

A CHANGING LANDSCAPE: A COMMENT ON ABORTION SERVICES IN THE MARITIME PROVINCES, 2014–2024

Martha Paynter and Clare Heggie

Background

The Maritime provinces—New Brunswick (NB), Prince Edward Island (PEI) and Nova Scotia (NS)—have long experienced disproportionate challenges in access to abortion services (Ackerman, 2015; Norman et al., 2016). However, important policy changes in the past ten years means that there is potential to substantially change this landscape. Nation-wide changes to policy include Health Canada’s approval of mifepristone in 2015 for medication abortion up to nine to ten weeks gestational duration (Health Canada, 2015; Health Canada, 2017; Linepharma, 2019); the subsequent removal of various regulatory restrictions on mifepristone resulting in a globally unique mifepristone policy in which it can be prescribed, dispensed and taken as a normal prescription (Munro et al., 2020; Carson et al., 2022); and the introduction of telemedicine provision of medication abortion (Ennis et al., 2021). Prior to the availability of medication abortion, abortion was almost exclusively available through procedures provided by a small number of physicians largely located in urban centres. There were only four facilities identified in Atlantic Canada in a 2012 national survey (Norman et al., 2016). Primary care prescription of medication abortion has decoupled provision from facilities; however, the number of providers/prescribers is unclear. The democratization of mifepristone access has also come with some challenges in accounting for abortion volumes, however, it is estimated that in 2021, 3092 abortions were provided in the Maritimes (CIHI, 2022).

Alongside the national changes, several Maritime-specific policies have influenced changes in abortion access, including: the launch of self-referral for publicly funded abortion in NB in 2015 and NS in 2018 (CBC News, 2015; Canadian Press, 2018); the introduction of public funding for mifepristone, starting in NB in 2017 (Bundale, 2017), and elsewhere in the Maritimes immediately following; the opening of the full-time Family Planning Clinic at the Moncton City Hospital in NB in 2015; the launch of procedural and medication abortion services as part of a new, comprehensive reproductive health program on PEI in 2017 (Saltwire, 2016); and the creation of a centralized, toll-free self-referral line for nursing intake and abortion appointments across NS in 2018 (Canadian Press, 2018). Members of the public, health professionals, and media remain under informed about these changes and their potential impact remains suboptimal. Lack of understanding can contribute to delays, unnecessary travel, and stigma (Erdman, 2016). We share this comment from our perspectives as a registered nurse abortion care provider, advocate and organizer, researcher, and educator in this field (MP), and as a community volunteer and academic trainee (CH). The past decade has brought significant progress, which we summarize and comment upon below. We argue that improving understanding of this progress will enhance patient access and refine the focus of future clinical, policy, and community efforts to advance care.

Context of Abortion Access in the Maritimes

In the Maritimes, lingering and persistent negative conceptualizations of abortion and stigma in the region present barriers to access (Erdman, 2016). The Maritime provinces were the site of important,

high-profile legal struggles. Prior to 1988, all legal abortion services in Canada were performed within hospitals. The *R v Morgentaler* 1988 Supreme Court of Canada (SCC) decision decriminalized abortion and allowed Dr. Henry Morgentaler, an early abortion provider and longstanding champion for abortion rights, to operate free-standing clinics across Canada. But the Maritime provinces forcefully resisted. In 1993, the Supreme Court of Canada ruled against the Province of Nova Scotia, which had attempted to ban abortions from being performed in free-standing clinics, namely clinics opened by Dr. Morgentaler in downtown Halifax (*R v. Morgentaler*, 1993). PEI withheld abortion services for thirty-five years, from 1982–2017 (Erdman, 2016; Bryenton, 2022), until compelled to offer them after a lawsuit was launched by local activists supported by Women's Legal Education and Action Fund (LEAF) pro-bono counsel Kelly McMillan and Nasha Nijhawan. For a decade (2003–2013), Dr. Morgentaler pursued a legal challenge against the Province of NB over its restrictions on public funding for services provided by free-standing abortion clinics (CBC News, 2013). After Morgentaler's death in 2013, the dispute languished, but was renewed by the Canadian Civil Liberties Association (CCLA, n.d.) in 2021. As a consequence of the legal turmoil in the Maritimes, members of the public, journalists, and even health professionals may misunderstand contemporary access in the region and may share incomplete or incorrect information.

Despite availability of mifepristone, medication abortion remains misunderstood (Sethi & Park, 2023; Vogel et al., 2016), and is frequently confused with emergency contraception, levonorgestrel, known under the brand name of Plan B, which has been an over-the-counter medication in Canada since 2008 (Eggertson, 2008). Furthermore, crisis pregnancy centres, funded through religious organizations that discourage abortion, are active across the region and may misinform patients and delay care (Arthur et al., 2023). Levesque (2013) conceptualized access to health services as inclusive of five dimensions of care (approachability, acceptability; availability/accommodation; affordability; and appropriateness), with five corollary dimensions, including: 1) Ability to perceive; 2) Ability to seek; 3) Ability to reach; 4) Ability to pay; and 5) Ability to engage. Patients cannot perceive access when information about that access is distorted, out of date, or shrouded in secrecy. Lack of publicly funded promotion and information regarding abortion and improvements to abortion services undermines the potential impact of important policy shifts, both from the perspective of providers implementing abortion care in their practices and for patients seeking care.

Challenges, Responses, and Future Directions

Across Canada, there are three consistent barriers to accessing timely, affordable abortion care: 1) travel requirements (Sethna & Doull, 2013), a result of inadequate numbers of competent, confident providers at all gestational durations, itself a consequence of inadequate training opportunities, stigma and belief-based denial of care; 2) private costs, whether directly associated with travel or indirectly as a consequence of time away from work, or as a result of inadequate insurance coverage; and 3) systemic discrimination faced by individuals in equity-deserving groups, such as Indigenous people, people of colour, disabled people, non-English speakers, newcomers to Canada, uninsured people, people living in poverty and with housing precarity, people who use drugs, and members of 2SLGBTQIA+ communities. Below, we describe progress in these three areas and offer specific foci for continued advocacy.

Travel

The most concrete improvement to reducing travel burdens in the Maritimes was arguably the 2017 establishment of the Sexual Health and Reproductive Services (SHORS), formerly Women's Wellness, program, offering procedural and medication abortion services in Summerside and medication abortion in Charlottetown. For the thirty-five years prior to SHORS opening, PEI residents always traveled off-Island. SHORS staff includes a full-time nurse practitioner, several physicians, and a nursing team. In addition to abortion and contraception services, SHORS provides a suite of sexual and reproductive health services, including testing for sexually transmitted infections, fertility work-up, and gender affirming care.

Although the PEI program's launch was more dramatic—and in response to a constitutional legal challenge—the opening of the Family Planning Clinic at Moncton City Hospital in NB in 2015 was similarly monumental (Horizon Health Network, 2014; Vitalité Health Network, n.d.). For the first time, New Brunswick boasted a publicly funded five-days-a-week clinic, offering procedural abortion and, once available in 2017, medication abortion. In 2015, the removal of an archaic regulatory requirement for two physicians' approvals prior to receiving publicly-funded abortion care, effectively allowed self-referral and significantly reduced travel burdens and delays. It was only in 2018 that NS introduced self-referral, coupled with a province-wide, nurse-staffed, toll-free telephone line to arrange care across the province.

The potential promise of medication abortion is that abundant primary care providers reduce the need for travel, expedite access and reduce the need for second and third trimester care, increasing patient safety and satisfaction overall. The realization of this promise depends on adequate numbers of providers becoming comfortable prescribers. In this regard, headway is being made swiftly: medication abortion went from less than 4% of abortion care prior to mifepristone approval to 40% in 2022 (CIHI, 2022), and the number of abortion providers increased fourfold between 2017 and 2019 (Norman et al., 2023).

The introduction of mifepristone and primary care prescribing may most significantly improve rural access to care (Dressler et al., 2013). The Maritimes have a high proportion of people living rurally. Approximately 50% of people in the Maritimes live in rural areas (41% in NS, 49% in NB, and 54% in PEI), markedly higher than the average of 18% in other provinces (Statistics Canada, 2022). A national survey by the Contraception and Abortion Research Team (CART) in 2019 found that the abortion workforce grew substantially with the introduction of mifepristone (Renner et al., 2022), and that 10% of abortions were provided by rural providers.

Further, almost half of all first-trimester providers were located in rural areas; a dramatic increase since the last such national survey in 2012 (Norman et al., 2016; Renner et al., 2022). Although there are concerns about rural and remote response to infrequent complications of medication abortion, such as hemorrhage or retained products requiring aspiration services, additional research by CART found no significant changes to the rate of adverse events associated with abortion after the introduction of mifepristone in Canada (Schummers et al., 2022). The answer to the question of "How Far is Too Far" for safe administration of mifepristone is unclear, and is, in fact, the focus of one of our current CIHR-funded projects (CIHR, 2023). The Maritime provinces are geographically smaller than other provinces, meaning the longest distance a patient could conceivably travel is much shorter than what

might be required in other areas of Canada. However, the impact of the increased number of providers on distance to care in the Maritimes has yet to be uncovered.

Gestational Capacity

A further challenge in the Maritimes is the lower gestational duration capacity. Unlike every other province, where at least one clinic or hospital provides care up to twenty weeks or beyond, the limit in the Maritimes is sixteen. Beyond sixteen weeks, patients must travel out of the Maritime region for care in Quebec or Ontario, or even to U.S. states such as Maryland and Colorado. It merits acknowledging that the populations in the Maritime provinces are comparatively small, comprising only 0.4 (PEI), 2.1 (NB) and 2.6 (NS) percent of the national population (Statistics Canada, 2022b). The number of patients seeking care beyond sixteen weeks is low; although such data is no longer collected or published by the Canadian Institutes of Health Information, members of the Reproductive Options and Services (ROSE) Clinic estimate they send less than two dozen patients per year out of the province of NS, the New Brunswick Abortion Care Network (NBACN) estimate a similar number, and SHORS in PEI, less than four. Although several physicians in the region are trained beyond sixteen weeks, they face barriers to providing this care including equipment availability, staffing, and administrative or leadership support. Publicly funded, elective procedural abortion care is now offered up to twelve to sixteen weeks in six Maritime locations: Bathurst, Moncton, Halifax, Truro, Kentville, and Summerside. One physician at the Moncton City Hospital provides care up to eighteen weeks when they are available. Efforts are currently underway in several jurisdictions to extend gestational capacity. A complementary effort is also being pursued by social workers and clinic leadership to enhance Medicare reimbursement timeliness and comprehensiveness for patients required to travel.

Provider training and mentorship

National and regional efforts to increase provider knowledge with respect to medication abortion have blossomed since 2017. Both the Society of Obstetricians and Gynecologists of Canada and the National Abortion Federation Canada offer online courses for continued professional development. The Nova Scotia Central Abortion Network (NSCAN) formed in 2018 to provide mentorship and support among new mifepristone prescribers. In 2023, the NBACN launched with a similar purpose. In 2022, the first of what has become annual Atlantic Abortion Summits was held in Halifax, bringing together clinical and community experts. Formal training opportunities in clinical university programs are more prevalent than they once were (Myran & Bardsley, 2018). Our experience, including lecturing on this topic at Dalhousie University and the University of New Brunswick medical schools, suggests that most medical students in the Maritimes receive a few hours of abortion content, as do nurse practitioner students. In 2020, Dalhousie University launched the first interprofessional education course on abortion in Canada, for students across all faculties (Paynter et al., 2022). This course is co-facilitated by a team of nurses, nurse practitioners, physicians, midwives, social workers and doulas, and has now been offered eight times. Abortion remains infrequently covered in undergraduate nursing curricula, although this may soon change. In spring 2024, the Canadian Association of Schools of Nursing (CASN) developed graduate competencies on abortion care for all student nurses (CASN, 2024). The CASN initiative was part of a national Health Canada-funded effort led by CART at the University of British Columbia to develop tools to enhance professional competencies in abortion care. These tools are collated at: <https://caps.sogc.org/>.

One area of increasing interest and capacity is what is known as no- or low-touch care, provision of medication abortion through telemedicine. With telemedicine, the in-person appointment with the patient is performed by phone or zoom, with blood work drawn locally, or avoided altogether if certain clinical requirements are met. Ultrasound, similarly, is rarely requisitioned. Canadian clinical practice guidelines to support this practice were published during COVID-19 (Guilbert et al., 2021). Provider comfort with this approach grows with experience and support from colleagues.

Finally, expanding the pool of eligible providers automatically expands potential access. In 2017, when Health Canada removed the early requirement that mifepristone prescribers be physicians, regulators in NB, NS and PEI and across the country authorized nurse practitioners as prescribers. There are differences between provinces in terms of nurse practitioner scope (CIHI, 2020). There are an estimated 235 NPs in NB (NPNB, n.d.), at least 222 in NS (NSCN, 2019), and fifty in PEI (CBC, 2019). Our research has found that nurse practitioners are most likely to implement mifepristone prescribing in their practice when they have training, mentorship, and peer support (Carson et al., 2022; Carson et al., 2023a; Carson et al., 2023b). The Canadian Association of Midwifery released a strategy in 2024 calling for medication abortion to be included in midwifery's scope of practice across the country (CAM, 2024); each of the Maritime provinces now has a midwifery program, with PEI's starting most recently.

Private Costs

Reducing travel requirements is critical to reducing private costs. However, in NB public funding for abortion service and related care, including blood work, ultrasound, and health professional services, also rests on patients holding a Medicare card (Government of New Brunswick, 2023). This excludes international students, migrant workers, and others. The Association of Atlantic Universities (AAU) reported 21,415 international students in the Maritime region in 2023–24 (AAU, 2024). Data from Immigration, Refugees and Citizenship Canada (IRCC) suggests that there were 7,465 temporary foreign worker permits issued in the Maritimes in 2022 (Patzelt & Laboissiere, 2023). While the absolute number of patients affected by restricted coverage may be small, the impact of unaffordable care on their lives is incalculable. Physician billing fees for procedural and medication abortion are \$160–180, but the additional costs, such as blood work, ultrasound, instrument tray fees, hospital fees, etc., can bring the cost of care into the thousands (Chabot, 2021). Telemedicine medication abortion is often the least expensive option for patients facing direct expenses for abortion care.

Care for equity-deserving groups

Improving care to meet the needs of equity-deserving groups is becoming a priority among abortion care providers. The availability of medication abortion unequivocally increases choice, reduces engagement with the formal health system, and may empower patients who face systemic discrimination from institutional spaces. Concrete efforts to enhance the gender inclusivity of Maritime abortion services are apparent, such as the name changes for both the programs clinics in PEI and NS: from Women's Wellness to SHORS and from the NS Women's Choice Clinic to Reproductive Options and Services (ROSE), respectively. Current Canadian research is identifying specific barriers to access for Indigenous Peoples (Monchalín et al. 2023a & 2023b) and youth (Munro et al., 2021). Abortion doulas may be one way to mitigate barriers to access for equity-deserving groups; doula programs and resources to increase non-clinical support and companionship in abortion care are also developing (Heggie et al., 2024; Wellness Within, 2024).

Unique contexts

New Brunswick

New Brunswick has long been an outlier in the context of abortion: it was the first province to criminalize abortion in the 19th century (McTavish, 2015); for twenty-five years after *R v. Morgentaler* it maintained an anachronistic requirement for therapeutic abortion committee approval of each abortion performed. However, NB was also the first province to respond to calls for public funding of medication abortion through provincial Medicare (Government of New Brunswick, 2017). Unlike any other province, it publishes quarterly public data on script volume and costs (Government of New Brunswick, 2024). By 2022, NB has, potentially, the highest relative uptake of medication abortion in the country: While the Canadian Institute of Health Information (CIHI)'s most recent statistics reveal that 40% of abortion in Canada was by medication in 2021, up from 4% in 2016, in NB that rate was 68% (Poitras, 2023; CIHI, 2022).

That said, NB faces unique disparities with respect to sexual health. The rate of teen pregnancy is twice that of the national average (Gill, 2024). A recent comparative analysis of provincial sexual health education programs across Canada found NB's to be one of the least comprehensive (Robinson, MacLaughlin & Poole, 2019), excluding eleven of the twenty-seven recommendations for core content according to the United Nations Educational, Scientific and Cultural Organization updated International Technical Guidance on Sexuality Education (UNESCO, 2018). In May 2023, former Education Minister Dominic Cardy publicly criticized Premier Blaine Higgs for "plans to gut sex education" (Canadian Press, 2023), a complementary campaign to the Progressive Conservative's government's notorious anti-LGTBQ+ education policies. New Brunswick's Department of Health and the Vitalité and Horizon health authorities provide minimal information about abortion services on their public websites (Government of New Brunswick, n.d.-a; Horizon Health Network, n.d.; Vitalité Health Network, n.d.). Tele-health (811) toll-free services do not include unplanned pregnancy among the symptoms for which their online "symptom checker" offers direction for care-seeking (Government of New Brunswick, n.d.-b). Furthermore, NB was ranked 11th out of thirteen jurisdictions in the 2023 Contraception Policy Atlas (Action Canada, 2023), largely due to the paucity of public information about pregnancy prevention options. What NB needs urgently is abundant, factual, and encouraging public information about how to access pregnancy prevention and abortion care. After years of advocacy, the province intends to establish a dedicated toll-free number to support patient navigation and access to care (Poitras, 2025).

Nova Scotia

Nova Scotia now boasts one of Canada's only nurse-run, comprehensive, self-referral toll-free access lines for direct booking of abortion care province-wide. This is a coup many others, including NBACN, are endeavouring to emulate. But, because of its geography, Nova Scotians still face the greatest travel burdens in the Maritime region. While the approval of mifepristone and establishment of the NSCAN supported availability of medication in the small distal cities of Yarmouth and Sydney, vastly improved access overall, those areas are still three to five hours from Halifax, where the vast majority of procedural abortions are performed. When patients are beyond nine to ten weeks, the Health Canada approved limit for mifepristone use at home, they simply must travel intra-provincially if not extra-provincially. Furthermore, while NB patients might be willing and able to drive to QC for second or third trimester care, it is that much further for NS patients, who usually fly. NS is home to the Maritime region's tertiary maternity and neonatal care centre, IWK Health, where abortion for fetal

anomaly and maternal indications is routinely performed in the second trimester. These services should also be available for patients who need this care.

Prince Edward Island

Having only opened in 2017, the SHORS clinic in PEI began with best practices other provinces and regions should emulate. From day one, the clinic normalized medication abortion, and approximately half of the patients opted for it. Nurse practitioner prescription was eagerly incorporated within the clinic, and the small team operates interdisciplinarily. Patients may communicate by email or text, reducing the barriers and potential privacy violations that can occur when information must be relayed through telephone calls. To complement mifepristone or for post-procedure, patients receive over-the-counter medications like acetaminophen in little envelopes to take home, minimizing additional stops and expenses at pharmacies. Nurses are on-call 24/7 to support patients experiencing medication abortion at home, reducing the burden on emergency departments for routine questions about bleeding and pain. The substantial cost of long-acting reversible contraception options such as intrauterine devices is included in care. Gestational age capacity started at twelve weeks and quickly expanded to fourteen and then sixteen weeks. The clinic, in the Prince County hospital, is spacious and sparkling. In 2022, the SHORS nurses received the Celia Posyniak Award of Excellence from the National Abortion Federation Canada for their extraordinary service. Having fought a very long and hard road (McKenna, 2018), PEI exemplifies the small, nimble, relational and conscientious care that the Maritimes is suited to provide.

Conclusion

The access achievements of the last decade in the Maritime provinces have been nothing short of incredible, but are often unappreciated, and are the direct consequence of dedicated activists', clinicians', and community organizers' labours. Having long been considered an abortion desert, the Maritime provinces have each demonstrated innovation and an appetite for change that has made a significant difference in patients' lives. These accomplishments ought to be better understood, but more importantly, the improved current state of abortion in the region must better promoted by public actors, including each provincial government and health authority. There are lessons and best practices to be shared among each other, and to be adopted outside of the region and across the country. Moving forward, beyond information promotion and normalizing the discussion of abortion, advocates and clinicians in the region can focus on expanding skills and training, challenging the ethics of charging non-citizens for care, and adjusting services to meet the needs of underserved populations.

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Martha Paynter, RN, PhD, is an Assistant Professor, UNB Faculty of Nursing.

Clare Heggie, MA, is a PhD Student, UNB Faculty of Graduate Studies, Interdisciplinary Studies Program.

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