Contraception

Contraception 95 (2017) 477–484

Original research article

"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☆

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Received 5 February 2017; revised 9 February 2017; accepted 10 February 2017

Abstract

Introduction: New Brunswick (NB)'s *Regulation 84-20* has historically restricted funded abortion care to procedures deemed medically necessary by two physicians and performed in a hospital by an obstetrician-gynecologist. However, on January 1, 2015, the provincial government amended the regulation and abolished the "two physician rule."
Objectives: We aimed to document women's experiences obtaining abortion care in NB before and after the *Regulation 84-20* amendment; identify the economic and personal costs associated with obtaining abortion care; and examine the ways in which geography, age and language-minority status condition access to care.
Methods: We conducted 33 semistructured telephone interviews with NB residents who had abortions between 2009 and 2014 (n=27) and after January 1, 2015 (n=6), in English and French. We audiorecorded and transcribed all interviews and conducted content and thematic analyses using ATLAS.ti software to manage our data.
Results: The cost of travel is significant for NB residents trying to access abortion services. Women reported significant wait times which impacted the disclosure of their pregnancy and the gestational age at the time of the abortion. Further, many women reported that physicians refused to provide referrals for abortion care. Even after the amendment to *84-20*, all participants reported that they were required to have two physicians approve their procedure.
Conclusions: The funding restrictions for abortion care in NB represent a profound inequity. Amending *Regulation 84-20* was an important step but failed to address the fundamental issue that clinic-based abortion care is not funded and significant barriers to access persist.
Implications: NB's policies create unnecessary barriers to accessing timely and affordable abortion care and produce a significant health inequity for women in the province. Further policy reforms are required to ensure that women are able to get the abortion care to which they are entitled.

Keywords: Abortion; Canada; Reproductive health; Health disparities; Mifepristone

1. Introduction

Canada is one of only a small number of countries without federal restrictions on abortion [1]. However, the procedure remains provincially and territorially regulated [2]. Although one in three Canadian women will have an abortion over the course of their reproductive lives [2], there are significant disparities in access to abortion care across the country, both between and within provinces [3–5]. Yet, even with Canada's "patchwork" landscape of abortion care, New Brunswick has long represented an outlier with regard to legislation [5]. The province's *Regulation 84-20* under the *Medical Services Payment Act* stipulates that provincial insurance only covers abortion care under specific circumstances. Until 2015, procedures eligible for coverage and reimbursement were required to be performed in a hospital facility, deemed medically necessary by two separate

☆ Conflicts of interest: The authors declare that they have no conflicts of interest, financial or otherwise.

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http://dx.doi.org/10.1016/j.contraception.2017.02.016
0010-7824/

medical practitioners, and provided by a physician who specializes in obstetrics and gynecology [6].

New Brunswick's legislation surrounding abortion coverage has faced significant criticism [7]. Indeed, in 1995, the former federal Health Minister Diane Marleau instructed provinces and territories to fund medically required procedures in medical clinics [8]. Later that same year, she issued a follow-up statement warning that provinces and territories that had yet to comply with this directive would face penalties [9]. Yet, more than two decades later, New Brunswick still fails to fund clinic-based abortion care. In July 2014, the Morgentaler Clinic in Fredericton, New Brunswick's only private abortion provider at the time, closed its doors after stating that it could no longer afford to provide services without provincial funding [10].

The clinic closure effectively mobilized a number of reproductive justice and rights groups to rally around the exceptional and punitive nature of New Brunswick's abortion legislation. In response to their targeted advocacy work, Premier Bryan Gallant amended *Regulation 84-20* such that as of January 1, 2015, two physicians are no longer required to sign off for women to access hospital-based abortion care and the providing physician was no longer required to be an obstetrician-gynecologist [11,12]. However, abortions performed outside of hospital settings, either within or outside of the province, remain ineligible for provincial reimbursement [12,13].

New Brunswick has a population of roughly 750,000 [14], and approximately 1,000 aspiration and surgical abortions are performed in-province each year [15,16]. At the end of 2016, there were four abortion-providing facilities in New Brunswick: two public hospitals; one regional hospital which only serves patients from the surrounding area; and Clinic 554, a freestanding medical center in Fredericton which began providing services in 2015 after the Morgentaler Clinic closure and a subsequent grassroots fundraising campaign [17,18]. The freestanding clinic is the only facility in the province that performs procedures past 13 weeks and 6 days [18].

Although there has been an abundance of anecdotal evidence to indicate that residents of New Brunswick face undue systematic barriers in obtaining abortion care, there has been a lack of rigorous investigation into women's abortion experiences in the province. In the summer and fall of 2014, we conducted a qualitative study to document women's abortion experiences in New Brunswick and to shed light on the impact of *Regulation 84-20* on access to timely and affordable care. In the second half of 2015, we conducted a follow-up component of the project in order to explore the impact of the amendment to *Regulation 84-20* that went into effect on January 1, 2015, on women's lived experiences.

2. Methods

From July 2014 through the end of 2015, we conducted semistructured in-depth interviews with 33 women who had obtained an abortion when they were residents of New Brunswick in two phases. From July 2014 through October 2014, we interviewed 27 women who had obtained at least one abortion in the 5 years prior to the interview (Phase 1). From July 2015 through December 2015, we interviewed six women who had obtained at least one abortion after January 1, 2015 (Phase 2). In addition, to be eligible for the study, women in both phases had to be at least 18 years old at the time of the interview, be sufficiently fluent in English or French to answer questions, and have access to a telephone or Skype.

2.1. Data collection

We recruited participants through a number of mechanisms including posting flyers in community venues and on online fora such as Kijiji and Craigslist and circulating the study announcement on listservs and through social media. After a participant expressed interest in the study, we conducted an initial intake call to provide additional information about the study, determine eligibility, provide the consent form and schedule a mutually convenient time for the interview.

The PI of the study (A.M.F.), a medical anthropologist and medical doctor with two decades of experience conducting qualitative research, and/or a trained member of our all-woman study team from the University of Ottawa conducted all telephone/Skype interviews. With permission, we audiorecorded the interviews, which averaged 60 min in length. Interviewers followed the guide that began with a series of open-ended questions about the participant's demographics and background, reproductive health history, pregnancy history, and general experiences accessing both primary and reproductive health care services. We then asked participants details about their abortion experience(s), including the circumstances surrounding the pregnancy that was terminated and the process of locating a provider, scheduling an appointment, obtaining the service and receiving follow-up care. Finally, we asked women about their retrospective feelings about their abortion(s), the ways in which services could be improved in New Brunswick, and their knowledge of and opinions about mifepristone; the gold standard medication abortion drug was not available during this study but had been approved by Health Canada during Phase 2 [19]. We took notes during the interviews and formally memoed shortly thereafter. All participants received a CAD40 (US$30) gift card to amazon.ca.

2.2. Data analysis

We began reviewing data as they were collected in order to identify common themes, draw initial connections between ideas and establish thematic saturation. Memoing after each interview served an integral role in this process and allowed us to reflect on the interviewer's impact on the data collection process [20]. Drawing upon interview transcripts, notes and memos, we conducted content and thematic analyses of the interactions using both predetermined categories and codes based on the

research questions and inductive analysis techniques to identify emergent ideas [20,21].

We used ATLAS.ti to manage our data, and K.J.L., a Ph.D. student in Population Health and the overall Study Coordinator, created an initial code book and served as the principle coder with support from J.E., a medical student who has worked with the PI on several qualitative research projects. A.M.F. reviewed both the codebook and the coded transcripts. Guided by regular team meetings and discussion, our thematic analysis centered on grouping categories of information, drawing connections between ideas and understanding relationships.

2.3. Ethical considerations

This study received approval from the Health Sciences and Sciences Research Ethics Board at the University of Ottawa. In this paper, we use illustrative quotes to showcase themes and ideas and narrative vignettes (See Figs. 1–5) to provide a more robust picture of individual women's experiences. We have removed and/or masked all personally identifying information and used pseudonyms throughout.

3. Results

3.1. Participant and abortion characteristics

Our participants ranged in age from 21 to 40 years old at the time of the interview and identified as both Anglophone (n=26) and Francophone (n=7). The women that we spoke with overwhelmingly identified as White (n=28) and resided in both rural and urban areas at the time of the abortion. The majority of our participants had a single first-trimester abortion either in the 5 years prior to the interview (Phase 1) or since the amendment to *Regulation 84-20* (Phase 2). We provide more detail about our participants in Table 1.

Our 33 participants provided detailed information about 36 abortions; all but one of these abortions involved aspiration or surgical procedures. Roughly one half of these abortions took place at an in-province hospital; slightly less than one half took place at the in-province clinic; and a handful took place out of province, including one participant who obtained a medication abortion with mifepristone/misoprostol in the United States (Maine). Consistent with the location of services, 17 of our participants reported that they paid out-of-pocket for at least one procedure. More than half of all participants reported that, after having made the decision to have an abortion, they had to wait 2 weeks or more to obtain the termination and four participants had to wait a month or more to access services. We provide more detailed information in Table 2.

3.2. Hospital abortions require multiple visits, which are often burdensome

Most of the women that we spoke with who had obtained an abortion in one of the providing hospitals in New Brunswick described the process as arduous and complicated. For those who obtained care when the two-physician requirement was still in place (Phase 1), an encounter with a referring physician was required. For those women, like Emily, who had a longstanding preexisting relationship with a family physician, obtaining a referral was relatively straightforward. However, Emily's experience (Fig. 1) appears to be exceptional; most of the women we spoke with who sought referrals experienced challenges. Addison, who was 33 at the time of the interview and 31 at the time of her abortion in 2012, explained:

Emily was in her mid-thirties, parenting two teenagers, and in the midst of breaking up with her partner when she learned she was pregnant in 2011. Emily decided to have an abortion because she was not in a financial position to care for another child. After confirming the pregnancy, she contacted her family doctor whom she has been seeing for several years. She described her relationship with her family physician as "good" and she felt comfortable discussing her options with him.

Because financial instability was an important factor in her decision to terminate the pregnancy, Emily explained to her doctor that she would rather not go to the Morgentaler Clinic and pay out-of-pocket. Her doctor referred her to the hospital in another city and she was able to schedule an appointment for two weeks later. However, in order to obtain the abortion had to meet twice with her family physician and make two visits to the hospital before she obtaining the abortion. All told,her first trimester abortion required five visits to health care practitioners.

Emily was happy with the care that she received both by her family physician and the hospital. And she is grateful that her family physician was willing to provide her with a referral. However, she expressed concern for other women, especially those who do not have a close relationship with a primary care practitioner. She believes strongly that there needs to be more education and awareness about abortion services in New Brunswick and better access.

Fig. 1. Emily's story.

Sadie was 17 and in a new relationship when she found out that she was pregnant in 2010. She was using the contraceptive vaginal ring and thus she did not spend a lot of time thinking about the possibility of becoming pregnant. But when she missed her period, she took an at-home pregnancy test and, once the pregnancy was confirmed, she took time to consider her options. After talking with her mom and her boyfriend, Sadie decided to have an abortion. She knew that she could not afford to pay out-of-pocket for the procedure at the province's one clinic, so she made an appointment at the hospital.

However, the "free" procedure at the hospital resulted in two separate appointments over two different days in a city more than three hours away from where she was living. The night before her abortion, Sadie's father drove both her and her best friend to the city and they stayed in a hotel overnight. Although she incurred significant financial costs for having to travel for her abortion and pay for accommodations, Sadie's procedure still ended up costing less than if she had the abortion at the clinic. She described the process as "expensive and hard."

Fig. 2. Sadie's story.

> I went to my doctor and my doctor at the time flat out said [he was] not willing to help me in any way because it was not [his] beliefs...I've heard of other people…they can't get referrals from doctors to get it done in a regular hospital setting, where Medicare would pay for it because of the doctor's personal beliefs.

Even after January 1, 2015, a physician referral was required; all four of our Phase 2 participants who obtained a hospital abortion in New Brunswick obtained a referral prior to the termination. When scheduling their appointments, none of these participants were aware of the policy change. However, one participant later found out that she did not need the referral from her family doctor; she was frustrated because obtaining this referral delayed her hospital-based procedure. As Sharon, age 30, explained, "When I left the family doctor, I was under the impression [that he needed] to send my chart to someone as part of a referral."

Yet irrespective of the need for a referral, women obtaining hospital abortions in New Brunswick are required to undergo multiple visits, a process that costs women time and money. On average, the hospital abortion process required three visits for our Phase 1 and Phase 2 participants. The challenges associated with multiple visits are showcased in Sadie's abortion experience (Fig. 2).

3.3. Women residing in New Brunswick incur significant out-of-pocket costs to obtain abortion care

Most of our participants had to pay significant sums out-of-pocket in order to obtain their abortion. Only half of our participants in both phases of the study obtained provincial funding for the abortion procedure itself. Yet even for those women, like Sadie, who did meet the requirements for provincial insurance coverage, the costs associated with travel and accommodations for multiple visits or multiple days were significant. Other women who received procedure coverage also spoke about the costs associated with lost wages and child care.

For women who obtained clinic-based abortion care in-province, the costs were considerable, a dynamic that was not altered with the 2015 amendment to *Regulation 84-20*. The out-of-pocket costs reported by our participants in both study phases ranged from CAD400 (US$300) to CAD1600 (US$1225), excluding travel costs. Unsurprisingly, this was a tremendous challenge for many of our participants,

Josephine was six weeks' pregnant when she made the decision to have an abortion in the winter of 2015. Her family physician referred her to the hospital to schedule an appointment; however, Josephine was told that based on current wait times, she wouldn't be able to have her abortion before she passed the gestational limit for services at the hospital. Feeling like she was out of options, Josephine was relieved to hear from her doctor that the free standing clinic in Fredericton had just reopened. She called to make an appointment at Clinic 554 and was told that her procedure would cost CAD850.

After a week of trying to come up with the money, Josephine only had CAD600. Panicked that she would not be able to find the rest of the money, she called the clinic and was told that they would cover the rest of the cost. She was forced to disclose her pregnancy to her mother so that she had someone to drive her to the clinic on the day of her procedure, which was 2 hours away from where Josephine was living, and help support her financially.

Fig. 3. Josephine's story.

When Daphne found out that she was pregnant in 2012, she immediately knew that she wanted to have an abortion and took steps to schedule her procedure. She first contacted the Morgentaler Clinic, but the staff explained that they were fully booked for several months. They offered to put Daphne on a wait-list but cautioned her that she could not be guaranteed an appointment. They explained that if she was eventually able to secure an appointment, she would likely have to wait more than two months and the delay would increase the cost of the procedure to CAD850.

Next, Daphne tried contacting a providing hospital. After waiting for more than week for her call to be returned she learned from hospital staff it would be at least a month before she could get an appointment. Feeling deflated, she finally contacted a clinic in Ontario and was able to schedule her abortion two weeks later.

In order to pay for her abortion and make the trip to Ontario, Daphne had to tell the man she was casually dating and her parents about her pregnancy. She had previously decided not to share her decision to have an abortion with her casual partner or her family, but felt like she had no other options given the circumstances. After waiting six weeks for an appointment, Daphne's abortion cost CAD400 and she incurred nearly CAD600 in travel expenses; she needed her partner to contribute to the abortion and stayed with relatives in Ontario to reduce costs. She described the emotional cost associated with the issues of disclosure and delays in care asthe biggest challenges.

Fig. 4. Daphne's story.

especially as women often described a lack of financial stability as one of their reasons for choosing to terminate their pregnancy. Vivian, aged 27, remarked, "I don't know how younger girls do it — who don't have cars or families that will help them." Women and their partners and families were resourceful in figuring out ways to cobble together resources. As Adrianna, age 24, explained, "[The abortion] was expensive. And we also had to make the trip…for it. My boyfriend actually ended up selling his four-wheeler…in order to be able to afford [the abortion]." Although Francophone women were unable to obtain abortion care in their preferred language, all of our Francophone participants described the overall inaccessibility of abortion care in New Brunswick as a more pressing issue and were more concerned about travel, cost and wait times than receiving French-language care. Antonia, 24 years old, found that the challenges associated with cost and travel were overwhelming and overshadowed the high quality of care she received at the abortion clinic: "I ended up having to pay for it out of my own pocket and go to [another town] and the experience was absolutely horrid." Indeed, Josephine's abortion, which took place in early 2015, captures many of these dynamics (Fig. 3).

A small number of our participants traveled outside of New Brunswick to obtain their abortion care. In addition to having to pay for both the costs of the procedure and the costs associated with travel, there seemed to be a lack of clarity about how the cost of the procedure was calculated.

Florence was a student in her early twenties when she became pregnant. After missing her period, she took an at-home pregnancy test that came back positive. She avoided talking to her family about the pregnancy for fear of judgment, but she decided to tell her partner and one of her friends.

Florence first consulted the internet to get a better idea of her options. She attempted to induce her own abortion with vitamins and herbs and then she tried to find a way to get mifepristone sent to her. However, neither strategy worked and she knew that she would not be able to afford an abortion at the clinic. She was scared to talk to her family physician about her pregnancy, so she called a walk-in clinic to get the necessary referral for a hospital-based procedure. She was turned down by five different clinics without seeing a physician once.

As a last resort, Florence made an appointment at the clinic and ended up having to pay more than CAD600 for her abortion. She also had to tell her parents about her pregnancy so that they could lend her the money for the abortion. She doesn't believe that she had fair access to abortion care.

Fig. 5. Florence's story.

Table 1
Participant characteristics (*n*=33)

		Phase 1 participants (*N*=27)	Phase 2 participants (*N*=6)	All participants (*N*=33) *n* (%)
Language	English	20	6	26 (79)
	French	7	0	7 (21)
Age	18–24	12	0	12 (36)
	25 and older	15	6	21 (64)
Race or ethnicity	White	23	5	28 (85)
	First Nations/Métis/Inuit	0	0	0 (0)
	Other/unspecified	4	1	5 (15)
Number of abortions during study period	1	24	6	30 (91)
	2	3	0	3 (9)
	3 or more	0	0	0 (0)

Table 2
Abortion characteristics (*n*=36).

		Phase 1 abortions (*N*=30)	Phase 2 abortions (*N*=6)	All abortions (*N*=36) *n* (%)
Location of abortion care	Hospital in NB	14	4	18 (50)
	Clinic in NB	13	2	15 (42)
	Facility outside of NB	3	0	3 (8)
Coverage of procedure	Provincial insurance	14	4	18 (50)
	Out-of-pocket	16	2	18 (50)
Gestational age at time of procedure	≤9 weeks	11	3	14 (39)
	>9 weeks to ≤12 weeks	10	2	12 (33)
	>13 weeks	9	1	10 (28)
Time between decision to terminate and procedure	≤2 weeks	6	5	11 (31)
	>2 weeks to ≤4 weeks	19	0	19 (53)
	>4 weeks	3	1	4 (11)
	Does not recall	2	0	2 (5)

As described by Tessa who had her abortion at 8 weeks' gestation in Halifax, "It seemed like people weren't sure. It could be anything up to $2000 (US$1535). So for me it was $1600 (US$1225), but I don't know if it's consistently the same price. It might vary." Daphne's experience further illustrates the complications and costs related to provincial policies that do not cover interprovincial services provided by clinics (Fig. 4).

3.4. Wait times and out-of-pocket costs influence disclosure

Daphne was among the many women in both phases of the study who described the social and emotional toll associated with being unable to obtain abortion care in a timely manner. After making the decision to have an abortion, the majority of our participants waited between 2 and 4 weeks to have their termination, irrespective of whether they had the abortion in-province or out-of-province. Paige, 25, discussed her emotions during what she described as the waiting game: "Your mind lingers all the time about what could happen...Even if you have made your decision. It would be a lot less stressful if ladies… could be like, okay, I want this done now. I don't want to wait three or four weeks, this is what I want."

Consistently, the cost and delays in care forced women to disclose their unwanted pregnancy and abortion to others. As Sadie explained, "The cost, the distance of travelling…I don't know, it would have been more private [to access care closer to home]. Maybe I wouldn't have told my family, maybe I wouldn't have…told my mother, my father." This was echoed by Florence and her experience (Fig. 5).

Similarly, Harper, age 21, had to borrow money from her parents to whom she did not originally want to reveal her pregnancy. She had to travel to Nova Scotia for her abortion and feels that New Brunswick's abortion policies are punitive for the women that live there. "And if I ever did have a daughter, I wouldn't raise her in New Brunswick. So the procedure itself I do not regret getting. But I am still getting over it a little bit." Indeed, for women who preferred to keep their pregnancy private, they often described having to disclose their decision to terminate to others as a point of continued reflection after the procedure.

4. Discussion

In 1988, the Supreme Court of Canada ruled in the *R v. Morgentaler* decision that restrictions on abortion violated Section 7 of the Canadian Charter of Rights and Freedoms which refers to the individual's right to life, liberty and security. However, our results indicate that residents of New Brunswick face considerable logistical, financial and emotional burdens in obtaining abortion care because of restrictive and non-evidence-based provincial regulations. Although the 2015 changes to *Regulation 84-20* represent an important step in aligning New Brunswick with the rest of Canada, the amendment does little to mitigate the challenges imposed by the province's refusal to fund clinic-based abortion care within or outside of the province. Indeed, our findings indicate that even if the elimination of the two-physician requirement were to be fully implemented, this would have only marginal impact on women's ability to access affordable and timely abortion care.

Similarly, in June 2015, abortion was removed from the list of medical services excluded from reciprocal billing agreements [13]. In theory, residents of any province are now able to obtain funded hospital-based abortion care anywhere in Canada. This change represents a hard-won victory as reproductive rights advocates across the country have long argued that New Brunswick's policy violated the portability principle of the Canada Health Act. However, our participants' stories highlight that physician's fees are only a small component of the out-of-pocket expenses incurred for care. Wait times and considerable delays in scheduling remain

common challenges in obtaining abortion care in New Brunswick, which will not be addressed by allowing residents to obtain hospital-funded abortion procedures elsewhere. Further, the lack of funding available for clinic-based care is still in violation of the principles of comprehensiveness and accessibility in the Canada Health Act.

In July 2015, Health Canada approved physician provision of mifepristone, for early pregnancy termination up to 7 weeks' gestation [19]. A body of research from around the world has shown that mifepristone can be safely and effectively provided through 9 weeks' gestation by family physicians and nurse practitioners outside of the hospital setting [22–25]. Although Health Canada's restrictions on both timeframe for use and clinician type are not evidence based and are limiting, the approval represents a window of opportunity to improve both the accessibility and timely delivery of abortion in New Brunswick and across Canada. Recent research indicates that Canadian women are favorably disposed to mifepristone and would be open to obtaining medication abortion care from both family physicians and nurse practitioners [4,26]. However, if New Brunswick continues to enforce its policy of requiring funded abortion care to be performed in a hospital setting, the potential of mifepristone will fail to be realized.

Relatedly, our results suggest that physician refusal is a pertinent problem that continues to occur and negatively impact women. This also represents another challenge to realizing mifepristone's potential. Across Canada, debates about whether physicians are obligated to provide patients with referrals for contraception and abortion persist [27]. As highlighted by the stories of the women that we spoke with, referring a woman elsewhere to obtain information or a referral for the procedure compromises patient care, especially when the procedure is time sensitive. Referrals, let alone referrals for referrals, create significant delays in scheduling and further contribute to the burden faced by those women seeking services. As an issue of public health, women need to be able to receive information about all of their legal options as well as referrals for services in a professional and a timely manner.

This is a qualitative study, and by definition, our results are not intended to be representative or generalizable. Although we reached thematic saturation in both phases of the study and are confident that the themes are significant, we are unable to assess the degree to which our participants' experiences are reflective of larger trends. Further, both phases of this study took place before mifepristone became available in Canada, and thus, we are only able to speculate on how current restrictions will impact the accessibility of medication abortion once introduced.

5. Conclusions

What has happened in New Brunswick represents a profound injustice. The province's policies not only create unnecessary barriers to accessing routine medical care but also produce a significant health inequity for women in New Brunswick. From a social justice perspective, New Brunswick's continued differentiation between abortion care and other medical care fails to prioritize women's health outcomes and creates undue financial and emotional burdens for those seeking services. Although recent changes to *Regulation 84-20* represent an important step toward creating more equitable access to abortion services in New Brunswick, they fail to address the fundamental issue that clinic-based abortion care is not covered through provincial insurance. Identifying ways to support coverage and portability is warranted.

Acknowledgments

Dr. Foster's 2011–2016 Endowed Chair in Women's Health Research was funded by the Ministry of Health and Long-Term Care in Ontario, and we appreciate the general support for her time that made this project possible. We are grateful to the Society of Family Planning for a mentorship grant that supported this work. We also thank all of the graduate students, undergraduate students and volunteers who have contributed to the Canada Abortion Study. The conclusions and opinions expressed in this article are those of the authors and do not necessarily represent the views of the organizations with which the authors are affiliated or the funders.

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