contrast, clinics were described as more accessible and less discriminatory contexts of abortion care. Clinics were characterized as more welcoming, private, and safer spaces for abortion access. Both the Morgentaler Clinic and Clinic 554 were set up to provide a wraparound service for people who were there to have an abortion. Unlike a hospital, they offered patients soft robes and counselling delivered by non-judgmental, attentive, and compassionate staff to reduce barriers and create a positive, validating environment for patients.

> *… it's good that hospitals are doing them, but the clinic is a better solution for women having abortions for a whole number of reasons. Confidentiality, just they're welcomed here. There's no prejudice. There's still stories of nurses who did not want to treat women coming in for abortions at the hospital. And so it was often not the most pleasant place.*

> *My thing with [Clinic 554] is, you didn't feel like you were in a hospital. And it takes the burden off what's happening, I think. It's not so… It has to be medicalized, I agree, but not so medicalized, it's like they're dealing with human people here. And every woman knows, when she's here, she's not going to get any bullshit or attitude.*

There are several (8) references to the barriers to accessing abortions present in the hospitals themselves, even if a patient is able to make their way there, or why clinics may be more appropriate or preferred places to access abortions. Two of our Francophone participants raised the concern that it is not always possible to access care in the patient's language of choice.

Given the level of stigma surrounding the procedure, and the relative "smallness" of the New Brunswick population, maintaining confidentiality is a concern. One participant described their concern about the lack of confidentiality and support for people doing their own research and advocacy as medical information and processes are increasingly online.

The stigma that abortion carries also means that the need for confidentiality in accessing abortion care becomes a barrier to accessing abortion care. Another interviewee discussed how accessing abortions is more difficult if you need to keep it confidential.

I can only imagine how hard that was for some of them. If they were in a home, as opposed to abortion, how they were going to handle that and get here and get back. If you worked, how do you take a day off work, what do you tell them? If you're a student, you skip school, but then you've got your parents to deal with, too. So it's pretty hard. And I expect it still is, for a lot. I mean, yes, you can get to Moncton, and that. You still have to get there. You still need to have someone with you. You still need to make arrangements off work. Or whatever you do, whatever your life is. You still have to find a day, and if it's something you want to be confidential, it's much harder.

Both the population of New Brunswick and the clinic building are small, so it was not possible, as one participant explained, to guarantee that you will not run into someone you know either at the hospital or in the clinic. One interviewee talked about their experience with patients and their challenges with maintaining confidentiality while seeking care in hospitals.

I've had patients that go to a hospital where they run into somebody in the waiting, in the post-op. In the, you know, a security guard in the parking lot, like, you name it. It's all the number of humans that you interact with. The person who does your lab, your blood test, the person who does the ultrasound, or the person who helps you change, the person who, like, tells you, you know, the room to go to. All the people that you interact with in the hospital setting in a small place like New Brunswick could be your neighbour, the spouse of your cousin, the… so what happens with these barriers? You know, sometimes people are forced to go to a place where their personal medical information is disclosed and then gossiped about. Because they have no control over the people that they're interacting with.

Patients are often uncertain, and there is widespread fear that there will be consequences for their care if they reveal that they want or have had an abortion. Participants told us that their families knew not to tell certain things to their family doctor who was Catholic or did not tell them about having an abortion because they thought they would be cut from the roster. There is lingering uncertainty about the professional obligation to provide referrals, and we heard of cases where doctors refused to perform a D&C because they objected to the procedure.

Furthermore, participants noted that a patient's identity, life circumstances, and health care needs may significantly shape what method of abortion is best for them. Different methods of abortion care have known advantages and disadvantages. From a research perspective, it is useful to examine the advantages and disadvantages under the criteria for meaningful access established above. To what extent are medical abortions free, certain, inclusive, and local?

COST: Both procedural abortions and medical abortions are publicly funded in some circumstances. As discussed, the funding is incomplete because procedural abortions

provided by clinics are not covered. People without Medicare are required to pay, and for them, procedural abortions are more expensive than medical abortions. However, the cost of a procedural clinic abortion is much lower than that of a hospital abortion. Ancillary costs such as pain management and transportation are not covered. For patients with Medicare coverage and local access, procedural abortions are closer to being free than medical abortions. For patients without Medicare coverage and/or lack of local access, medical abortions are closer to being free. Neither method is fully funded.

CERTAINTY: Procedural abortions can be considered more certain because of their higher success rate. They are also more certain because they are available for a greater range of gestational ages, which is important because patients may be unsure how long they have been pregnant. A medical abortion is also a much longer process and patients report feeling less certain about whether the degree of pain or bleeding they experience is normal. Certainty of outcome is achieved immediately for procedural abortions, but for medical abortions, patients need to wait for the outcome of their follow-up blood work. Certainty of access and certainty of outcome were extremely important to our respondents and may help explain why nationally, two thirds of patients have procedural abortions rather than medical abortions. Hospital abortions are seen as less certain than clinic abortions because of gestational age limits, unclear communications, and the long shadow of hostile governmental regulation.

INCLUSION: Under this criterion, we consider access for patients with different identities and life situations. We analyze how various forms of social marginalization might affect abortion access.

Youth and younger adults make up a large percentage of people accessing abortions. Their age may constrain their choices regarding medical abortion because they may not have access to their Medicare card or to funding for ancillary costs. They often have a lower level of privacy in their living arrangements when living with parents or roommates. They tend to have less experience with contraception and are more likely to discover a pregnancy later. Their experience with medical abortions may be poorer because they have less experience with pain management and will experience more uncertainty about whether their symptoms fall within the normal range. On the other hand, their ability to choose procedural abortions may be constrained by a lack of local access and lack of transportation, close monitoring of their school attendance and a lack of privacy with respect to any absences, and low access to funding if a clinic abortion is their only local access.

At least one third of patients accessing abortions are parents. For them, access to medical abortion may be constrained by the need for multiple appointments, which is often incompatible with childcare arrangements. Many lack paid sick leave, which again impacts the ability to attend multiple appointments. It also affects their ability to arrange for an overnight stay for a funded procedural abortion in a hospital. These factors are even more significant for single-parent households. Being in an abusive relationship, particularly one exerting coercive control, may require a high level of confidentiality and limit opportunities for absences from the home. A lengthy period of bleeding or being

unwell may also attract close scrutiny. For racialized and Indigenous parents, any gap in childcare raises fears of child protection interventions.

A person who does not have safe housing may simply be unable to have a medical abortion. A participant described the barriers that not having safe housing and sanitation infrastructure pose for people accessing abortions, especially medication abortion.

> *I mean, imagine if you're a homeless person, without a toilet, without menstrual pads, or products, any form of sanitation, without a place to wash yourself, right? Your vagina, or your hands, and they are telling you the only option is for you to take this pill and go home and bleed for an average of 10 days? Right? How is that access to an abortion? That is not access to an abortion.*

That said, it is also extremely challenging for someone who does not have safe housing to access a funded hospital abortion, particularly if it is not available locally.

As discussed, abortion is a necessary and common procedure for many different types of patients. To be accessible, it must not only meet the needs of the mainstream, but policymakers must be particularly attentive to the needs of people who are members of human rights protected groups or who are experiencing differential barriers.

4.5.2 Challenges for Providers

Health care professionals and allied service providers noted the lack of formal training on abortion for medical providers, stating that nursing schools do not teach the subject at all, and, as stated above, medical schools devote very little time to it except in a specialized OB/GYN residency.

> *And now, because 554 has been so vocal during the pandemic about this and how much it's impacted patients during a pandemic, that Moncton Hospital started to say that they would provide abortions up to 16 weeks less a day dependent on whether they have a provider. Not all the doctors that work there are competent to provide abortion care up until the sixteenth week. I don't know how many, if the few, that one or two that do, if they don't happen to be scheduled that week, then the person's out of luck and they'll have to travel to a different province. So it's not reliable. It's not like this is care you can guarantee... would be guaranteed access to in New Brunswick.*

Lack of training opportunities directly affects patients. One participant noted that the lack of trained providers who can provide procedural abortions means that New Brunswick has a lower standard of care for pregnant people than anywhere else in Canada.

> *That's the standard of care. That should be the standard of care in Canada. Any abortion, the patient may choose to manage with medications or with the procedure. And we don't offer that in New*

Brunswick. So every person having ... let's call it a miscarriage, right? A spontaneous abortion. When they come into the emergency room, they are offered only medication. And that's because we don't have the staff, the OR space, the OR time, or perhaps, I don't know, but perhaps the willingness of physicians to train, and then be able to provide D&Cs, so, because heaven forbid they be elective, right?

Training is also required regarding the social context of people in need of abortion care. One participant described the need for service providers providing wraparound services to understand all the socioeconomic factors affecting a person's health and health care needs.

Despite the importance of training more providers, there are significant barriers to training new providers in New Brunswick, including that there are not enough trained providers and places that provide abortions in New Brunswick to train providers, and that the stigma of providing abortions and the professional and personal repercussions that come with providing abortions discourage people from wanting training to become abortion providers.

There's no training, so when you think about how do we get abortion providers, I don't know. We have to go back to like med school and residency and how doctors become trained. We have, for instance, in Saint John, there's a family practice residency program, but in Saint John there's no abortion providers that do D&Cs, right? So where are they supposed to get the training? Unless they go out of their way to try and set up an elective and they won't get any training, at least regionally. If they go out of their way to set up an elected with us, you know, regionally. Or if they go out of their way to set up an elective somewhere else.

Well, the thing about getting trained to competency in medicine is that you have to do something enough times to feel like you could do it safely, even if it's not routine, if there are unexpected challenges, right? So we don't offer that in New Brunswick. So between 554 and the Moncton and Bathurst clinics, you [would have]...let's say, they [med students] get a two-week elective. They get 6 days of exposure to abortion care if they travelled all over the province, every region, and if all of our OR days were scheduled on different days of the week, and even then they wouldn't be allowed to do it elective because the other 2 days they would have to fill in somehow. And how are they going to do that? Go to Halifax? I mean, maybe. It depends. As long as everyone's OR days are on different days. Where are they gonna get the fifth day of the week? Are you gonna go to Newfoundland? Go to PEI?

The lack of training and support for providers is not limited to procedural abortion care but also impacts treatment via Mifegymiso. One participant described some of the challenges faced by nurse practitioners who have the professional license to prescribe

medical abortion but lack the support for this additional responsibility. While having the capacity to prescribe medical abortion may democratize access in theory, training and mentorship are key.

> *… Prescribing medication abortion is just super straight forward, but until you get the hang of it, you wanna have someone who can mentor you.*

> *We all know medication abortion's extremely safe, but should something go wrong, and yes there is the odd hemorrhage, there is the odd time you need procedural follow-up, that as a prescriber you won't get the support to have that follow-up or emergent care, right?*

For medical practitioners, some felt that the professional environment can be hostile. There can be personal and professional repercussions for being pro-choice, including exposure to violence and harassment, and being snubbed or frozen out of professional opportunities.

> *So there's no training. There's no adequate training in New Brunswick for someone to become abortion provider. And then, why would you? Because it's very apparent to incoming physicians that if they do, they won't get a call group. They won't, you know, be allowed to practice. And then, let's say they're from Fredericton and their family's here and this is the only place in the world they want to work. If they know they're going to be so poorly treated and not have a call group, and not be able to be employed or hired here, and they just won't. Just not worth it to risk everything that they value in life to provide care for a small number of people. So I think the training is a big barrier.*

Clinic-based services, despite the lack of Medicare funding, have played an essential role in abortion provision in the province but that has come at a high cost to the Clinic providers, allied organizations, and the public health care system. Participants discussed how the two clinics, despite not being funded by the government, have been an integral part of abortion care provision in the province. As one participant noted:

> *[The government] just allows [abortion] to be offloaded by 554, even though they're not getting any funding. They allow it to happen.*

This includes care after the gestational limits of the hospitals. When people are not able to access a timely appointment, staff at the hospitals will suggest contacting the clinic and

the provincial government has always relied on the clinic to provide abortions past a certain gestational age. As one participant pointed out,

> *The hospital referred out of hospital to the clinic from 13/6 to 15/6. So it's not a safety concern.*

We find that clinic-based abortion care is a very important component to providing meaningful abortion access, and that the province has placed a tremendous burden of providing abortion access on clinic-based providers and volunteer organizations. All the gaps we have identified are ultimately caused by a lack of governmental commitment to ensuring free, certain and inclusive abortion care services that provide local access.

4.6 Stigma and Myths

Stigma and myths about abortion were two themes that emerged in the interview and focus group data, although somewhat less frequently than the other themes discussed in this report. Participants spoke to the experiences of stigmatization and/or the fear of stigmatization, and identified and reproduced a number of myths about abortion care. It is not surprising that stigma and myth characterize, at least in part, the abortion story in New Brunswick. Where access to good information about abortion is de-prioritized or, in some cases, outright stymied, stigma and myths flourish.

4.6.1 Stigma

In writing about abortion stigma in Ireland, Cullen and Korolczuk argue that abortion stigma, "While observable as a global phenomenon, is constructed locally through various pathways and institutions…". [115] Hughes, [116] in exploring the link between decriminalization and stigma takes up, as one case study, abortion in the Maritime provinces. She documents the continued significant stigmatization of both abortion providers and those accessing abortion in the period since decriminalization. Within New Brunswick, what became clear from the interviews and focus groups is that stigma about abortion in New Brunswick continues despite the changes to both criminal law and healthcare policy, and operates and is reproduced within three key sites: the medical system, the political system, and among civil society, specifically anti-choice organizations.

At the level of the political system, some of the participants felt that the views of government officials who guide the development of policies that limit access are not rooted in the requirements for good health, but in anti-choice ideology. Participants discussed areas where either the actions or inaction of government, and the appearance

[115] Pauline Cullen and Elżbieta Korolczuk, "Challenging Abortion Stigma: Framing Abortion in Ireland and Poland," *Sexual and Reproductive Health Matters* 27, no. 3 (2019): 6 https://doi.org/10.1080/26410397.2019.1686197.

[116] Jula Hughes, "Perfectly Legal, but Still Bad: Lessons for Sex Work from the Decriminalization of Abortion," *University of New Brunswick Law Journal* 68 (2017), 232-252.

of influence by the anti-abortion movement over policymakers, have contributed to a climate that is hostile to both abortion seekers and providers.

Today, procedural abortion in New Brunswick is not talked about openly by the provincial government, but is, as the introduction of this report discusses, ignored, and erased. Unlike the overtly anti-choice ideology expressed by Premier Frank McKenna,[117] abortion is rarely spoken about in public. Premier Blaine Higgs admitted in a Radio-Canada interview to being pro-life but on the abortion issue he has one line, that there are no barriers to abortion care in the province.[118] Avoiding a straightforward public conversation about abortion as a regular part of any health care system shrouds the procedure in shame and stigmatizes patients. Rather than leadership from the province on providing reliable information about abortion care, the public is met with silence or outright denial that New Brunswickers need and want more abortion care than is currently being provided. This reluctance to discuss abortion care perpetuates stigma about the procedure itself and those who want it. As one participant noted:

> *Not discussing abortion openly makes stigma against the providing and accessing of abortion worse, and as a result anti-abortion activism and sentiment gets very directed at where abortion is visible, such as the clinic and also people seeking abortions … it didn't go anywhere when the clinic went away. Those feelings and those sentiments, if anything, have gotten stronger because they're hidden–*

Within the medical system, participants reported either knowing of or dealing with medical practitioners who, based on their own beliefs, denied reproductive health services ranging from birth control prescriptions to D&Cs, referrals for abortion, and tubal ligation. Certainly, a refusal to provide access to reproductive health care is a judgmental act and reproduces stigma. One participant raised the problem of anti-choice ideology among hospital staff and the need to prepare patients for the "climate of shame" in the hospitals.

> *It's not just whether it's funded or not. It's deeper than that. You don't want to go into the hospital to have it done, where staff maybe, like there was a climate of fear and shame in the hospital. I always have to prepare my patients for their appointments, to say listen, this may happen so make sure you take someone.*

Shame and stigma have a detrimental impact on patients seeking medical care.

Finally, stigma was identified as being reproduced by anti-choice organizations and movements. Next to the Morgentaler Clinic and then Clinic 554 is a "women's care centre," an anti-choice organization that at one point had a vigil-style window display of a plastic fetus. The anti-choice movement in New Brunswick targeted the Morgentaler

[117] *Ibid.*

[118] "Blaine Higgs se dit «pro-vie» et ne veut pas réviser son approche sur l'avortement | Radio-Canada.ca," *Radio-Canada*, accessed October 5, 2023, https://ici.radio-canada.ca/nouvelle/1882852/avortement-debat-legalisation-acces-politique.

Clinic and Clinic 554 with regular protests, necessitating volunteers to escort abortion patients in and out of the building. There remains at least one NB Right to Life march in Fredericton, and participants referenced the existence of anti-choice billboards and posters in the province. Such public displays of anti-choice sentiment, especially when pointed directly at patients, reproduce shame and stigma and create additional labour for clinic volunteers and staff.[119]

One respondent described the negative impact of the anti-choice protesters outside the Morgentaler Clinic and later Clinic 554 for patients seeking care. Another respondent suggested that the emotional stress caused by anti-abortion protesters would likely make the abortion procedure more uncomfortable or painful than it would be normally. While most of the abortion protesting died down when Clinic 554 was opened as a family practice, participants noted that the anti-choice movement has become more subtle, and that it is also possible that it has become more powerful. As one participant stated, "My sense is that the antis are up higher now…" with others having attested to seeing people in positions of power, including medical professionals, senior government officials, and Premier Blaine Higgs, participating in anti-choice activist activities.

The effects of abortion stigma are borne disproportionately by patients from equity-denied groups whose experiences of "social stigmatization [are] exacerbated when they seek abortion care", such as gender minorities, those who are racialized, and those who experience poverty.[120]

Some participants described observing a slight reduction in the stigma surrounding abortion since 2015. They attributed the effect to the work of advocates and the public discussions and statements from provincial and federal politicians in traditional and social media about the closing of the Morgentaler Clinic. Participants suggested that more open, public discussions might encourage people who have had an abortion to feel more comfortable sharing their own experiences. These observations may represent hopeful developments but given the multiple reported impacts of anti-abortion stigma, or even perceived anti-abortion stigma on patients and providers, there is an urgent need for government leadership to take action to reduce stigma about a common health care procedure.

4.6.2 Myths

In addition to recounting observations and experiences of stigma, participants identified a number of myths about abortion that circulate in the absence of good information and an open conversation about abortion care. There were two types of myths that appeared in our data: myths that were observed by participants and myths that were perpetuated by participants.

[119] Rebecca Lentjes, Amy E. Alterman, and Whitney Arey, "'The Ripping Apart of Silence': Sonic Patriarchy and Anti-Abortion Harassment," *Resonance* 1, no. 4 (2020): 422–42, https://doi.org/10.1525/res.2020.1.4.422.

[120] Cullen and Korolczuk, "Challenging Abortion Stigma.", 8.

Myths observed by participants came from in-person conversations, by word of mouth, or on social media. Examples included a number of anti-abortion talking points: four mentions of myths about abortion as an unsafe procedure, four mentions of "abortion as birth control" rhetoric, two mentions of doctors performing abortions because it is profitable, and myths about who gets an abortion.

I think there's also a myth about who accesses abortions. I still think there is a myth that it's this irresponsible party girl who is just going around, or I heard people say that people just use it as a form of birth control…

This is indeed a myth. One in three people with a uterus in Canada will have an abortion in their lifetime, many of them people who already have children.[121]

Additional myths identified by participants included that there was "nowhere" to access an abortion, and that abortion care in New Brunswick was more restrictive than it actually is. Myths perpetuated by participants included the idea that abortion is a complicated, difficult procedure, requiring general anesthetic, that abortion was never covered under Medicare in New Brunswick, and that there is a weight limit for Mifegymiso.

As with stigma, there is a need for government leadership and a fostering of open dialogue about abortion as part of a reproductive health care system. Without open access to good information, stigma and myth will persist. The lack of local, clinic-funded abortion affects timeliness, the certainty of outcomes, and heightens stigma while denying abortion seekers a common health service.

5.0 Conclusion and Recommendations

This report has documented numerous sociopolitical, legal, informational, and logistical barriers to procedural abortions in New Brunswick, as well as some barriers to medical abortion. Resoundingly, the qualitative and quantitative data demonstrate that the status quo in New Brunswick is not one where publicly funded procedural abortion is "very accessible." The reliance on Clinic 554 to access procedural abortions, the misinformation present in everyday discussions of all aspects of abortion care, the significant labour involved in identifying existing pathways to publicly funded abortion care, the emotional strain caused by the uncertainty involved in waiting for hospitals to return calls to set a date, and the stress and financial costs involved in organizing transportation to hospitals are just a few examples of how access to publicly funded abortion is made unnecessarily complex. Moreover, the qualitative data shows that the impact of these barriers to Medicare-covered abortion is not borne equally, but creates disproportionate hardships for patients who experience poverty, who live in rural communities, who are racialized and experience racism within medical spaces, and who do not have access to a pro-choice primary care provider or a primary care provider who is knowledgeable about abortion in New Brunswick. For abortion care to be truly accessible in New Brunswick, it must be local, certain, inclusive and free. What follows are key recommendations that emerged

[121] Shaw and Norman, "When There Are No Abortion Laws: A Case Study of Canada."

from the research. These reflect both the insights of the many stakeholders we spoke to during the research.

While the data from this project makes it clear that the Government of New Brunswick needs to act to ensure that abortion is accessible for all who want one, access is not only a provincial issue. The federal government has a role to play in expanding abortion access across the country, especially in rural communities and among equity-seeking groups who face additional barriers. A leadership role for the federal government is particularly important for New Brunswickers where the province has lost credibility in abortion care due to a persistent unwillingness to acknowledge and address access gaps. The following recommendations speak, therefore, to steps that can be taken by both levels of government.

Recommendation 1: The Government of New Brunswick should repeal paragraph 2.01(b) a.1 of Schedule 2 of the General Regulation under the Medical Services Payment Act NB Reg 1989-84-20.

The most popular and longstanding recommendation is the repeal of Regulation 84-20 (a.1)of the[122] which limits Medicare coverage for procedural abortion to three hospitals in two cities. Removing this regulation does not require a legislative amendment but merely an order-in-council. The repeal would allow medical professionals trained in abortion care to offer Medicare-covered procedural abortions in their own communities, thereby reducing the logistical and financial barriers identified through this research such as transportation and overnight stays, additional time off of work, childcare, and identifying a trusted support person to accompany the patient. Additionally, the repeal of 84-20 (a.1) should reduce wait times for both abortions and other reproductive care services in New Brunswick's overburdened hospitals.

Repealing 84-20, however, is only a starting point for improving abortion access in the province. Additional work around information gaps and rural access, for example, needs to be considered if procedural abortion care in New Brunswick is to be truly integrated into the landscape of the province's health care system. To date, the federal government has tried to encourage the New Brunswick government to address access gaps in abortion care by withholding a portion of the Canada Health Transfer that reflected extra billing and user charges paid by patients in need of abortions.[123] It is time for the federal government to consider other policies to support more equitable access to not only procedural abortion care but all abortion care across the country. The following recommendations address potential tools to facilitate abortion access beyond withholding CHT funds.

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[122] *General Regulation - Medical Services Payment Act,* NB Reg 1989-84-20.

[123] Health Canada, *Canada Health Act Annual Report 2020-2021*, (Ottawa: Health Canada, February 2022), https://www.canada.ca/content/dam/hc-sc/documents/services/publications/health-system-services/canada-health-act-annual-report-2020-2021/canada-health-act-annual-report-2020-2021-eng.pdf.

Recommendation 2: The Government of Canada should direct CIHI and Statistics Canada to develop and implement a national strategy for addressing data gaps in abortion care.

Misinformation about abortion is one of the most significant barriers to abortion care in New Brunswick, including procedural abortion care. A lack of knowledge about gestational age limits, different types of abortions and abortion procedures, where to get an abortion, who can provide an abortion, and the cost and risks of abortion permeated the data. This misinformation or missing information was not limited to patients but emerged in relation to health care providers who do not offer abortion care as well. Grassroots groups such as Reproductive Justice New Brunswick and MyChoiceNB, and national organizations such as the National Abortion Federation and the Canadian Abortion Providers Support forum, have sought to address these persistent issues of misinformation and missing information. There is, however, also a need for government leadership on the issue. The province, given its history of anti-abortion politics and persistent unwillingness to acknowledge existing barriers to abortion care, has limited credibility on the issue.

Canada is home to abortion organizations and abortion and health educators and scholars who are working to dispel myths and misinformation,[124] [125] calling for curriculum changes in medical education,[126] and have developed Mifegymiso tools for pharmacists,[127] [128] to name a very few interventions. Fortunately, the federal government has recognized the need to support and build on this expertise and has announced $3.5 million for projects led by Action Canada and the National Abortion Federation to improve access barriers, including access to "accurate reproductive health information".[129] Action Canada will expand the Access Line and Sexual Health Information Hub while the National Abortion Federation of Canada will provide financial assistance to those in need of abortion care, train health care providers in abortion care, and support abortion facilities.

To complement this work of improving access and knowledge and dispelling myths, there is a need for the federal government to support the development of a national plan for abortion data gathering and analysis. As discussed at length in this report, the lack of

[124] Roopan Gill and Wendy V. Norman, "Telemedicine and Medical Abortion: Dispelling Safety Myths, with Facts," *MHealth* 4 (2018): 3, https://doi.org/10.21037/mhealth.2018.01.01.

[125] Action Canada for Sexual Health and Rights, "Common Myths About Abortion," April 5, 2023, https://www.actioncanadashr.org/campaigns/common-myths-about-abortion?psafe_param=1&gclid=CjwKCAjwpJWoBhA8EiwAHZFzfuzgLP7IL4VIplbBYrsJfWQ4aGD8pfhxTHMU3wLfhyvImXt2lVt4NxoCsVMQAvD_BwE.

[126] Julia Lew and Ashley Waddington, "Therapeutic Abortion in Undergraduate Medical School Curricula: A Systematic Review of the Literature," *Journal of Obstetrics and Gynaecology Canada* 41, no. 5 (2019): 723. https://doi.org/10.1016/j.jogc.2019.02.202[126]

[127] Ashley Bancsi and Kelly Grindrod, "Medical Abortion: A Practice Tool for Pharmacists," *Canadian Pharmacists Journal / Revue Des Pharmaciens Du Canada* 152, no. 3 (2019): 160–63, https://doi.org/10.1177/1715163519840270.

[128] Nevena Rebic et al., "Pharmacist Checklist and Resource Guide for Mifepristone Medical Abortion: User-Centred Development and Testing," *Canadian Pharmacists Journal / Revue Des Pharmaciens Du Canada* 154, no. 3 (2021): 133–221, https://doi.org/10.1177/17151635211005503.

[129] Health Canada, Government of Canada, *Government of Canada Strengthens Access to Abortion Services*, May 11, 2022, https://www.canada.ca/en/health-canada/news/2022/05/government-of-canada-strengthens-access-to-abortion-services.html.

access to reliable, comparable data on both procedural and medical abortion frustrates the ability of scholars, health care providers, and policymakers to assess the need for abortion, the efficacy of current abortion mobilized access strategies, and the capacity of existing health care systems to meet abortion need. For example, the Canadian Institute for Health Information once reported significantly greater data on abortion care in New Brunswick, including abortion numbers broken down by gestational age data, which is vital to understanding the impact of Mifegymiso. We recommend that the federal government provide support to the Canadian Institute for Health Information in developing a more robust database of abortion information across the country and request Statistics Canada to include questions about abortion on the census, specifically about Mifegymiso usage.

Recommendation 3: The Government of Canada should work with provincial and territorial governments to develop and implement a rural abortion access strategy.

The qualitative data demonstrate that a key logistical barrier to abortion access in New Brunswick is geography. As of the last census, more than 49% of the New Brunswick population lived in rural communities[130]. People living in rural areas often have farther to travel for abortion care and live without reliable access to public transit, making transportation to hospitals or Clinic 554 more difficult and, in many cases, more expensive. At the same time, internet coverage in many rural parts of New Brunswick is poor, frustrating access to reliable information. These barriers are especially concerning for northern New Brunswick, a mainly rural part of the province, which has a high rate of poverty and is home to a largely Francophone population who may experience language barriers in the process of travelling south for abortion care.

These barriers to abortion care for rural populations are not limited to New Brunswick. Across the country, people living in rural and remote communities experience "enormous travel burdens to access [abortion] care,"[131] as well as higher rates of economic poverty[132] that make the financial costs of accessing health care especially burdensome, resulting in poorer health overall.[133] [134] Paynter[135] offers recommendations for improving access in rural and remote communities, such as allowing midwives and nurse practitioners to provide procedural/surgical abortions and mobilizing the wealth of knowledge among medical professionals to better distribute Mifegymiso (the abortion pill) through a no-touch prescription model. The potential of Mifegymiso to address disparities in abortion

[130] Statistics Canada, "Population Growth in Canada's Rural Areas, 2016 to 2021," February 9, 2022, https://www12.statcan.gc.ca/census-recensement/2021/as-sa/98-200-x/2021002/98-200-x2021002-eng.cfm.

[131] Martha Paynter, "How Can Canada Improve Access to Abortion Care?," University of New Brunswick, *Women's Health Research Cluster* (blog), March 24, 2023, https://womenshealthresearch.ubc.ca/blog/how-can-canada-improve-access-abortion-care.

[132] C. Ruth Wilson et al., "Progress Made on Access to Rural Health Care in Canada," *Canadian Family Physician* 66, no. 1 (2020): 31–36, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7012120/.

[133] *Ibid*.

[134] Deanna White, "Development of a Rural Health Framework: Implications for Program Service Planning and Delivery," *Healthcare Policy* 8, no. 3 (February 2013): 27–41, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3999556/.

[135] Paynter, "How Can Canada Improve Access to Abortion Care?"

access in rural areas is also noted by Norman et al.,[136] and Renner et al.[137] Norman et al.[138] further notes that the majority of procedural/surgical abortion providers in Canada are family doctors and, in an earlier study, suggests that "moving surgical abortions out of operating rooms [in hospitals] and into local ambulatory care facilities"[139] could improve access in rural areas. We would recommend, given the capacity of family physicians to perform surgical/procedural abortions, that this service be provided in family practice clinics to improve rural access. The federal government, in collaboration with the provinces and territories, expert stakeholders named above, and organizations like Rural Road Map Implementation Committee, [140] the National Collaborating Centre for Indigenous Health, and la Société Santé en français, should develop a rural and remote abortion-specific access strategy to provide the resources required to implement these and other solutions to the rural and remote access problem. Every person who wants an abortion should be able to have one as close to their community and care networks as possible.

Recommendation 4: Governments at all levels should collaborate on strategies for meeting the needs of members of equity-seeking groups requiring reproductive healthcare, including striking an inter-ministerial committee.

As stated at the beginning of the report, Reproductive Justice is about more than access to abortion. It is about access to the economic and social supports that allow for comprehensive reproductive autonomy. [141] [142] That is, reproductive justice is only achieved when women and gender minorities have comprehensive access to reproductive health care and the social and economic supports that provide them with the means to control when and how they reproduce, the structure and size of their families, and how they use birth control.[143] [144] While access to medical and procedural abortion is certainly

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[136] Wendy V Norman et al., "Could Implementation of Mifepristone Address Canada's Urban–Rural Abortion Access Disparity: A Mixed-Methods Implementation Study Protocol," *BMJ Open* 9, no. 4 (2019): e028443, https://doi.org/10.1136/bmjopen-2018-028443.

[137] Regina M. Renner et al., "Abortion Services and Providers in Canada in 2019: Results of a National Survey," *CMAJ Open* 10, no. 3 (2022): E856–64, https://doi.org/10.9778/cmajo.20210232.

[138] Norman et al., "Could Implementation of Mifepristone Address Canada's Urban–Rural Abortion Access Disparity."

[139] Wendy V. Norman et al., "Barriers to Rural Induced Abortion Services in Canada: Findings of the British Columbia Abortion Providers Survey (BCAPS)," *PLOS ONE* 8, no. 6 (2013), 6: e67023, https://doi.org/10.1371/journal.pone.0067023.

[140] An organization co-sponsored by the College of Family Physicians of Canada and the Society of Rural Physicians of Canada. See https://www.cfpc.ca/en/member-services/committees/rural-roadmap-implementation-committee

[141] Zakiya Luna, *Reproductive Rights As Human Rights: Women of Color and the Fight for Reproductive Justice* (New York University Press, 2020), https://web-p-ebscohost-com.proxy.hil.unb.ca/ehost/ebookviewer/ebook/bmxlYmtfXzI0NjU0MDNfX0FO0?sid=607c907e-0a88-4a83-b810-99568fac9189@redis&vid=0&format=EB&rid=1.

[142] Loretta Ross and Rickie Solinger, *Reproductive Justice: An Introduction* (University of California Press, 2017), https://web-p-ebscohost-com.proxy.hil.unb.ca/ehost/ebookviewer/ebook/bmxlYmtfXzE0Nzc5ODFfX0FO0?sid=9b00b477-8163-45f7-848c-4d2075d2224c@redis&vid=0&format=EB&rid=1.

[143] *Ibid.*

[144] Luna, *Reproductive Rights As Human Rights: Women of Color and the Fight for Reproductive Justice.*

part of reproductive justice, simply providing better access to abortion care will not address the gendered and racialized poverty and persistent transphobia that, fundamentally, denies so many people control over where and how they reproduce or choose not to reproduce, parent or choose not to parent, and otherwise build their families. At a minimum, the economic and medical oppression of equity-denied groups must be addressed, including the devaluation and, in some cases, limitation of the reproductive capacities and choices of racialized, Indigenous,[145] [146] disabled,[147] and other equity-deserving groups.

The federal government can play a role in supporting reproductive justice beyond implementing the recommendations above. From a policy perspective, the federal government could create an inter-ministerial committee (e.g., Ministries of Health, Indigenous Services; Families, Children & Social Development; Housing, Infrastructure & Communities; Women & Gender Equality & Youth; Rural & Economic Development; Diversity Inclusion & Persons with Disabilities; Mental Health & Addictions) to work together on complementary policymaking across these portfolios, with meaningful reproductive autonomy in Canada as the goal. Such an undertaking would be a continuation of the federal government's community to a GBA+ approach to policymaking and program design.[148]

New Brunswick was the first province to provide Medicare coverage for Mifegymiso and is well positioned to be a leader in providing comprehensive, publicly funded abortion care, that is, abortion care that is free, certain, inclusive and local. New Brunswick already has the institutional capacity to expand abortion access. There are two health authorities coordinating healthcare in a small place with a small population. Moreover, as this research has demonstrated, there is a wealth of knowledge in the province about the steps that need to be taken to address persistent access gaps that disproportionately impact equity-deserving groups. The time to act is now.

[145] Karen Stote, *An Act of Genocide: Colonialism and the Sterilization of Aboriginal Women* (Halifax: Fernwood Publishing, 2015).

[146] Chaneesa Ryan, Abrar Ali, and Christine Shawana, "Forced or Coerced Sterilization in Canada: An Overview of Recommendations for Moving Forward," *International Journal of Indigenous Health* 16, no. 1 (2021): 275–90, https://doi.org/https://doi.org/10.32799/ijih.v16i1.33369.

[147] Tobin LeBlanc Haley, "Intimate Constraints: A Feminist Political Economy Analysis of Biological Reproduction and Parenting in High-Support Housing in Ontario," *Palgrave Communications* 3, no. 1
(2017): 1–12, https://doi.org/10.1057/s41599-017-0053-9.

[148] Women and Gender Equality Government of Canada, "Government of Canada's Approach on Gender-Based Analysis Plus," September 18, 2023, https://women-gender-equality.canada.ca/en/gender-based-analysis-plus/government-approach.html#commitment.

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7.0 Appendices

Appendix A: Database management and cleaning methods.

We received anonymized clinical practice data from Clinic 554 for the years of 2015 through 2022. Of the original dataset of 1075, only 1007 entries fit the inclusion criteria of having received procedural abortion care. Of these remaining entries, 132 were missing health zone data and 13 were missing gestational age data. This missing data was managed through pairwise deletion.

The cost of an abortion at Clinic 554 is dependent on gestational age (GA) which is measured in weeks and determined by product of conception and ultrasound records. When GA is less than 14 weeks a procedural abortion at Clinic 554 costs $700. When GA is 14 weeks or more the cost is $850. The Clinic 554 database contained GA and financial assistance data. These two variables were used to calculate out-of-pocket payments, also known as patient billing. Abortion cost was determined by GA and any financial assistance contributions were subtracted from this total cost to determine the amount paid out-of-pocket. E.g., If a procedural abortion was provided for a GA of 12 weeks the total cost would be $700. If clinic records indicate that a $200 subsidy from Action Canada was provided, that leaves a remainder of $500 in patient billing.

In the 13 cases where GA data was missing, average imputation was used to calculate patient billing. This set the GA for these entries to 'less than 14 weeks' and therefore the more conservative $700 total cost was used in calculations. In two exceptions, entries with GAs of less than 14 weeks were set to a cost of $850 as records stated that over $800 had been covered pro bono. The final exceptions to patient billing calculation are 10 entries where financial assistance was accessed but the amount received was not recorded. In one of these cases the missing amount was a non-profit subsidy and average imputation for that year was used. All other cases split the remaining cost evenly between recorded payment types.

Appendix B: Crosstabulation of key variables

Crosstabulation of key variables

Procedural Abortions Frequencies

	N		Year of Clinic Visit (N = 1007)								Region (N = 875)				Valid NB Medicare (N = 1007)		Patient Age (N = 1004)					Medically Assessed Gestational Age (N = 994)		Out-of-pocket (N = 1007)		
			2015	2016	2017	2018	2019	2020	2021	2022	Moncton Area	Saint John Area	Fredericton Area	Northern NB	Yes	No	≤17	18 - 24	25 - 29	30 - 34	35+	≤ 8 weeks	9 + weeks	Completely	Partially	None
Procedural Abortions	1007	100%	202	218	202	105	107	75	50	48	12.69%	23.77%	55.09%	8.46%	71%	29%	2%	38%	27%	17%	18%	65%	35%	85%	8%	7%

Note. Procedural abortion is also called surgical abortion. Region was provided by Clinic 554. Entries where NB Medicare card was left blank or recorded as 'None' or 'Unknown', were upcoded as 'No'. Sample size varies due to missing data in the following variables: Patient Age (3 missing entries); Medically Assessed Gestational Age (13 missing entries); and Region (132 missing entries).

Medically Assessed Gestational Age of Procedural Abortion

	N		Year of Clinic Visit						Region				Patient Age								Out-of-pocket					
	N		2015 - 2017		2018 - 2019		2020 - 2022		Fredericton Area		Outside Fredericton Area		18 - 24		25 - 29		30 - 34		35+		Completely		Partially		None	
≤ 8 weeks	644	65%	418	67.9%	128	62.1%	98	57.0%	309	64.6%	244	63.0%	234	62.9%	157	59.2%	113	69.8%	130	76.0%	571	67.2%	40	51.9%	33	49.3%
9 + weeks	350	35%	198	32.1%	78	37.9%	74	43.0%	169	35.4%	143	37.0%	138	37.1%	108	40.8%	49	30.2%	41	24.0%	279	32.8%	37	48.1%	34	50.7%
N	994	100%	616	100%	206	100%	172	100%	478	100%	387	100%	372	100%	265	100%	162	100%	171	100%	850	100%	77	100%	67	100%

Note. Sample size varies due to pairwise deletion of missing data and suppression of the ≤17 age category. Sample sizes are affected as follows: Medically Assessed Gestational Age (GA), N = 994 (13 missing entries); GA by Year of Clinic Visit, N = 994 (13 missing entries); GA by Region, N = 865 (142 missing entries); GA by Patient Age, N = 970 (13 missing entries and 24 suppressed entries); GA by Out-of-pocket, N = 994 (13 missing entries).

Note. Sample size varies due to pairwise deletion of missing data and suppression of the ≤17 age category.

How much of was paid out-of-pocket?

	N		Year of Clinic Visit						Region				Medically Assessed Gestational Age				Valid NB Medicare			
	N		2015 - 2017		2018 - 2019		2020 - 2022		Fredericton Area		Outside Fredericton Area		≤ 8 weeks		9 + weeks		Yes		No	
Completely	859	85%	543	87.3%	183	86.3%	133	76.9%	387	80.3%	346	88.0%	571	88.7%	279	79.7%	595	83.5%	264	89.8%
Partially	80	8%	50	8.0%	19	9.0%	11	6.4%	46	9.5%	29	7.4%	40	6.2%	37	10.6%	66	9.3%	14	4.8%
None	68	7%	29	4.7%	10	4.7%	29	16.8%	49	10.2%	18	4.6%	33	5.1%	34	9.7%	52	7.3%	16	5.4%
N	1007	100%	622	100%	212	100%	173	100%	482	100%	393	100%	644	100%	350	100%	713	100%	294	100%

Note. Out-of-pocket payment category was determined by the amount of financial assistance patients received, absence of other payment type, and the cost of abortion. Entries where NB Medicare card was left blank or recorded as 'None' or 'Unknown', were upcoded as 'No'. Sample size varies due to pairwise deletion of missing data: Out-of-pocket by Region, N = 875 (132 missing entries); and Out-of-pocket by Medically Assessed Gestational Age, N = 994 (13 missing entries).