“We Have the Law, We Need the Access!”: Activism,
Access & The Social Organization of Abortion in New
Brunswick

by

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A thesis submitted to the Faculty of Graduate and Postdoctoral
Affairs in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

in

Department of Sociology & Anthropology
Institute of Political Economy

Carleton University
Ottawa, Ontario

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Abstract

This dissertation explores the role that feminist pro-choice activists have played in resisting and reshaping the social organization of abortion care in New Brunswick. Using political activist ethnography (PAE), my research demonstrates the ways in which activists may help to reveal the social relations organizing abortion access in order to ultimately transform them. Building on PAE and movement-relevant theories, I argue that movement spaces are key sites of knowledge production, and thus offer a useful starting point for research that aims to challenge and transform social relations of ruling.

Contemporary research on abortion in Canada has largely centered on the unequal regional distribution of abortion services, the disproportionate impact of access barriers among marginalized women and communities, and the role of provincial governments and health authorities in allocating abortion services in the context of Canadian federalism. My dissertation extends these conversations by offering a case study into the unique access barriers imposed by the provincial government in New Brunswick, as mediated by the province's *Medical Services Payment Act*. Based on twenty-five in-depth semi-structured interviews, two years of participant observation with Reproductive Justice New Brunswick (RJNB), as well as archival research into the history of abortion regulation in the province, I trace how the closure of the Fredericton Morgentaler Clinic helped spark a grassroots movement to expand abortion access and repeal the province's public funding restrictions for clinic abortions.

Through exploring the ways that activists have helped to reveal the social organization of abortion in New Brunswick, I argue the importance of attending to activist accounts when developing policies around sexual and reproductive health. Indeed, there is much to learn from activists' work to expand abortion access in New Brunswick. Activists, as I show, have helped demonstrate the lines of fault that exist between the institutional coordination of abortion services on the one hand, and patient experiences accessing the procedure on the other. It is due to these lines of fault that activists have increasingly oriented themselves toward a framework that makes visible the ways that access is entangled in social relations of oppression and benefit. In expanding access to abortion, it is important that activists and policymakers alike interrogate the historical, social, political and economic conditions that have led to the uneven and unequal distribution of abortion care in the Canadian context.

Acknowledgements

This dissertation would not have been possible without the support and care of my wonderful partner and husband, Scott Lewin. Thank you for always believing in me, for reminding me of my strengths, for pushing me to just keep writing, and for always being there when I need you the most. I am so grateful for all that you are and do. I love you.

I would also like to express my endless gratitude, respect and admiration for my supervisor and mentor, Dr. Alexis Shotwell. Your encouragement, wisdom and support have been indispensable to this project. Thank you for always reminding me that other worlds are possible, and for teaching me about the transformative power of community and connectedness in developing projects for social change.

I am deeply appreciative for my committee members, Dr. Jackie Kennelly and Dr. Melissa Haussman. Thank you for your guidance, insights, suggestions and support.

Thank you to all those who participated in my research project. Thank you to the members of Reproductive Justice New Brunswick, the Fredericton Youth Feminists and the Abortion Rights Coalition of Canada. Thank you to the staff and volunteers at the Fredericton Morgentaler Clinic and at Clinic 554. Thank you to everyone who lent their time, recounted their experiences, and trusted me to tell their stories with rigor and care.

Endless gratitude and love for Melissa Conte, whose brilliance, kindness, love and support has nourished me throughout my doctoral degree. Melissa, you are my feminist co-educator, co-learner, co-teacher and co-conspirator. Thank you for always being there.

My dear colleagues and friends, who have continued to teach me the in the most unexpected, radical and queerly delightful ways: Max Chewinski, Pavlo Bereas, Jessica Azevedo, Jen Amirault, Matthew Conte, Lyndsay Gray and Ryan Lux. Thank you for everything, always.

To my sweet, sweet KSMF: Grace Spain and Cameron Landry. You two have been with me since the beginning. Thank you for your unwavering support, empathy, confidence and cheerleading.

For Dr. Zelda Abramson: Thank you for convincing me to get my PhD. I would not be who I am today without your mentorship, guidance, generosity, and unconditional love.

And to my family. To my mother and father, Mary and Jim Rodimon, for sacrificing so much to see their children flourish. Your support means worlds. To my brother, Maxwell Rodimon, for your endless curiosity and your unmeasured brilliance. For Linda and Stanley Rodimon, for always encouraging me to follow my dreams, and for always pushing me to stay curious.

Dedication

This dissertation is dedicated to those who have been forced to navigate the many barriers to accessing reproductive healthcare in New Brunswick and across Canada, and to those who are actively working to resist the control, regulation and stigmatization of women's bodies, reproduction and sexuality. Thank you for all the work that you to make this world a better place.

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List of Acronyms

Abortion Rights Coalition of Canada (ARCC)

Canada Health Act (CHA)

Canadian Association for the Repeal of the Abortion Law (CARAL)

Canadian Bar Association (CBA)

Canadian Medical Association (CMA)

Fredericton Youth Feminists (FYF)

Medical Services Payment Act (MSPA)

Therapeutic Abortion Committee (TAC)

New Brunswick Medical Society (NBMS)

Ontario Coalition for Abortion Clinics (OCAC)

Reproductive Justice New Brunswick (RJNB)

List of Research Participants

Abbie Moser

Abbie Moser is a member of the Fredericton Youth Feminists. When I interviewed Abbie, she was a Grade 12 student at Leo Hayes High School in Fredericton, New Brunswick.

Allison Webster

Allison Webster is the former assistant manager of the Fredericton Morgentaler Clinic, and currently a counsellor at Clinic 554. She is an active member of and spokesperson for Reproductive Justice New Brunswick and a board member for the Abortion Rights Coalition of Canada.

Hannah Gray

Hannah Gray is an active member of and former spokesperson for Reproductive Justice New Brunswick. She is also a former volunteer at the Fredericton Morgentaler Clinic, as well as the Fredericton Sexual Assault Centre.

Jaden Fitzherbert

Jaden Fitzherbert is a former volunteer clinic escort at the Fredericton Morgentaler Clinic, and a former member of Reproductive Justice New Brunswick.

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Jessi Taylor is an active member of and former spokesperson for Reproductive Justice New Brunswick. She is also a former sexual health educator in New Brunswick.

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Joyce Arthur is the executive director of the Abortion Rights Coalition of Canada. Joyce is a long-time feminist, pro-choice activist in Canada, having played a major role in the former Pro-Choice Action Network (PCAN) during the 1990s.

Judy Burwell

Judy Burwell was the second manager of the Fredericton Morgentaler Clinic and a member of Reproductive Justice New Brunswick. She is also a dedicated activist for climate justice, and a long-time activist for reproductive health and rights in Canada.

Jula Hughes

Dr. Jula Hughes is a member of Reproductive Justice New Brunswick and a law professor at the University of New Brunswick in Fredericton. She is also a long-time advocate for reproductive health and rights.

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Dr. Karen Pearlston is a member of Reproductive Justice New Brunswick and a law professor at the University of New Brunswick in Fredericton. She is also a long-time queer activist in Canada.

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Maggie Fitzgerald-Murphy is a member of Reproductive Justice New Brunswick and a doctoral candidate in the Department of Political Science and the Institute of Political Economy at

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Megan Hill

Megan Hill is a member of the Fredericton Youth Feminists. When I interviewed Megan, she was a Grade 12 student at Fredericton High School in Fredericton, New Brunswick. She is also a volunteer with AIDS New Brunswick and has participated in several forums with the Canadian Centre for Gender and Sexual Diversity in Ottawa, Ontario.

Marilyn Merritt-Gray

Marilyn Merritt-Gray is a member of Reproductive Justice New Brunswick. She has been a registered nurse in New Brunswick since the 1970s, having worked at both the Fredericton Morgentaler Clinic and Clinic 554. Marilyn is also an active volunteer with the Provincial Green Party.

Max Arsenault

Max Arsenault (pseudonym) is a staff member at Clinic 554.

Shona Newton

Shona Newton is a member of Reproductive Justice New Brunswick and a former volunteer at the Fredericton Sexual Assault Centre. At the time of our interview, Shona was also conducting research on abortion access in New Brunswick, as part of her MA degree at the University of New Brunswick in Fredericton.

Simone Leibovitch

Simone Leibovitch is the former manager of the Fredericton Morgentaler Clinic, and currently works as a counsellor at the Morgentaler Clinic in Ottawa. She is also a former member of Reproductive Justice New Brunswick, and has been involved in feminist work for decades, in particular around women's shelters and violence against women.

Sorcha Beirne

Sorcha Beirne is a former member of the Fredericton Youth Feminists,

Tabatha Armstrong

Tabatha is a former volunteer clinic escort at the Fredericton Morgentaler Clinic and an active member of Reproductive Justice New Brunswick.

Tracy Glynn

Tracy is a PhD Candidate and instructor at St. Thomas University in Fredericton. She is a member of Reproductive Justice New Brunswick, and is also actively involved in local, national and trans-national struggles for social justice.

Valerie Edelman

Valerie is the manager of Clinic 554. She moved to Fredericton from Vancouver to establish and run Clinic 554 with Dr. Adrian Edgar. She is also a member of Reproductive Justice New Brunswick, and is on the Board of AIDS New Brunswick in Fredericton.

Chapter 1: Introduction

It was midmorning on Thursday, April 10th, 2014. I was sitting with my laptop when I noticed the headlines: “Morgentaler clinic in Fredericton closing after operating at a loss” (Global News 2014), “Abortion issue arises in N.B. with Morgentaler Clinic closure,” (Bissett 2014a), “Morgentaler Clinic, New Brunswick’s only private abortion facility, closing” (Toronto Star 2014). The news was overwhelming. Having recently moved to Ottawa from rural Nova Scotia, I knew how important the Fredericton Morgentaler Clinic was for people living in the Maritimes, where women often experience disproportionate barriers to accessing abortion care (Sethna et al. 2013; Sethna and Doull 2012; Shaw 2006). At the time of its announcement, the clinic had been providing over 60% of New Brunswick’s annual reported abortions (Glynn 2014). As I read the news, I could not help but think of the implications this would have for women living in the Maritime Provinces. For two decades, the Fredericton Morgentaler Clinic had been providing abortion care for women from New Brunswick, Nova Scotia and Prince Edward Island (PEI).¹ What would its closure mean for abortion access in those provinces, I wondered, where abortion providers are already so few and far between

¹ This I knew from experience, having lived in Nova Scotia while pursuing my undergraduate and Master’s degrees. During those years, I heard several stories about the challenges that PEI women face when seeking abortion care. For years, women in PEI have been required to travel out of province to access the procedure, often travelling to Nova Scotia or New Brunswick to do so. For those living in Nova Scotia, the only place to access an abortion is the Queen Elizabeth II Health Sciences Centre. For Nova Scotians who either preferred clinic abortions or surpassed the hospital’s gestational limit, however, the Fredericton Morgentaler Clinic was often their only option.

(Shaw 2005; Sethna & Doull 2012)? I sat at my desk for hours that day, poring over news articles and social media, searching for more information.

A press conference was held inside the Fredericton Morgentaler Clinic on the day of the announcement. Outside the clinic, dozens of people gathered along the snowy sidewalk in a show of solidarity, while a handful of staff, volunteers and community members stood inside, watching and listening as Simone Leibovitch, the clinic manager, made her announcement: “It breaks my heart to have to do this. It absolutely does” (Global News 2014). She continued:

The reality is we can’t stay open and provide abortions that are not publicly funded. It’s impossible [...] As far as I’m concerned, the solution to this problem is up to the government of New Brunswick [...] They need to repeal Regulation 84-20. It’s a barrier to healthcare. It’s always been a barrier to healthcare (Simone Leibovitch, quoted in Bissett 2014a).

For years, the Fredericton Morgentaler Clinic had been subsidizing the cost of abortion care for patients who could not afford to pay out-of-pocket for the procedure. As someone who had lived in the Maritimes for most of her adult life, I was shocked to learn this only as the clinic was closing. How could I not have known about the province’s funding restrictions, I wondered?² I continued to sift through the news, learning more about Regulation 84-20 with each article I read: originally passed in 1989, the regulation denied insurance coverage for abortion services unless two doctors deemed the procedure medically necessary. It also required abortions be performed in approved hospitals by medical specialists (Bissett 2014a, 2014b; Global News 2014). As a result, any patient

² My lack of knowledge around Regulation 84-20 is indicative of what Lianne McTavish refers to as the cyclical quality of abortion care in New Brunswick, with “attention rising and falling as the restricted access to abortion becomes visible and then fades into the background once again” (2008:130).

who has accessed an abortion at the Fredericton Morgentaler Clinic has been denied insurance coverage for their procedure (ibid).

As I continued my research that morning, I came upon an article published by the *NB Media Co-op*, an independent news source covering stories from the perspective of those who have been “ignored or misrepresented in corporate media” (NB Media Co-op 2013). Written by members of the Abortion Rights Coalition of Canada (ARCC) and the *NB Media Co-op*, the article provided a summary of the events leading up to the clinic’s closure, and called attention to the role that preceding provincial governments played in restricting access to abortion care in the province—in particular, through promulgating and upholding Regulation 84-20, Schedule 2(a.1) of New Brunswick’s *Medical Services Payment Act* (Abortion Rights Coalition of Canada and NB Media Co-op 2014). Like Simone earlier that morning, the article called for action on behalf of the provincial government:

The New Brunswick government should join the rest of Canada. The government must repeal Regulation 84/20 [sic]. They enacted it with the stroke of a pen, they can take it away with the stroke of a pen [...] The denial of abortion services is an abuse of power and demonstrates a blatant lack of concern for the health of women (ibid).

As I read this, I was again struck by the realization that the only abortion clinic in Atlantic Canada was closing due not to lack of demand, but to a policy that had for years precluded clinic abortions from the province’s public funding model. While I was frustrated to discover my own ignorance, I was furious to learn that provinces were still enforcing anti-abortion policies, nearly three decades after the procedure was decriminalized in Canada. I was not alone in my fury. In that same article, it was

announced that an ad hoc committee – which would soon become Reproductive Justice New Brunswick (RJNB) – had formed in the wake of the clinic’s closure:

Reproductive justice advocates have formed the Ad Hoc Committee for NB Reproductive Justice in response to the news that the clinic is closing. Meetings are being planned and social media sites, websites and email sites are being created. A rally organized by the Fredericton Youth Feminists is being organized for Thursday, April 17th at 12:30pm at the NB Legislature. To find out more, email: choixnbchoice@gmail.com (ibid).

This article felt like a rallying cry for activists and a warning to the provincial government. Its historical analysis of the present situation, its clear call for social and political action, and its critical projection of a future without the Morgentaler Clinic, in which “marginalized women in the province [would] suffer the most” (ibid) succinctly summed up the situation in New Brunswick, through the lens of a political activist. This was the first publication following the clinic’s announcement that not only argued for the government’s complicity in the closure of the Morgentaler Clinic, but which also revealed plans for grassroots mobilization. To solve the problem of access in New Brunswick, those on the ground called upon the provincial government to repeal Regulation 84-20, to ensure public funding for abortions provided in clinic settings, to expand regional access to abortion services in the province, and to provide comprehensive, accurate and non-judgmental information about sexual and reproductive health (SRH) (Abortion Rights Coalition of Canada and NB Media Co-op 2014).

As I recall the events that led to this project, I realize that I began conducting research on the day the clinic announced its closure. In the weeks following the announcement, I meticulously made note of important information. I wanted to know more, so I continued to closely follow the news coming out of Fredericton. When RJNB’s website went live on April 11, I was quick to read through their blog, to follow them on

social media, and to learn from their work on the ground.³ On April 17, when the Fredericton Youth Feminists (FYF), together with members from RJNB, held the Rally for our Right to Accessible Abortion, I stood with them in solidarity at Ottawa's sister rally on Parliament Hill. Later that evening, I sat glued to my laptop as I watched the footage from the Fredericton rally on YouTube. It was only after this series of events – the closing of the Fredericton Morgentaler Clinic; the rallies and demonstrations; the #SaveTheClinic crowdfunding campaign; the opening of Clinic 554 – that I began to formally conduct research into the landscape of abortion care in the province.

Starting from the experience of feminist pro-choice activists, my dissertation explores the role of the Canadian state and medical authorities in restricting, regulating and distributing abortion services in New Brunswick, as well as the key role of activists in resisting and transforming the social organization of abortion care in the province.⁴ In my inquiry into the shape of feminist pro-choice organizing in the province, I have been guided by the following research questions:

1. What are the historical, social and political circumstances that have led to the contemporary struggle over abortion access in New Brunswick?

³ Though RJNB did not announce its formation until May 14, its website, [choixNBchoice](http://choixNBchoice.com), acted as a launchpad for much of the news and organizing coming out of Fredericton in April 2014.

⁴ Following scholars such as Kinsman (2006) and G. Smith (1990), I use the term **social organization** to help reveal how people's activities are coordinated by social relations of ruling. Specifically, my project investigates understand the role that institutions (such as the federal and provincial governments, medical organizations and regional health authorities, as well as social movements) play in mediating abortion access in Canada—that is, in determining where, when, how, and under what conditions abortion care may be delivered at the local, provincial and national levels. As part of this project, I also aim to situate the social organization of abortion access within the ongoing history of interlocking oppressions under a white supremacist, capitalist hetero-patriarchy. In other words, I use the concept of social organization to make visible: 1) the social relations that organize abortion access in Canada (i.e., those institutions that regulate and distribute abortion care), as well as the work that activists do to transform the social organization of abortion access; and 2) the ways in which systems of inequality shape people's ability to obtain safe, timely and affordable abortion care.

2. What can activists tell us about the social organization of abortion in New Brunswick, as well as in Canada more broadly?
3. What role have activists and their allies played in expanding access to abortion, and what is their vision for the future of abortion access in the province?

Research methods

In the fall of 2015 I travelled to Fredericton, New Brunswick to conduct a series of in-depth, semi-structured interviews with feminist pro-choice activists, clinic staff, volunteers and service providers, as well as representatives from New Brunswick's provincial health authorities. During this research trip, I became an active member of RJNB, one of several activist groups that has led the ongoing struggle for abortion access in the province. For two years, I conducted participant observation in RJNB collective and committee meetings, public forums and events hosted by RJNB, as well as meetings between members of RJNB and representatives from the provincial government and provincial health authorities. During this period, I also conducted textual analyses of activist documents and online media, provincial and federal texts governing abortion, media releases by the provincial government, news media covering the abortion issue in New Brunswick, as well as archival documents that I uncovered from the Provincial Archives of New Brunswick during my stay in Fredericton. Together, these three methods – which I expand upon in the next chapter of the dissertation – have enabled an in-depth analysis of the social, political and historical relations that coordinate abortion

access in the province.

Theoretical framework & methodological approach

My interest in pursuing this research project emerged through my own experience as a reproductive health and rights activist, as well as the personal connection I felt to the loss of the Fredericton Morgentaler Clinic. At a theoretical level, my project was largely informed by research that I recently conducted into the reproductive justice movement in the United States, as well as my identity as an anti-oppressive feminist. As I have learned through my research, the reproductive justice framework is particularly helpful in understanding how people's social locations are implicated in their experiences of sexual and reproductive health. One intention of reproductive justice activism is to carve out space for people living at the margins of society to reflect upon, critique, and ultimately dismantle the systems of oppression that perpetuate reproductive injustices within their communities (Siliman et al. 2004). When I heard that a reproductive justice collective had formed in New Brunswick, then, I was already grappling with what this framework might mean in the Canadian context. Although this question was not a formal guiding point for investigation, it resurfaced from time to time throughout the research process, most notably during conversations around RJNB's name, as well as discussions around the meaning of "access." As I demonstrate in the dissertation, the reproductive justice framework was a site of tension and negotiation among activists, coming in and out of focus as they grappled with their vision for the future of abortion access in the province.

In developing my research plan, I searched for a methodology that would work alongside a vision for reproductive justice, as well as my political and pedagogical

commitment to grassroots activism and knowledge production. That is, I sought a methodological framework that could maintain an orientation toward transformative social change while also investigating the social relations that organize the regulation and distribution of abortion care in New Brunswick. This led me toward political activist ethnography (PAE), a reformulation of institutional ethnography (IE) into a distinct form of inquiry for social movements and for activists (Frampton et al. 2006b). Inspired by Dorothy E. Smith's materialist method (1990, 2005, 1974, 1987, 2001), PAE researchers begin their investigation from the standpoint of activists, in order to trace how people's everyday experiences are socially organized through relations of ruling. Apart from PAE, my approach to research has also been informed by Douglas Bevington and Chris Dixon's (2005) conception of "movement-relevant theory." This led me toward an entire body of literature on movement-based knowledge production, rich with lessons on how to conduct research that is useful, relevant and in conversation with activists and the movements they engage in. Together, these theories form the basis of my research methodology, which I explain in more detail in Chapter 2. During the research process, I set out to talk with and listen to activists. I explored, from their perspective, how abortion is socially organized in New Brunswick, with the intention of producing research that may assist in future efforts to expand abortion access in the province.

Contributions to the literature

While many scholars have addressed the role of institutional power in the distribution of abortion services in Canada, fewer have addressed how feminist activists are resisting institutional power to make abortion care more accessible in their

communities and across the country. Recent studies on abortion in the Canadian context have centered on three core themes: (1) the unequal regional distribution of abortion services in Canada (Johnstone 2012, 2014; McTavish 2015; Sethna et al. 2013; Sethna and Doull 2012, 2013; Shaw 2006); (2) the disproportionate impact of barriers to abortion access among low-income women, young women, Indigenous women and those residing in Northern and Atlantic Canada (Sethna et al. 2013; Sethna and Doull 2013; Shaw 2006, 2013a, 2013b); and (3) the role of provincial governments and health authorities in allocating abortion services in the context of Canadian federalism (Hausman 2001, 2005, 2010, 2015, Kaposy 2009, 2010, Tatalovich 1996, 1997).⁵ Still, there are some outliers: Katrina Ackerman (2012), Paul Saurette and Kelly Gordon (2013) have provided insight into the social and political impact of anti-abortion discourse and organizing in Canada; Lorna Weir (1994, 1995) has written on the impact of leftist organizing in the early feminist abortion movement; and Shannon Stettner (2012, 2016) has helped call attention to the “discursive erasure” of women who have been on the front lines of abortion organizing in Canada, as well as the diverse experiences of women seeking abortion care across the country. With few exceptions – including most notably the work of Lianne McTavish (2006; 2015) and Shannon Stettner (2012, 2016), much of the contemporary literature on Canadian abortion politics tends to overlook the importance of local, community-based strategies for resisting abortion regulation, as well as the valuable contribution of activist knowledge in the development of SRH policy. My

⁵ Throughout the dissertation, I use the term “women” rather than “people” or “patients” to help illustrate the gendered politicization of sexual and reproductive healthcare. During my research, however, many activists were intentional in using gender-neutral language in discussions around abortion, as discourses around “women” so often work to exclude and erase the fact that people of all genders may require abortion care.

research extends current discussions of abortion access in Canada by exploring how activists in New Brunswick are disrupting institutional power to bring dynamic and substantial change to the distribution of abortion services in their communities, while also mapping the social relations that contribute to the uneven access to abortion services across the province. Furthermore, through my theoretical and methodological framework, my dissertation offers a sociological analysis to the relationship between activist knowledge production, social change and abortion access in the Canadian context.

Outline of dissertation

Following this introductory chapter, I map out the theoretical framework that has informed my research, as well as the research methods I used to collect data for the dissertation. I begin by briefly examining the history and core principles of the reproductive justice framework and its vision for an intersectional approach to resisting and transforming ongoing histories of reproductive oppression. I then turn to a discussion of institutional ethnography (IE), political activist ethnography (PAE), and what I refer to as movement-based theory and research, offering insights into the epistemological, ontological and methodological offerings of each. In the second part of the chapter, I continue to narrate the serendipitous series of events that led to my research site, and offer a thorough account of the data collection process, as well as the methods used to analyze the data that I collected while in the field.

In Chapter 3, I explore the historical foundations of the contemporary movement for abortion access in Canada, drawing attention to the evolving roles of the state, the medical community, and the feminist pro-choice movement in shaping abortion policy between 1869 and 1994. This chapter reviews the literature on abortion access, activism

and policy in the Canadian context, revealing the social, political, and material relations that have shaped today's struggle for expanding access to the procedure in New Brunswick. In this chapter, I show that despite decriminalizing abortion in *R v Morgentaler* (1988), the fact that the Supreme Court also granted provincial and territorial governments autonomy over the regulation of abortion services has led to restricted access in many areas of the country. In this same discussion, I begin to reveal common threads between the history of feminist pro-choice activism in Canada and the contemporary movement for abortion access in New Brunswick. In so doing, I demonstrate the integral role that abortion clinics have played in the history of pro-choice feminist organizing in Canada, and show how several iterations of feminist pro-choice activism in Canada have conceived of the relationship between rights, access and structural inequalities.

Chapter 4 is the first of three substantive chapters of the dissertation. Here I present New Brunswick as a case study for understanding the shift in abortion jurisdiction – that is, from federal to provincial and territorial – that occurred following the 1988 Supreme Court decision. In this chapter I reveal the province's decades-long conflict over abortion clinics, and demonstrate how successive provincial governments have restricted access to abortion through promulgating and upholding anti-abortion provisions in the province's *Medical Services Payment Act*. In the final section of this chapter, I provide a window the experiences of working at the Fredericton Morgentaler

Clinic during these years, and begin to unravel the social, material and political relations that led to the clinic's closing in 2014.

In Chapter 5, I provide a contemporary history of the events that unfolded in New Brunswick following the announcement of the clinic's closure. Here I rely on data collected through interviews and participant observation to present the experiences of activists as they resisted, reshaped, and ultimately transformed the social organization of abortion services in the province. In presenting these findings, I discuss the formation of Reproductive Justice New Brunswick (RJNB), explore how my research participants organized against what they consider the "crisis of access" in the province, assess the connections that activists have made between access, inequality and reproductive justice, and examine several key strategies, campaigns and direct actions that have led to the current landscape of abortion care in New Brunswick.

In Chapter 6, I reflect on the role that the provincial government and the medical community have played in both expanding and restricting access to abortion services from 2015 onward. Here I analyze New Brunswick's public funding model for abortion care, tracing the institutional coordination of services in the province. In this chapter, I argue that the provincial government's recent moves to remove barriers to abortion care in the province have resulted in an optics of change and a semblance of access in New Brunswick. Despite recent changes in the social organization of services, clinic abortions continue to be ineligible for public funding, while patients seeking hospital abortions continue to face structural barriers to accessing timely and affordable care. As a result, activists in New Brunswick are continuing to push for the repeal of Regulation 84-20, while also grappling with the immediate access barriers imposed by the province's

hospital system. This, I argue, is a reminder of the usefulness of attending to activist accounts when developing abortion policy,⁶ and of holding a reproductive justice framework firmly in place when advocating for expanded access to care.

I close the dissertation by restating the connections between activist knowledge production, social change and abortion access in the context of New Brunswick. In this concluding chapter, I summarize the key analytic takeaways of the dissertation, provide a brief discussion of the project's implications for developing comprehensive SRH policy, and offer several insights for future research in the area. Near the end of the chapter, I reflect on RJNB's most recent campaign to expand abortion access in the province, highlighting the collective's ongoing demands of the provincial government, as well as the work that remains ahead of us.

⁶ That is, if policymakers wish to create meaningful policy that reflects the diverse needs of women who seek abortions, then it would be advisable for them to consider activists as key stakeholders, and to include them in discussions and decision-making processes around abortion and related sexual and reproductive health policy.

Chapter 2: Theoretical Implications & Research Design

Introduction

In this chapter I explore the theoretical and methodological foundations for my dissertation research. I begin by introducing the core principles of the reproductive justice (RJ) framework. Developed by women of colour organizers in the United States, the RJ framework offers an intersectional analysis to issues of sexual and reproductive health and rights by demonstrating how these issues are connected to systems of oppression and benefit.⁷ This framework has been central to my own thinking around the politics of reproduction in general, and of abortion access in particular, as it helps to expose the ways in which one's ability to obtain safe, timely, and affordable care is contingent upon their social location. Following this overview, I briefly introduce institutional ethnography (IE) as method of sociological inquiry that takes people's everyday experiences as a starting point for investigating social relations and social organization. Here I unpack key terminology used in IE circles—terminology which, despite its usefulness for asserting the relational character of the social world, often casts IE writing as overly technical and, at times, inaccessible. I then introduce the core methodological framework for my doctoral research through the literature on political activist ethnography (PAE). A reformulation of IE, PAE is an approach to research that begins from the perspective of activists to trace how social relations of struggle are coordinated by textually-mediated relations of ruling. Central to this method is the notion that

⁷ Here I am referring to the ways in which systems of inequality work to privilege or benefit certain groups of people, while marginalizing or oppressing others.

beginning our inquiry from the perspective of activists can provide researchers with important political insights into social organization and social change. In this same section, I discuss how PAE research has the capacity to break from the technical and inaccessible genre of past IE projects, and provide an opening for work that is politically useful and oriented toward social justice. The third section of this chapter comprises an overview of movement-relevant theory (MRT) and the literature on movement-based knowledge production, to discuss how researchers might engage in work that is relevant for social movement struggles. Here I discuss the relationship between knowledge produced in social movement spaces and knowledge produced in academia, problematize the activist-academic binary that is reproduced in so many activist and academic spaces, and discuss some of the advantages and challenges involved in conducting academic research with and for social movements. In the final section of this chapter, I discuss the methods that I used to collect and analyze my data for this project. Here I describe how I operationalized the theoretical and methodological insights of IE, PAE and MRT during the research and writing process, and reflect on my approach to using in-depth interviews, participant observation, and archival research to investigate the social organization of abortion in New Brunswick.

Reproductive Justice

The reproductive justice framework emerged through women of colour organizing in the United States as a means of demonstrating how the “control, regulation, and stigmatization of female fertility, bodies, and sexuality are connected to the regulation of communities that are themselves based on race, class, gender, sexuality, and

nationality” (Silliman et al. 2004:4).⁸ This intersectional and inclusive framework places women’s lived experiences at the centre of its politics, calling attention to the ways in which interlocking systems of oppression shape the conditions under which marginalized women, and Black women, Indigenous women, and women of colour in particular, can make healthy decisions about their bodies, their sexuality and their reproduction. While women of color organizers had been developing similar holistic analyses for decades, the movement for reproductive justice gained traction in the United States in the 1980s and 1990s, against the backdrop of a mainstream reproductive rights movement which excluded, silenced and further marginalized the voices and experiences of women of colour. Due in part to its emphasis on individual privacies and civil rights, such as the right to safe and legal abortion, the mainstream movement for reproductive rights did little to address the complexity of reproductive oppression as experienced among women at the intersection of multiple social relations of inequality. This has resulted in the further marginalization of women of colour, Indigenous women, poor women, women with disabilities, and many other communities whose organizational efforts have historically fallen outside the scope of the mainstream movement for reproductive rights (Ross 2006; Siliman et al. 2004; A. Smith 2005).⁹ Issues such as sterilization abuses,

⁸ The term of “women of colour” was coined in 1977 at the National Women’s Conference in Houston, Texas. Rather than affirming a biological or racial designation of women, the term evokes a political and solidaristic relationship “in opposition to sexist, racist, and imperialist structures” of domination (Siliman et al. 2004:3, 19). As suggested by Loretta Ross of the SisterSong Women of Color Reproductive Justice Collective, those who self-identify as women of colour are making a conscious commitment “to work in collaboration with other oppressed women of colour who have been minoritized” (2011).

⁹ It is important to note that these tensions are not the result of malevolent practices on behalf of the mainstream movement for reproductive rights, whose efforts have contributed to major wins for women’s rights throughout United States history. Rather, they are the result of a movement that has fought predominantly on behalf of the experiences within its constituency, which

access to culturally relevant reproductive healthcare, the ability to bear and parent one's child free from violence, as well as a nuanced analysis of the intersections of race, class and ability were often overlooked and underrepresented within the mainstream movement. Below, activist and scholar Marlene Gerber Fried points to strategies that reveal the implicit white middle-class subjectivity of the reproductive rights movement:

...framing the issue in terms of privacy and civil rights rather than in terms of women's liberation and freedom; shaping the strategy and politics in accordance with the concerns of white middle-class women and ignoring the diverse needs of other groups of women; relying on those in power to create change rather than pursuing grassroots empowerment strategies; and isolating abortion from other issues (1990:2-3).

Dissatisfied with this narrow approach, many women of colour began to organize for a broader agenda that would encompass the full spectrum of reproductive health needs, as identified and defined within their communities (Nelson 2003:4). In the 1980s, a surge in women of colour organizing emerged around issues of reproductive health and rights in the United States, including but not limited to the National Black Women's Health Project, the National Latina Health Organization, the Native American Women's Health Resource Center, and Asians and Pacific Islanders for Reproductive Health (Siliman et al. 2004). Then, in 1994, the impromptu *Women of African Descent for Reproductive Justice* caucus gathered at the Illinois Pro-Choice Alliance Conference, coining the term "reproductive justice" as a framework that would speak to women of colour's diverse and

happens to be overwhelmingly white and middle class. Rather than creating a united front in the struggle for comprehensive reproductive health and rights, these actions have deterred the participation of those groups whose reproductive needs do not fit within the narrowly defined visions and strategies of the mainstream movement.

intersectional experiences with reproductive health, as well as other social justice issues that are essential for the achievement of reproductive freedom (Ross 2006:16).

As an organizing principle, reproductive justice has been defined by Asian Communities for Reproductive Justice (ACRJ) as the “the complete physical, mental, spiritual, political, social and economic well-being of women and girls, [which] will be achieved *when women and girls have the economic, social, and political power and resources to make healthy decisions about our bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives*” (ACRJ 2005: 1, emphasis in original). This definition, which is used widely by organizations within the reproductive justice movement, is grounded in the “full achievement and protection of women’s human rights,” (Ross 2006: 14). This comprehensive framework addresses the importance of fighting not only for legal rights, but also for the “necessary enabling conditions to realize these rights,” which is a struggle that is particularly central to the lives of many women of color, Indigenous women, poor women, women with disabilities, immigrant women, and other marginalized communities across the globe. In this way, reproductive justice advocates call attention to the relationship between structural inequalities and the possibility for women to exercise their reproductive autonomy. Among the diverse demands of the reproductive justice movement is access to comprehensive and affordable healthcare, childcare, housing and education; access to culturally appropriate family planning without coercion; an end to sterilization abuse; the

right to bear and to parent their children; as well as ability to access safe and legal contraception and abortion (Nelson 2003; Ross 1992).

In recent years, an increasing number of activist organizations have gravitated toward the reproductive justice framework as a way to expand the scope and reach of their struggles around issues of sexual and reproductive health and rights. This has been met with cautious optimism by many reproductive justice organizers, who have expressed concerns over pro-choice organizations co-opting the term to further their political agenda without prioritizing the leadership of women of color, or acknowledging the work that women of color have done to challenge and expand the scope of pro-choice organizing over the past several decades (Ross 2006; Luna 2011; Simpson 2014). For instance, Jessica Danforth of the Native Youth Sexual Health Network has troubled the tendency for Canadian non-profits and activist organizations to tack the word “reproductive justice” onto their work without interrogating their complicity in systems of oppression and benefit. As an example, Danforth describes having encountered pro-choice organizations that declare their support for reproductive justice, “but then say the most racist, Islamophobic statements about women in hijab needing to be ‘saved’ [...] That’s not real RJ to me because to me, it starts with respecting self-determination and knowing that you can’t be the expert about someone else’s life” (Danforth 2010:4–5). Similarly, Andrea Smith writes that all reproductive justice work “must make the dismantling of capitalism, white supremacy, and colonialism central to its agenda, and not just as principles added to the organizations’ promotional material” (2005:135).

In Canada, the tension between pro-choice and reproductive justice (historically referred to as “reproductive freedom”) has been present among feminist activist circles

for decades. In later chapters of the dissertation, I examine how these tensions have played out both in the broader national and historical context, as well as in contemporary organizing around abortion access in New Brunswick. While it is important not to conflate pro-choice and reproductive justice organizing, I argue that feminist pro-choice activists should hold a reproductive justice framework firmly in place when advocating for access to abortion. This means fighting not only to establish more services in hospitals and clinics, but also for the necessary enabling conditions for people to obtain care within those spaces. As described earlier, this sort of organizing requires an understanding of how abortion and other SRH issues are connected to systems of inequality. It also requires actively working to disrupt and abolish such systems.

Institutional Ethnography

While my research project uses political activist ethnography (PAE) as its core methodological framework, it is useful to first explore some key terms from the field of institutional ethnography (IE), which has formed the basis of much PAE research. IE emerged in the 1970s through the work of Dorothy E. Smith (1974, 1987, 1990, 2001, 2005) as a critical and feminist approach to conducting sociological research.¹⁰ IE researchers begin their inquiry from people's everyday experiences in order to determine

¹⁰ It is worth noting that many scholars have since critiqued D.E. Smith's approach to sociology for neglecting to fully engage with the rich and diverse body of literature that similarly problematizes issues of objectivity, experience and knowledge production (Luxton & Findlay 1989), as well as for shirking an analysis of the complexities of gender as it intersects with race, sexuality, class, age, and so on (Hill Collins 1991). Indeed, the most D.E. Smith seems to engage in feminist literature is in her use of the term "standpoint," which she borrows from Sandra Harding (1993, 2004) while the remainder of her theoretical grounding can be attributed to a blending of Marx's materialist ontology with Garfinkel's ethnomethodology (D. E. Smith 2005, 1987, 1990).

how their lives are organized and regulated by society's institutions.¹¹ Central to this mode of inquiry is what D.E. Smith (2005:209) and others (Bisaillon 2012; Deveau 2008; Mykhalovskiy and Church 2006; G. Smith 1990) have referred to as an “**ontological shift**,” or an understanding of the social world as a complex and coordinated network of people's everyday activities. While IE researchers attribute much of the ontological shift to Marx & Engels (1998 [1947]),¹² they add to their analysis the notion that our everyday activities and practices alone do not comprise the social world, but instead are constantly working in concert, or sometimes at odds, with one another. It is thus the ongoing *coordination* of our everyday activities that organize, and are in turn organized by, the social world. These activities are often referred to in IE as “**work**” (Bisaillon 2012; D. E. Smith 2005). In the IE sense, work designates a broad conception of human activity, which includes paid labour and reproductive labour, as well as smaller, everyday practices, such as researching where to access an abortion, travelling to obtain the procedure, coordinating childcare, taking time away from paid labour, organizing a pro-choice demonstration, or drafting briefing documents on the benefits of funding abortion clinics.¹³ In this way, IE and PAE researchers are particularly oriented toward investigating people's activities and their

¹¹ In IE and PAE circles, **institutions** are defined broadly as complex networks centered around a particular function, such as healthcare, education or incarceration (D. E. Smith 2005:225). They are, in other words, dynamic processes in which people's activities work in concert with one another in the management, administration and organization of society (D. E. Smith 1990).

¹² In *The German Ideology*, Marx & Engels critique the German idealist philosophers for reifying social activist by abstracting consciousness from its socially coordinated character to that of an *a priori* existence. Marx & Engels' alternative – that ideological thought is directly connected to the production, diffusion and naturalization of ruling class ideas – provides us with a dialectical theory of knowledge as produced by actual people in the context of their everyday lives. Particularly demonstrative of the connection between ideology and the ruling class is the oft-cited excerpt, “The ideas of the ruling class are in every epoch the ruling ideas...” (Marx and Engels 1998 [1947]:39).

¹³ In my research, I consider each of these as integral to the “work” of accessing an abortion, as well as the “work” of increasing abortion access in New Brunswick.

coordination, which they often refer to as “**social organization**” (Campbell 1998; Frampton et al. 2006c; Kinsman 2006; Rankin and Campbell 2009; D. E. Smith 2005; G. Smith 1990; Smith 2001). Beginning from people’s experience is thus a useful starting point for investigating how people’s everyday activities are implicated in, and coordinated by, social relations of ruling.¹⁴ Tracing these social relations helps IE researchers to understand how the world works and how it is put together (that is, its social organization), often with the goal of changing it.

In conducting their investigation, IE and PAE researchers look toward a **line of fault** or **disjuncture** between people’s everyday experiences and the way those experiences are represented within official discourses and relations of ruling (Frampton et al. 2006c:33). This concept is particularly useful for attending to differences in social location (Bisaillon 2012). As I demonstrate later in the dissertation, for example, there are two lines of fault that I have noted in my research: the first is between the federal mandate for universal healthcare and the provincial regulation of abortion services, while the second is between the provincial government’s representation of abortion access on the one hand, and the ways in which abortion care is understood and experienced by patients, activists and service providers on the other. There are thus two sites of exploration within IE and PAE research: the local, everyday world of experience as it is described to us by our informants, and the extra-local world that is situated outside the boundaries of everyday experience, coordinated through institutions and the texts they rely on. “**Texts,**” D.E. Smith

¹⁴ The term “social relations of ruling” is also referred to within IE and PAE circles as “ruling relations.” It is used in this context to demonstrate “connections between the different institutional relations organizing and regulating society” extra-locally through texts (Frampton et al. 2006: 37).

argues, are key to understanding the connection between our local activities and the extra-local organization of ruling relations, and are integral to the way that institutions function in society (2005). Texts can thus provide a way of understanding how the extra-local coordination of people's work in institutional settings organizes and regulates the everyday experiences of people in local settings (D. E. Smith 1990, 2005).¹⁵ Borrowing from IE, I use the concept **"extra-local"** to illustrate the network of ruling relations that coordinate the local experiences of activists seeking to expand access to abortion care in New Brunswick. As I make clear, this network of ruling relations includes but is not limited to the federal and provincial governments, regional health authorities, service providers and hospital boards, as well as political allies and opponents—all of whom work extra-locally to regulate, distribute and implement abortion services in the province.

Political Activist Ethnography

At the core of my dissertation's methodological and theoretical underpinnings is the claim that those who are working for social change hold particular social and political insights into the social organization of the issues they are up against. While IE offers researchers a method for tracing social organization by starting from people's everyday experiences, PAE provides researchers with a firmer orientation toward social change by beginning its inquiry from the perspective of activists. That is, while IE attends to the everyday experiences of ordinary people entangled in mutually constituting relations of ruling, PAE unapologetically focuses on people who are interested in changing the world,

¹⁵ The term "texts" is used here to refer to diverse forms of writing, speaking and representation through which ruling occurs, and may include policy, legislation, court proceedings, provincial and municipal regulations, statistical analyses, reports, news media, etc.

as well as the social relations that shape it. Still attuned to tracing social organization, the role of the researcher in PAE is to engage in an analysis that will help determine “effective direction[s] for activism” (G. Smith 1990:87). While IE researchers often speak of explicating social relations in order to ultimately change them, it is not explicitly clear how IE alone may contribute to a project that is centered in social justice and activism. In this section, I introduce PAE as a developing method for sociological inquiry, demonstrating its usefulness for research that seeks to trace the social relations of struggle that activists engage in through working toward social change.

PAE: A Research Method for Activists and Social Movements

Political Activist Ethnography (PAE) was first introduced by the late activist and sociologist George Smith (1990), who worked closely with Dorothy E. Smith during his years at the Ontario Institute for Studies in Education (OISE) at the University of Toronto. It was G. Smith’s reformulation of IE, as a methodology for social movements and for activists, which laid the groundwork for researchers to explicate social relations as they occur within terrains of social and political struggle. Integral to G. Smith’s method was the use of “political confrontation as an ethnographic resource” (1990:629). This is perhaps most evident in his work with the Right to Privacy Committee (RTPC), a community organization that was set up to help defend those who were arrested in the 1980s bath raids in Toronto (ibid). The objective of his research was to explore, from the standpoint of political activists, how administrative apparatuses work and how they are organized. In this study, G. Smith traced the social organization of police practices of gathering evidence of the “criminal practices” they witnessed in the Toronto bathhouses.

This evidence was inputted into a disclosure document as a “mandated course of action” that was coordinated by the bawdyhouse section of the *Criminal Code of Canada* (ibid). This project made two significant contributions to the field of PAE: (1) it demonstrated how to conduct research *for* gay people, as opposed to treating them as “docile objects of study,” and (2) it illustrated the significance of texts in exploring how ruling relations (codified in this instance in the *Criminal Code*) operate extra-locally by coordinating the everyday experiences of people (G. Smith 1990:630) This project also offered a substantive contribution to activism: it provided activists with a renewed strategy for confronting ruling relations (which made the bath raids possible in the first place) by calling for concrete changes in the *Criminal Code*, rather than attributing the bath raids to homophobia within the police force (ibid). It is this third contribution that I believe sets PAE apart from IE. While many IE studies have explored ruling relations as they coordinate experiences within institutional work settings, such as nursing homes (Diamond 1992), youth shelters (Nichols 2014), hospitals (Campbell 1998; Rankin and Campbell 2009), and municipal governments (Turner 1995, 2011), fewer IE studies have engaged with the work of making change as it occurs *outside* of institutional settings, in the everyday practices of activists. While PAE similarly traces how social relations coordinate everyday experience, it does so from the perspective of activists who seek to disrupt institutionalized and textually mediated relations of ruling. As George Smith described it, PAE can best be understood as:

a method of using grassroots political organizing as a means of describing how people’s lives are determined from beyond the scope of their everyday world... it provides a way of exploring, from their standpoint, how the world works and how it is put

together, with a view of helping them to change it (1990:629)

Research in the field of PAE has thus far included studies such as Viviane Namaste's (2006) exploration into how the institutional (and textually-mediated) management of sex and name changing practices in Quebec disrupt the integration of female-to-male transsexuals in Quebecois society;¹⁶ John Clarke's (2006) investigation into the "history and workings" of gentrification practices in Toronto and the use of direct action tactics (such as housing takeovers by the Ontario Coalition Against Poverty) as methods of resistance; and Gary Kinsman's (2006) work on "mapping the social relations of struggle" in the Toronto bath raids of the 1980s, as well as the ongoing confrontations between activists in the global justice movement and the local, national and international bodies that sustain and reinforce global capitalism. In each of these studies, PAE researchers demonstrate that, in taking up the standpoint of activists, sociologists may be able to produce research that is useful for social movements and for the struggles they engage in. In this way, PAE aims to produce "insider's knowledge" into the workings of the institutions that activists encounter in their everyday work. By investigating the organizing logics of ruling relations, PAE researchers aim to engage in research that can lead to more effective forms of activism, and that opens up spaces for activist intervention into ruling relations (Frampton et al. 2006b:9).

Despite its introduction nearly thirty years ago, PAE remains a developing methodology that has not gained much traction within the sociological literature. In fact,

¹⁶ The term "transsexual" is used by Namaste to describe individuals "who are born in one biological sex but who identify as members of the 'opposite sex,'" and who "use hormones and undergo surgical interventions to modify their primary and secondary sex characteristics" (2006:160).

to date there has only been one edited collection published on the subject, *Sociology for Changing the World* (Frampton et al. 2006c), though another collection on the subject is nearing its final stages of publication (Hussey and Bisailon n.d.). This has had at least two significant impacts on researchers engaging in these methods. First, it has meant that most of the work on PAE is still located firmly within the realm of IE. This is most clearly illustrated by PAE researchers' use of terms such as ruling relations, social organization, line of fault and standpoint, which, as in IE, are used as methodological tools to uncover how local experiences are shaped by broader social relations, which are themselves located within institutional settings, and coordinated extra-locally through texts. There is also, again, a specifically Marxist implication in using these terms, rooted in an ontological commitment to understanding the social world as put together through people's concrete and coordinated activities. Again, if forms and experiences of oppression and social injustice are organized through the actual practices of people, then they can also be disrupted, undone, and changed through our practices.¹⁷ Terminology that locates these practices within people – thus maintaining their social, material and relational character – is critical to PAE projects insofar as it helps researchers avoid language that “participates in the reification of our social world” (Frampton et al. 2006a:256). Instead, this language (though tedious and, perhaps at times, clunky) helps us to focus on how social practices and relations produce, reproduce and reinforce the way our society works. This focus, in turn, enables us to find openings, weaknesses and contradictions in the forms of social organization we face, in order to more effectively

¹⁷ I refer to this as Marxist in the sense that it recalls Karl Marx's Eleventh Thesis on Feuerbach: “The philosophers have only *interpreted* the world in various ways; the point is to *change* it” (1998 [1845/1947]: 571).

challenge them (ibid).

The second impact of the relatively sparse literature on PAE is that its methods for data collection remain flexible and open to interpretation. While both IE and PAE projects typically utilize interviews, participant observation and texts to collect data for their research, proponents of PAE have opted against setting strict parameters or conventions around what a PAE project might look like in action. Most often, data collection in IE and PAE is considered a non-linear process of discovery: we listen closely to our research participants, who will perhaps lead us to another participant; a document or a text; a meeting or a direct action. At the same time, documents themselves might lead us to discover new sites for observation or research participants to interview: for example, it was only through a critical reading of the *Medical Services Payment Act* that I decided to reach out to Horizon Health Network, one of New Brunswick's two regional health authorities, to get a sense of how they organized their abortion services following the amendment to Regulation 84-20. This flexibility presents certain challenges for those who are conducting ethnographic research. Not knowing what direction our data will take us in requires an openness when we set out to conduct research. This openness is not always conducive to a well-organized or timely research project—indeed, in my experience, tracing connections between the local practices of activists and the extra-local relations of ruling has opened up more possibilities for research than can be contained in one dissertation. The problem then becomes a matter of choosing which path to take, which institutions to narrow in on, and which social relations to explicate. In my research, I have done my best to circumvent this by revisiting my interviews, re-engaging with activist-generated texts, and following up with activists themselves to get a better

sense of which direction would be most useful and relevant for the struggle itself. Indeed, one of the core aims of PAE is to produce research that is relevant and useable for activists in their work for social change. In this way, the perspective of activists is not simply a starting point for research, but rather an orientation to the research project itself.

Starting from the Standpoint of Activists

In PAE, starting our inquiry from the standpoint of activists is a political undertaking — one that aims to take up the standpoint of those whose knowledge and understandings of a situation have been marginalized and pushed to the sides, as opposed to the standpoint of those whose voices are most amplified. As Roxana Ng defines it, the term “standpoint” used in this way indicates a “*political* vantage point from which one views the world and identifies the seer as an interested and invested knower, rather than a disinterested, neutral and ‘objective’ one” (2006:179, emphasis in original). Of course, this usage has its roots in D.E. Smith’s *Everyday World as Problematic*, which helped to create “a way of seeing, from where we actually live, into the powers, processes and relations that organize and determine the everyday context of that seeing,” (Smith 1987:9). This standpoint – that of women, of people, of “the oppressed,” etc. – has, according to D.E. Smith and others,¹⁸ been largely overlooked, silenced, and excluded

¹⁸ Apart from D.E. Smith, scholarly work on standpoint theory is perhaps most frequently attributed to Sandra Harding (1991, 1993, 2004), who considers how knowledge is shaped by our social location in the relations of ruling. Her work, like that of D.E. Smith, holds that the experience of women offers a unique perspective from which to understand– and, indeed, theorize – the social world. Nancy Hartsock (1998, 2010), too, draws on Marxist theory to demonstrate how, due to systems of power and inequality, women’s experiences differ greatly from those of men, producing within women a “privileged vantage point on male supremacy [...] that can ground a powerful critique of [...] the capitalist form of patriarchy,” (Hartstock 2010:316). Adding significant texture to standpoint theory, Patricia Hill Collins (1991) integrates an intersectional analysis into her call for scholarship that begins from the experiences of Black

from the relations of ruling that organize our society. Taking these standpoints as our starting place has thus opened up space for researchers in IE and PAE to ask: what are the social relations that generate our experiences? How are our experiences of oppression, exclusion and marginality connected to social organization? And additionally: what are the material realities that have been made possible through our very exclusion?

Following D.E. Smith's broad conceptualization of work (2005), proponents of PAE have come to understand activist practices (including though not limited to direct action, meetings, placard-making, drafting of documents, media interviews, and research) as integral to the everyday work of making change (Hussey 2007, 2012; Kinsman 2006; G. Smith 1990; Thompson 2006). Central to this idea is how activists and researchers may gain insights into the social organization of ruling regimes through moments of confrontation. In my own research, I found that activists often gained insights into the way abortion care is governed in New Brunswick through their experiences working or volunteering at the Fredericton Morgentaler Clinic and Clinic 554; through meetings with the Minister of Health and representatives from the regional health authorities; through research conducted via Right to Information and Privacy Requests; through direct actions and demonstrations protesting the distribution of abortion services; as well as through media publications that followed these events. That we may uncover aspects of social organization through activist confrontation and research is central to PAE's epistemological commitment to knowledge as produced by and through everyday practices and interactions with others. PAE researchers thus push back against reified and

women, whose lives have been shaped by the interlocking dimensions of race, gender and class oppression.

objective forms of knowledge, which obscure the social relations of oppression and benefit that organize the social world, in favour of a reflexive, social and active epistemology. To be sure, taking activists' experiences and knowledge seriously does not necessarily mean privileging their perspectives, but rather starting from them and orienting ourselves to them. What are activists finding in their own work? What kinds of contradictions emerge from their confrontations with relations of ruling? What puzzles them the most about the social relations they seek to transform? These are the sorts of questions that PAE projects take on when starting from the perspective of activists.

It should be noted that, in PAE as in IE, starting from the standpoint of individuals or groups does not necessitate a universalized subject, nor does it lend itself to the creation of objective "truths." What starting from a standpoint does, however, is begin our inquiry from a particular social location that is situated against and outside of relations of ruling (G. Smith 1990).¹⁹ Just as IE begins from an embodied standpoint, in PAE that standpoint is explicitly that of an activist. Yet, as activists and as people who rely on access to reproductive healthcare, our experiences of exclusion, marginalization and oppression likely manifest differently depending on our social location.²⁰ For example, as activists who are also academics, some of us may have more access to spaces where important decisions are made regarding our sexual and reproductive health. As activists who are also involved in abortion clinic work, we may have more of an impact

¹⁹ The assertion that activists are located outside of ruling relations is a sticky one for Marxists who consider the social world to both shape and be shaped by human consciousness and practical activity. If we are complicit in relations of ruling while also struggling against them, then how can we possibly be thought to exist outside of them?

²⁰ I use "us" and "our" here to indicate a political and epistemological statement of solidarity: I consider myself among those with and for whom I write.

on how clinic spaces, abortion services and people who have abortions are perceived in the media and in public discourse. As activists who have also had abortions, we may be more attuned to the intricacies of seeking out, paying for, and obtaining an abortion. There is thus not one single narrative that speaks to how we are excluded from decision-making practices related to the distribution and regulation of abortion care.

One strategy for conducting PAE research that pushes against essentialist claims to “truth” or “experience” is to interview a variety of activists who are situated differently within the movement. In my own research, this has included activists of different age groups and generations; activists who had been involved in RJNB since it emerged and those who had only recently joined; activists who had left RJNB; activists who had worked or volunteered at the Morgentaler Clinic; activists who work or volunteer at Clinic 554; activists involved in national advocacy work; activists situated in and outside of academia, etc. Another non-essentialist strategy for investigating the social world from the standpoint of activists is to remain critically attuned to reflexivity and representation. For instance, the starting point of my research is explicitly that of my research participants—it is from *their* stories, narratives and experiences that I began my research. Thus, while the themes present in my dissertation may resonate with the experience of other activists, advocates and service providers located in other regions, provinces or territories, they are not representative of the “typical” pro-choice or reproductive justice activist experience in Canada or elsewhere.

In terms of research practice, then, PAE requires that researchers take seriously “people’s experiential, contextualized, and particular knowledge of what happens in their lives,” rather than explaining away these happenings through the use of abstract

categories and concepts (Bisaillon 2012:617). As in IE projects, PAE researchers do not start and end their analysis in people's experience, but instead seek to understand how that experience is connected to broader social relations of ruling. PAE researchers recognize their research participants as "active knowers in the real world," whose experiences and perspectives offer valuable knowledge for social and political inquiry (G. Smith 1990: 631). The method proposed by many PAE researchers thus often mirrors that formulated in IE projects: start from experience, map your way outward, and watch the interconnections proliferate (D. E. Smith 2015). The three-fold research design proposed by D.E Smith and taken up by several PAE researchers looks something like this:

- (1) Start with activist experiences. Conduct interviews and participant observation to explore what struggles activists are engaging in, and what institutions they are struggling against.
- (2) Analyze interviews and field notes, looking for references to institutions and ruling relations.
- (3) Trace these ruling relations to uncover their textual mediation. What texts connect the extra-local relations of ruling to the local experiences of activists? How are these texts mediators of social organization?

As discussed above, the objective of exploring the textually mediated relations of ruling is to locate spaces where we might apply political pressure for social change. However, due to the relatively sparse literature on PAE, I have found there is little guidance for *how* to ensure that our research is aligned with the motivations and strategies of the activists and movements with and for whom we write. It is in part due to this absence that I turn to the literature on movement-based theory and knowledge production, in order to provide a way "in" to collaborating with activists to produce relevant and radical research for social

change.

Movement-Based Theory & Knowledge Production

In my reading, I have found the literature on movement-based theory and knowledge production to echo, and indeed expand upon, many of the ontological, methodological and epistemological offerings of PAE. However, at present there is relatively little discussion between these two bodies of literature. Aziz Choudry (2013, 2014) is the only scholar I have found that gives significant consideration to PAE as a methodological approach to activist-oriented research, citing the work of George Smith (1990), Gary Kinsman (2006), and Roxana Ng (2006) as useful examples. In this section I intend to enrich the discussion between these two bodies of literature. First, I explore how alternative writings on social movements (that is, those that critique and/or oppose what has come to be known as “social movement theory”) position movements and activism as active sites of knowledge production. This, I argue, is in line with the ontological and epistemological commitments of PAE, rooted as they are in a historical materialist conception of the social and of knowledge production. I then turn toward a discussion of the relationship between academia, activism, research and social change, paying close attention to the concept of relevance in research practice and the dissemination of research findings (Bevington and Dixon 2005; Flacks 2004). Here I also attend to issues of power and reflexivity within the research process, drawing again on PAE’s unique approach to exploring ruling relations by starting from the standpoint of activists. Finally, I reflect on the ethical commitments that several of these researchers (both in movement-theory and PAE) have flagged as central to producing research with

and for – as opposed to on or about – social movements. Using my own research experience as a guide, I trace what it might look like to dynamically engage with activists during the research and writing process, as well as the challenges and advantages that such an engagement may entail.

Social Movements as Sites of Knowledge Production

My entry point into the literature on movement-based theory and knowledge was a piece by Douglas Bevington and Chris Dixon titled “Movement-relevant Theory: Rethinking Social Movement Scholarship and Activism” (2005). As I read their article, I was struck by the authors’ critique of the mainstream literature on social movements, and by the way they encouraged researchers to listen to, engage with, and remain accountable to the very movements we find ourselves writing about. And while this critique (and the authors’ proposed alternative) are indispensable to my dissertation research and writing, here I wish to explore one particular assertion that is embedded within their work: that activists and movement participants are already engaging in theoretical and epistemological work from which we can learn (Bevington and Dixon 2005). This thread in their writing reminded me of insights by Gary Kinsman, who has consistently - both through personal conversation and in his chapter in *Sociology for Changing the World* (2006) - argued that research, theorizing, and knowledge production are integral to the everyday work of activism and social movements.²¹ It was this very epistemological

²¹ It is worthwhile to note that for the past several years I have worked closely with Gary Kinsman on the AIDS Activist History Project (AAHP), a SSHRC-funded research project in the Department of Sociology and Anthropology at Carleton University. Spearheaded by Dr. Gary Kinsman and Dr. Alexis Shotwell, the AAHP explores the history of AIDS activism in Canada

overlap between Bevington & Dixon (2005) and Kinsman (2006) that has led me to further investigate the parallels between these two bodies of literature.

To begin, I would like to firmly assert that social movements and activist spaces are, indeed, active sites in the production of knowledge. I have found the work of Aziz Choudry (2013, 2014, 2015) to be quite generative in thinking through this assertion. Rather than focusing on the kinds of research that can be conducted on or about social movements, Choudry's work addresses how activists themselves are conducting research and producing theory on the ground. Following Casas-Cortes et al (2008), Choudry uses the concept of "knowledge-practices" to illustrate the "processes and practices of activist research" situated outside of academia (2013:128). These knowledge-practices, or the collective "creation, reformulation and diffusion" of knowledge, are integral to the work of social movements (Casas-Cortés et al. 2008:17). It is through these practices, and the research embedded within them, that alternative knowledges may be "constructed, disseminated and mobilized as a tool for effective social action/organizing" (Choudry 2013:128).

Unlike traditional research conducted within academia, which despite its heterogeneity, often culminates in a final report, thesis or series of articles, the research and knowledge produced within social movement settings manifests in diverse forms and genres. Meetings, workshops, email exchanges, informal discussions, direct actions, protests, the production of texts, images and media (pamphlets, interviews, posters and placards, speeches, slogans, demonstration songs) are key sites where research and

through a series of oral history interviews with people involved in direct action-oriented AIDS activism during the 1980s and 1990s.

knowledge-practices are enacted by activists and social movement participants (Casas-Cortés et al. 2008; Choudry 2013; Choudry and Kuyek 2012). As Casas-Cortés et al. (2008) argue, because they are embedded in the everyday work of making change, activists' knowledge-practices are at once situated and material. As any form of knowledge, that which is produced within social movements must not be considered neutral or objective, but rather distinctly political and embodied, with an aim toward social transformation. In terms of PAE, then, activists' experiences are a useful starting point for research that seeks to investigate how certain practices (in this case, access to abortion) are organized by and through relations of ruling. We can then map these relations of ruling (Kinsman 2006) by attending to the institutions that activists confront in their struggle for social change.

It should be noted that this epistemological orientation, which I have taken up throughout my dissertation, is grounded in the very social character of knowledge production. For Choudry (2014), attending to the social character of activist knowledge production entails an understanding of "the ways in which everyday struggles are not only the means to build movements, alliances, and counterpower but are generative of, and in turn informed by, the learning/knowledge aspects of this activity" (95). This recalls an earlier point by Casas-Cortés et al (2008) and Kinsman (2006): that knowledge-practices and theorizing are integral to the everyday work of social movements. These knowledge-practices arise not only out of formal educative processes (reading, attending seminars, and so on; useful though they are) but also in and through action, organization and experience. Elaborating on the social character of knowledge production, Choudry (2013) references George Smith's (1990) suggestion that research

material can be “derived from moments of confrontation,” enabling the researcher – whether activist, academic, or otherwise – to “explore how power in our world is socially organized” (144). Often, this work helps to reveal a line of fault, or disjuncture, between our experiences and knowledge of the social world and the ways in which the world is represented in authoritative discourses (Bisaillon 2012).

Within academia, the tendency to overlook moments of confrontation and other related forms of activist activity as rich sites of knowledge production can largely be attributed to the ideological separation of theory/knowledge and practice/action (Kinsman 2006; Choudry 2013, 2014; Cancian 2003; Casas-Cortes et al. 2008; Bevington & Dixon 2005). It is by way of abstraction that the role of “activist” and “academic” are so often conceived as operating along a binary: activists make change on the ground, while academics theorize it. The activist-academic binary thus reproduces the same binary that Marx & Engels discuss in *The German Ideology* (1998 [1947]), wherein philosophers are somehow able to lift themselves out of the very world they write about. The work of Stuart Hall (1986) is particularly useful here: while neither activist nor academic thought can be considered “truer” than the other, they must both be considered as partial; or, more specifically, as representative of the social location in which we find ourselves. This has real effects: how we act and what we write depends on how we define, experience, and relate to the situation at hand (39). This is inextricably linked to relations of power, and the hierarchical silos within which we place different forms of knowledge. Critiquing this hierarchy, Choudry (2014) argues that “activist research, learning and organizing can often be mutually constitutive,” and that knowledge production within movement networks is “dialectically related to the material conditions experienced in struggles for

social and economic justice" (113). Knowledge generated in activist circles, then, should be viewed as no less useful for social movement researchers than academic theory.

Indeed, these forms of knowledge often overlap, intersect, and inform one another.

Yet what of those about those us who find ourselves located simultaneously within and against the academy, both as activists and academics? Speaking of activism and academia in binary terms falls short of addressing the complexities of intersectionality and identity formation: there are many activists who are also engaged in academic work, and many academics that find themselves drawn to activism. How we come to define these identities is thus complicated; they vary in accordance to circumstance and context. For instance, I often refer to myself as an activist-academic, in a similar manner that Laura Bisaillon (2012) uses the term “activist scholar” to describe someone who “foregrounds the political aims of the research she or he carries out” (610). While activist-academics are indeed located within the academy, they tend to also participate in local, regional or national civil society organizations, social movements, direct actions and/or other political work. In my own experience, working as an activist-academic has meant writing, thinking and theorizing from the ground up—that is, using my position within the academy to further the social and political aims of groups situated at the margins of society.

In conducting my research, I have found it challenging to classify my research participants along the lines of activist, advocate, academic or service provider. This is not because my participants are not these things, but because so many of them identify with two or more of these roles at any given moment. To mediate this, I use the blanket term “activist” to describe all research participants who have contributed to the struggle for

expanding access to abortion services in New Brunswick. Here I evoke an expanded definition of activist, which acknowledges the different forms of mobilization – from direct actions to social media; from blogging to drafting media releases and reports; from service delivery to working as a clinic escort; from research to meetings – involved in the work of making change. From this view, to engage in activist work is to begin where we are already situated; using our skills and experiences to create a more just and equitable world. This means shedding the notion that an activist is somehow set apart from ordinary people, and instead considering the ways in which ordinary people, through their everyday work, are indeed capable of creating extraordinary social and political change.

Keeping Research Relevant: Academics, Activism and Social Change

As a distinct mode of inquiry and an alternative starting point for movement-based writing and research, PAE and movement-relevant theory are useful paradigms for a project that seeks to uncover social relations, in order to ultimately transform them. Researchers who utilize these approaches take seriously the knowledge that is produced within activist and social movement circles, viewing them as unique sites for research that is oriented toward social justice. Yet at the same time, researchers do not seek to reify or romanticize the knowledge that is produced within activist and movement settings, but to instead remain critical throughout the research process. Because objectivity is rendered impossible in any research project, our ability to remain reflexive about the information we are uncovering is key to producing accounts that are rich, rigorous and well-documented. This means attending to the ways that activists themselves reproduce ideological accounts of the social world. Indeed, this sensibility is central to the work of PAE researchers. One of the clearest examples of this is George

Smith's (1990) research into the social organization of bathhouse raids in Toronto. Starting from the experience of activists enabled G. Smith to trace how the local experience of gay bath-goers is coordinated by the extra-local relations of ruling. Through his research, G. Smith found that, while many activists were pointing toward the latent homophobia within the police force, it was the *Criminal Code of Canada* that made it possible for the raids to happen in the first place. Thus, G. Smith (1990) argued, rather than engage in public relations work to "improve gay-police relations," political activists should instead call for changes to the *Criminal Code* that would transform the textually-mediated relationship between the state on the one hand, and gay bath-goers on the other (630). Similarly, in his research into the management of the AIDS epidemic in Ontario, G. Smith (1990) describes how AIDS activists often explained the crisis by attributing agency to concepts such as "homophobia," "AIDS-phobia" and "bureaucratic red tape" (634). Through this work, G. Smith helped reveal a new starting point for activist resistance: specifically, the "lack of a mandate and managerial infrastructure" to deal with the effective delivery of life-saving AIDS treatments (ibid). In both cases, G. Smith (1990) demonstrates the importance of PAE research for co-creating strategies for effective activism and movement-building. By starting from the standpoint of activists, PAE researchers are able to move beyond everyday experiences of political confrontation to describe the "extra-local, ideological determinations of local events" (ibid: 635).

It is in large part due to G. Smith's research, which took many principles of IE and applied them to activism, that PAE has gained some momentum in academic circles over the past two decades. One of the key objectives of this work, and perhaps that which most reflects those of movement-relevant theory, is the commitment to producing

research that is useful for those engaged in struggles for social change. Frampton et al. (2006) reference this in their introduction to *Sociology for Changing the World*:

“We wish to trouble the “theory” produced about social movements that takes them as objects of analysis. Rejecting forms of knowledge that posture as being “neutral” and “objective” but hide a standpoint based in ruling social positions, political activist ethnography aims at developing knowledge about social organization from the standpoints of movements for social justice and the oppressed themselves” (10).

Setting themselves apart from traditional sociology and, in particular, the work of social movement theorists, proponents of PAE not only recall the situated and social character of knowledge, but also engage in research that helps explicate the relations of ruling that activists and social movements come up against in their struggles for social change. This mode of inquiry lends itself well to the methodological direction that many movement-based researchers and writers gravitate toward in their work: that of producing research *with* and *for*, rather than *on* or *about*, activists and social movements (Choudry 2013, 2014, 2015; Casas-Cortes et al. 2008; Bevington & Dixon 2005; Barker & Cox 2002).

Doing relevant work as academics (and, perhaps, activist-academics) means not viewing ourselves as lending superior knowledge to activists, but working alongside activists to develop knowledge that may be conducive to our collective struggles. Surely, because scholars are situated in the academy, we have unique tools at our disposal: access to libraries, materials and titles that may bring about more opportunities for research. Yet deconstructing the – oft-hierarchical – silos of categorization between activists and academics becomes important here: these are not distinct categories of people, but instead complex, intersecting and overlapping dimensions of people’s lived experiences. Further, activists and academics – and activist-academics – are not homogenized groups, but instead are actual people engaged in specific practices, with different forms of knowledge

emerging from their lived experiences. As described earlier in this chapter, nearly all my research participants consider themselves at once activist *and*: activist and academic; activist and service provider; activist and volunteer; activist and writer; activist and educator. Indeed, blanket categorizations often serve to obscure, reify and silo complex social processes and identities. Rupturing typologies, then, allows us to move past a static and hierarchical understanding of social relations, toward one that is situated, fluid and co-constitutive.

Dynamic Engagement with Movements: Advantages and Challenges for Research

Researchers incorporating movement-generated knowledge into their methodology tend to demonstrate an alignment with and commitment to the activist groups and movements with which they work (Bevington & Dixon 2005; Choudry 2013, 2014; Cancian 1993). Like PAE, the researcher's orientation to and relationship with social movements is crucial to producing accurate and (hopefully) useful information about the issues that activists are up against. According to Bevington & Dixon, this approach to research necessitates a "dynamic engagement with movements in the formulation, production, refinement, and application of the research" (2005: 190). The key word here is **dynamic**: engaging with the movements we are writing about in this way means building and maintaining relationships with movement participants, which requires a good deal of work on behalf of the researcher and the informants themselves. First, researchers must gain access to the movement with which they wish to research. This can be particularly challenging if the researcher is not already active within that movement. Demonstrating an ongoing interest and commitment to the issues the

movement is up against is particularly important for developing this kind of dynamic relationship with movement participants, though this kind of orientation will not in and of itself grant a researcher access to movement spaces. As is the case with most community-engaged research, the researcher must first reach out to movements, introduce themselves and their research interests and objectives, seek approval for conducting the research, and determine (through conversation with movement participants) whether their research will prove useful or relevant for the movement itself. Researchers then must recruit participants for the project, aiming to collaborate with them in the collection, analysis and writing up of the data as much as possible. One of the strategies that Cancian (1993) has found helpful for maintaining a relationship with movements and community organizations is to become actively involved in these spaces by attending meetings, volunteering one's labour, or participating in actions or events. This kind of work can also provide a way of giving back to the community: in this sort of dynamic engagement, the researcher's relationship with the movement does not need to end once the thesis is defended and the articles are published. Conducting relevant research might mean sharing and mobilizing one's research findings in formats that make sense for movement participants, including but not limited to presentations, final reports, briefing documents, workshops, etc.

Of course, establishing and maintaining these kinds of relationships can be challenging. Being involved in activist organizations can provide avenues for resisting traditional relations of domination between researchers and the population they wish to study, but it can also burden both researchers and research participants with additional

labour.²² As Ian Maxey (1999) reminds us, not all informants will have the capacity for “dynamic engagement” with researchers—indeed, neither will all academics. In discussing his research with activists, Maxey reflects on his initial desires to involve movement participants in the writing and analysis process, only to find that many either did not have the time to commit to this kind of work or did not care to be included in this phase of the process. What he realized through this was that much of his intention for including movement participants was “at least partially an attempt to placate [his] own fears of writing of/for/over 'them' and thus falling into a role of manipulator and misrepresenter” (1999: 205). Coming to this realization forced Maxey to reconcile his desire to break down the activist-academic binary and the methods he used to go about doing this. Finding alternative means for including activists in the writing phase thus became central to Maxey’s research: rather than asking activists to help write, edit and provide feedback on a manuscript, he opted for gauging their insights through a single conversation, which he then transcribed into an academic article (1999).

Another challenge to engaging dynamically with the movements we research is the ability for researchers to remain critical of the positions, insights, strategies and ideas that movements take up in their work for social change. Maintaining an historical materialist commitment to knowledge production is useful here: even the most radical of social justice movements do not take place in a vacuum, but are rather actively shaped by the social relations of ruling in which they are located. It is thus important not to

²² This is most often a question of privilege: which academics have the mobility and time to engage with movements in this way? Which activists have the capacity to engage with researchers on an ongoing basis? Indeed, the dynamics of these relationships will necessarily shift depending on the social location of both researcher and participants.

“romanticize” political movements (Casas-Cortes et al 2008), but to recognize them as produced through people’s ongoing activities within the social world. As Choudry (2014) argues, “social movements and activist milieus are also terrains of struggle over power, knowledge and ideas, including what constitutes legitimate or authoritative knowledge” (93). Rather than reifying social movements, we must recognize them as comprised of actual people working in concert, or sometimes at odds, with one another to create change. And because activist practices are shaped both by interpersonal and broader social forces, even the most progressive social movements are likely to reproduce ways of thinking and doing – including the hierarchization of knowledge and experience – that bolster the status quo. In my own research, I have found that using PAE methods in tandem with a movement-relevant approach to research has been generative in maintaining an orientation that is at once receptive to and critical of the knowledge produced within movement circles. This is not to fall back into the academic-activist binary, but to again recognize the very situated character of knowledge as that which shapes and is shaped by social forces. In this way, PAE provides a useful approach to mediating this through mapping and tracing how social relations coordinate people’s practices, including those knowledge-practices that are developed within movement spaces (Hussey 2012).

Finally, there are definite challenges to producing radical (in the sense of getting to the root of social issues) and activist-based research within the confines of academia. This includes the very genre of academic writing, which so often takes the form of theses, publications and reports. Our writing, like our research, is interpreted through our own lens, published under our own name, using language that is often technical and perhaps

inaccessible. Often, these are requisites for academic success: for defending the thesis, for publishing the article, for securing the job. Many of the academic standards for research (embodied in ethics review boards and funding opportunities) differ from more collective forms of research such as those found in PAE, participatory action research (PAR), or community-based participatory research (CBPR), which presents challenges to researchers who take up these methodologies (Barker and Cox 2002). And while much of activist research is geared toward challenging and transforming power relations and systemic inequalities, academics pursuing movement-relevant research should remain reflexive of their social location within those relations, and how this will impact the kind of writing and knowledge they are able to produce. Balancing the kind of research and knowledge we wish to produce with the reality of funding structures, hiring committees and academic publishing processes thus presents unique obstacles to work that is critical, radical and aligned with social justice movements.

Data Collection & Analysis

I collected data for my project using three interrelated and interdependent research methods: (1) a series of twenty-five in-depth, semi-structured interviews with activists, advocates, service providers, and representatives from provincial health authorities, all of whom are, or have been, involved in efforts to expand or regulate abortion access in New Brunswick; (2) participant observation in RJNB collective and committee meetings, as well as public forums and events led by RJNB; and (3) textual analyses of activist-generated documents and media sites, provincial and federal texts governing abortion at the local and extra-local level (most notably New Brunswick's

Medical Services Payment Act and the *Canada Health Act*), email correspondence between staff at Horizon Health Network, media releases from the Provincial Government of New Brunswick, provincial, national, and international news media covering the abortion issue in New Brunswick, and archival documents that I sourced from the Provincial Archives of New Brunswick in Fredericton. I consider these three approaches interrelated in the IE and PAE sense: combining interviews, participant observation, and textual analysis has enabled me to center the experiences, voices and objectives of activists while also tracing upward and outward to uncover the ruling relations within which abortion access is situated.

Throughout my research, I approached data collection as an emergent process of generating knowledge for further exploration. Under this framework, the “phases” of my research were non-linear, and I often found them to bleed into and inform one another. For instance, though I technically began the formal research process through interviews, I was actively reading (and thus analyzing) news media and activist-generated texts prior to writing my dissertation proposal. Because I have a long-standing interest in issues of reproductive health, rights and justice, following the stories coming out of New Brunswick were a routine part of my life prior to choosing a research focus for my dissertation. Through this preliminary research, I was already able to generate ideas about which institutions might be responsible for the coordination of abortion care in New Brunswick. These ideas were shaped not only through my own understanding of events, but also through a careful reading of what activists themselves were saying—in interviews with the press, in their direct actions and protests, on social media, and through the press releases and other documents that they generated in their work. How

activists were representing the abortion issue in New Brunswick became central to my preliminary investigation as well as my data collection. The experiences I gained through preliminary research then became integral to the research process, as they shaped and informed how I came to understand my topic, who I chose to interview, what questions I asked, and how I have chosen to “write up” the data I collected. In the following pages, I provide a summary of my research design, and discuss how I have operationalized PAE and MRT methods throughout the research process.

Entering the Field

It was at the 2015 meeting of the Canadian Sociological Association Congress in Ottawa, Ontario, that I first met Tracy Glynn. A founding member of Reproductive Justice New Brunswick (RJNB), Tracy was sitting at a nearby table at Second Cup while I met with a colleague to discuss my research interests. As our meeting drew to a close, Tracy caught my eye. “Excuse me,” she said as she looked up from her laptop, “I heard you talking about RJNB. My name is Tracy Glynn.” I knew this name. A columnist for the *NB Media Co-Op*, Tracy had written extensively on abortion access and activism in New Brunswick. I told her about my proposed research, my plans to travel to Fredericton in the fall, and how I had been closely following the events as they unfolded – the closing of the Morgentaler Clinic, the opening of Clinic 554, the amendment to Regulation 84-20, and all of the activism in between. Excited about my project, Tracy handed me her business card and agreed to help me recruit activists to interview during my stay in Fredericton. We met again days later, discussing her connections and experiences in New Brunswick, and reviewing the intentions and objectives of my research project. She

suggested I reach out to several activists in Fredericton, and that I reference her name when inviting them to participate in my research. She also assured me that she would put in a good word with the general membership of RJNB, encouraging members to participate in my study. In this way, Tracy would act as my “gatekeeper” to the activist community in Fredericton.

Recruiting participants

Using Tracy’s suggestions as a starting point, I began to search for other names: those who were active on social media, those who had been interviewed by the press, those who had spoken at rallies in Fredericton, and those whose research and writing I had encountered in blogs, academic journals and online magazines. I compiled a list of twenty-eight potential research participants, and then set out to recruit as many of these participants as possible. Operating out of Ottawa, I relied on email correspondence to introduce myself, to provide an overview of my research, to invite people to participate in my study, and to schedule dates, times and locations for interviews.²³ In addition to Tracy’s suggestions and my own research, I generated a snowball sample through the help of my established participants. During each interview, I listened for references to people who were not yet on my list, but whom my interview participants considered to play an active role in the abortion issue in New Brunswick. My list of potential research participants grew to thirty-six people, including a number of active and past members of RJNB, the Fredericton Youth Feminists (FYF) and the Abortion Rights Coalition of

²³ See Appendix A for standardized email invitations and consent forms, as approved by the Carleton University Research Ethics Board (CUREB)

Canada (ARCC), current and former clinic managers from the Morgentaler Clinic, Clinic 554 and the Mabel Wadsworth Clinic in Bangor, Maine, former clinic escorts from the Morgentaler Clinic, and representatives from the provincial government and the regional health authorities.²⁴ In the end, I was able to narrow this sample down to a list of twenty-five key informants. These were people whose names were cited most by activists, and whose position in the social relations of struggle (activist, service provider, clinic staff, etc.) made them particularly important for my project.

I met two significant challenges when recruiting research participants. The first was the willingness on behalf of representatives from both the provincial government and Horizon Health Network to participate in my study. For instance, despite ongoing correspondence with the CEO of Horizon Health Network, John McGarry, in which he expressed a willingness to participate in my study, McGarry stopped responding to my emails once I proposed a date and time for our interview. After multiple emails over the course of nine months, it was clear that I would not be interviewing McGarry, who played a key role in the decision to expand abortion services to a second hospital in Moncton, following the provincial government's commitment to eliminating barriers to abortion access. Through a close reading of several Horizon Health Network texts I had collected, I was able to locate the names of three additional representatives who had been

²⁴ Although I initially planned to interview only activists, advocates and government employees, my interviews with activists and textual analysis of the *Medical Services Payment Act* led me to seek additional information from staff at the Moncton Hospital and Horizon Health Network, who were able to clarify certain themes that arose during my interviews with activists (such as long wait times, “arbitrary” gestational cut-offs for surgical abortions, and the “illogical” decision to expand abortion services to The Moncton Hospital).

involved in the Moncton decision. I was able to recruit one of these to act as an informant for my study.

Recruiting representatives from the provincial government was similarly challenging. I first contacted the offices of Premier Brian Gallant and Health Minister Victor Boudreau in early July 2015. Despite frequent correspondence with the staff in Gallant and Boudreau's offices, I was unable to secure an interview with either. Instead, I was urged to arrange an interview with a representative from the Acute Services branch of the Department of Health. While this was not the interview I had hoped for, it did provide interesting insight into the provincial government's role in allocating abortion services across the province.

In May 2016 I followed up once more with my contact at Premier Gallant's office. During this correspondence, I was invited to speak with the Deputy Minister of Health, Tom Maston, on behalf of the Premier. A telephone interview was arranged for June 7. The day before, I sent Maston's executive secretary a consent form to participate in my research, and asked that he sign, scan and return the form prior to our interview. The morning of our interview, I received an email notifying me that Maston would "not be participating in the interview," and that his department would be "pleased to provide information on the organization of abortion services" but "would not be offering opinions or comments" on the issue (email communication, July 7). Frustrated, it became clear to me that the only access points I would have for the provincial government would be

through email correspondence, public documents, and the one interview I had already conducted.

In-depth, semi-structured interviews

One of the advantages of using in-depth and semi-structured interviews for collecting data is that they provide research participants with the space to talk about their experiences from their own standpoint. As Sarah Tracy (2013) writes, interviews allow participants to voice their own “rationales, explanations, and justifications for their actions and opinions,” while also revealing the “specific vocabulary and language” that they use to describe the issues at hand (132). The experiential, embodied accounts of reality that are described to researchers during the interview process are significant in two key ways: first, they allow the participant to respond directly, and in detail, to questions posed by the researcher; and second, they help researchers to capture the complex and situated character of experience and knowledge production.

In the context of IE and PAE, Devault & McCoy (2001) have written on the importance of treating research participants not as a population of subjects, but as informants whose knowledges are central to tracing the social organization of the phenomena at hand. Many feminist and social movement researchers have taken up a similar orientation to the relationship between researcher and participants. As Blee & Taylor (2002) write, conducting semi-structured interviews with social movement participants gives interviewees the opportunity to “generate, challenge, clarify, elaborate, or re-contextualize understandings of social movements” and the issues they come up against in their work for change (94). Using interviews to collect data on social

movements thus provides the researcher with “a window into the everyday worlds of activists,” which can then be written up in ways that maintain the “subjects’ voices, minimizing, *at least as much as possible*, the voice of the researcher” (ibid: 96, emphasis added).

Nearly all my research participants (with the exception of one service provider, one government employee and one representative from Horizon Health Network) declined my offer for a pseudonym. While I did not ask participants to explain their decision, a small handful mentioned that they wanted their names included in this history as a reminder of their experience with the movement. Others, in particular those who had been quoted or featured in the media, saw no reason to use a pseudonym; they had already been identified as central to this struggle, so my inclusion of their full names would have little impact in this regard. I also assured each participant that they would be given access to the full transcript prior to my writing the dissertation, that they were welcome to ask that certain parts of the discussion not be included in my thesis, and that they had the right to withdraw from the study at any time, up until December 2016.

Coding

Once I returned to Ottawa, I transcribed each of my interviews verbatim using the transcription software ExpressScribe. While arduous and time-consuming, transcription is also a highly political task. The simple act of transcribing – our decisions regarding what to include and what not to include, from grammar and punctuation to tone, facial expressions, and outward emotions such as crying or laughing – ultimately determine the final, textual representation of our research participants. Thus, my own political,

substantive, and theoretical interest in the topic was present throughout my interpretation of the participants' experiences. To mediate this, I strived to maintain the words of my participants in my coding scheme as much as in my analysis, and to remain reflexive of my own social position throughout the transcription, coding and writing processes.

Once transcribed, I coded each interview into manageable chunks for analysis. In qualitative research, coding interview data refers to the practice of creating conceptual labels and categories for analysis. Rather than use more traditional computer-aided qualitative data analysis software such as Nvivo, I opted for Scrivener, a writing software with similar coding, grouping and tracking functions. Taking a PAE approach to coding meant utilizing interviews in the same way a researcher might use texts to explicate social relations. For instance, rather than coding in an overly abstract manner – that is, applying theoretical concepts to excerpts in an effort to “make sense” of them – I sought primarily to trace connections among and between the institutions and organizations that played a role in coordinating abortion access. At the same time, I was also interested in how activists conceptualized their own understanding of “access.” I found myself wondering: what frameworks, conceptual tools, and theories were these activists using to make sense of the situation they were confronting? My approach to coding was to then combine PAE and MRT sensibilities, to trace the relations of ruling in which abortion access was

embedded, and to explore activist knowledge production as a useful site for social transformation.

Mapping

As discussed earlier in this chapter, the practice of mapping is central to PAE and IE research. Yet despite this centrality, there is no uniform method or protocol for mapping social relations. There are, however, several examples from researchers, including Dorothy E. Smith (1987, 2005), Marie Campbell and Frances Gregor (2002), Gary Kinsman (2006), and Susan Turner (2006), which have acted as useful guides for my own mapping exercises (see Appendix B). The maps I produced during the research process acted as visual representations of the social relations of struggle that activists have confronted in their work to increase access to abortion. I began my maps at the “base” level of activism, and, with the assistance of interviews and textual analyses, I traced upward and outward to connect the work of activists to the work of institutions and organizations, including the federal government, the provincial government, regional health authorities, hospitals, clinics, medical organizations, and political allies. Also included in these maps are the texts mediating these relations of ruling, including the *Canada Health Act*, *R v Morgentaler* (1988), and New Brunswick’s *Medical Services Payment Act*. In my own experience, this practice of mapping was most useful for visualizing the spatiality of relations of ruling, and for making connections between the

institutions, organizations and texts that contribute to the social organization of abortion access in New Brunswick.

Participant observation

I became a member of RJNB during my stay in Fredericton. I have since played an active role on the Political Action Committee (PAC) and the ongoing campaign to repeal Regulation 84-20. Over the course of more than two years I have attended over a dozen committee and collective meetings. Following these meetings, I produced handwritten jottings, or unfiltered and unprocessed notes, to record specific phrases, concepts, discussions, themes, as well as the overall feel of the meeting.²⁵ These notes, which took the place of more formal fieldnotes, have been useful for revisiting these meetings to further contextualize data that has been generated elsewhere.

Due to my affiliation with RJNB, I consider my research role as somewhere between “complete participant” and what Sarah Tracy (2013) refers to as “active member researcher.” While complete participants are fully affiliated in the groups with which they research, they tend to do so covertly. In comparison, the active member researcher shares membership in the group, though predominantly for the purposes of the research itself (Tracy 2013). For instance, had I not been researching abortion access and activism in New Brunswick it is unlikely that I would have joined RJNB. Instead, I likely would have engaged in solidarity work through local or national initiatives and campaigns. That said, I do plan to continue my membership with RJNB after the dissertation is complete,

²⁵ By “feel,” I am referring to the emotional or affective context of the meeting. Was the meeting rushed? Did participants seem cheerful, stressed, upset, anxious, excited?

and I would like to consider my research as aligned with the objectives of activists on the ground—specifically, to expand access to abortion services and to advocate for reproductive justice in New Brunswick and across Canada.

To be sure, my experience of balancing the roles of researcher with that of activist has not been without challenges. In each interaction I have with members of RJNB, I am situated as at once a researcher and an activist. As these identities cannot be separated out from one another, I have made no intention to bracket my role as researcher or my role as activist depending on the circumstance. In Sarah Tracy's (2013) text on conducting qualitative research, she speaks of this discomfort in terms of Victor Turner's (1987) concept of "liminality," or that "sense of being betwixt and between two locations:" close enough to gain an understanding of the events (or, in my case, to contribute to activist work), yet far enough to analyze the situation from the standpoint of a researcher (76). Instances of such liminality occur most often when I find myself compelled toward an analysis that is different from, or critical of, that of my research participants. Rather than reconcile these differences throughout the dissertation, I have instead presented the perspectives and voices of my participants, while also offering my own analysis of the situation.

Textual analyses

Texts have played a key role in helping me to explicate the relations of ruling that coordinate abortion services in New Brunswick. Past research in PAE has provided openings for researchers who seek to understand the relationship between textually-mediated social relations and the lines of fault that emerge between activists and the

institutions they come up against. Analyzing texts in this way entails a close reading of pertinent documents in order to understand how they are operationalized—specifically, how they enter into and shape official discourses and practices around the distribution, regulation and restriction of abortion care. Although I consulted a wide range of texts in my research, two of these have emerged as key coordinators of abortion access in New Brunswick: the *Canada Health Act* (CHA) and New Brunswick’s *Medical Services Payment Act* (MSPA). While the CHA organizes the theoretical accessibility of provincial healthcare services by specifying the conditions and criteria that provinces must meet to be eligible for federal transfer payments, it is left up to the provinces to interpret and meet these conditions and criteria, and to allocate service provision locally. In my research, I explore how the CHA has entered into the organization of abortion services in New Brunswick, providing an opening for the promulgation and upholding of Regulation 84-20, Schedule 2 (para a.1), as well as Section 2.01b, Chapter M-7 of the MSPA, which restrict publicly funded abortions to hospital settings. Through these same textual analyses, I have also sought to uncover how the everyday experiences of people on the ground in New Brunswick are coded into, and thus coordinated by, each of these texts. These experiences include clinic staff and physicians, whose facility fees are not covered by provincial health insurance; people seeking abortion care, who must choose between a publicly funded service at a hospital or an out-of-pocket service at the clinic; and activists and advocates, who work to make abortion services more accessible by advocating for the repeal of Regulation 84-20.

Other texts that have been central to my analysis include archival documents, news media and activist-generated resources. The bulk of archival documents I have used in

this analysis were uncovered at the Provincial Archives of New Brunswick during my time in Fredericton. These were located with the assistance of the archival staff, who helped me to sort through every collection containing the word “abortion” from 1988 onward. Of these, the ones that I found to be most significant to my research were news clippings and letter correspondence between 1988 and 1994, during which several significant events related to abortion access occurred.²⁶ Archival research enabled me to trace the historical circumstances that have both informed and coordinated current struggles for expanding access to abortion in New Brunswick, in particular those occurring in clinic settings. Likewise, I have used online and print news articles from May 2014 to present-day to contextualize the national and international attention that was generated by the closure of the Fredericton Morgentaler Clinic and the upsurge of activism around abortion access in the province.

Finally, I have found activist-generated materials to be particularly useful for exploring how activists have conceptualized and mobilized around abortion access in New Brunswick. As a collective, RJNB uses Google Drive to ensure that each member has access to resources such as minutes, briefing notes, research and reports, and ongoing

²⁶ As I explore further in the dissertation, events include, though are not limited to: the Supreme Court’s decision to strike down the abortion provision in the *Criminal Code of Canada* (*R v. Morgentaler* 1988); abortion provision becoming a matter of provincial healthcare allocation governed by the *Canada Health Act*; the New Brunswick Minister of Health revising the *Medical Services Payment Act* to restrict abortion services unless performed by a specialist, approved by two doctors, and performed in a hospital facility (*Medical Services Payment Act*, 1989); Henry Morgentaler initiating (and winning) a lawsuit against the government of New Brunswick for refusing to pay for abortions for New Brunswick residents that were performed at the Montreal Morgentaler Clinic (*Morgentaler v. New Brunswick [Attorney General]*, 1989); Premier Frank McKenna going on record to promise Morgentaler the “fight of his life” to ensure an abortion clinic would not be opened in New Brunswick (1989); Henry Morgentaler announcing that he would be opening an abortion clinic in New Brunswick (1991); Henry Morgentaler opening his clinic in New Brunswick (1993); the Supreme Court of Canada holding that a similar law and regulation in Nova Scotia was unconstitutional (*R v Morgentaler*, 1993); and so on.

campaign materials. As a researcher, I have found that having access to Google Drive has given me unique insight into the everyday practices of RJNB. My ability to consult these textually-mediated online forums at any time has helped guide my research in directions that are relevant to the collective and to creating social change on the ground in New Brunswick. I have also used resources generated by ARCC, FYF, Action Canada for Sexual and Reproductive Health and Rights, and the now-defunct Pro-Choice Action Network (PCAN) to gain a broader sense of how other activists and advocates make sense of the social organization of abortion in New Brunswick and across Canada. In conducting my analysis, I argue that we must first consider the historical context that shapes Canada's contemporary landscape for abortion care. It is to this history that the next chapter turns.

Chapter 3:

A Social History of Abortion Access in Canada

Introduction

In this chapter, I discuss the historical foundations of the contemporary movement to expand abortion access in Canada, focusing on the evolving roles of the state, the medical community and feminist pro-choice activism in shaping abortion policy between 1869 and 1988.²⁷ As I demonstrate, this history is central to understanding the line of fault that exists between the federal and provincial regulation of abortion care, as well as the political resistance that has formed in response to this regulatory regime. I preface this historical investigation with a brief overview of the current state of abortion access in Canada, drawing attention to the uneven landscape of service provision across the country. As this chapter shows, the patchiness with which abortion services are made available in Canada can be traced back to several key moments in the history of abortion-related policy, discourse and service provision. In exploring these historical moments, I trace how the state and the medical community have regulated abortion through discourses of criminalization and medicalization and provide insights into the history of activists' efforts to resist the regulation of abortion care. I explore how pro-choice activists and allied organizations have sought to expand abortion access by emphasizing a more liberal feminist agenda of women's constitutional rights, liberties and freedoms on the one hand, and socialist discourses around access, social inequalities, and reproductive freedom on the other. Extending from past claims by Lorna Weir (1995), I show how,

²⁷ This time period spans the enactment of Canada's first restrictive abortion law in 1869 to the decriminalization of abortion in *R v. Morgentaler* (1988).

both historically and today, feminist activists in Canada have positioned abortion clinics as central to the material struggle to expand access to the procedure, and as symbolic rallying points for political agitation and transformative social change.

Abortion Access in Canada Today: Travel & Regional Inequalities

It has been thirty years since the Supreme Court of Canada's landmark decision in *R v. Morgentaler* (1988). On January 28, 1988, the Court ruled that the abortion provisions laid out in the *Criminal Code of Canada* infringed upon women's Charter right to life, liberty and security of the person (Tatalovich 1997). There have since been no federal laws governing abortion in Canada. Instead, due to its status as a medically necessary health service, the provision of abortion services falls under the jurisdiction of provincial and territorial health departments. Thus, although access to abortion is federally mandated under Canada's *Charter of Rights and Freedoms* and regulated under the *Canada Health Act*, it is up to individual provinces and territories to determine the implementation and distribution of services within their jurisdiction. As I demonstrate in this chapter, this relationship has opened a line of fault between the federal mandate for universal healthcare on the one hand, and the provincial regulation of abortion services on the other. This has led to the current "patchwork" landscape of abortion care in Canada (Eggertson 2001), in which the ability to obtain a safe, timely and affordable abortion varies depending on one's social and geographic location. Today, the uneven distribution of abortion services across the country has left many communities without adequate access to the procedure.

Many scholars have written about the uneven distribution of abortion services in

Canada, as well as the implications this has for people's ability to access care (Ackerman 2016; Dressler et al. 2013; Eggertson 2001; Haussman 2001, 2015; Johnstone 2014; Johnstone and Macfarlane 2015; Norman et al. 2009; Sethna et al. 2013; Sethna and Doull 2012, 2013; Shaw 2006; Vogel 2015). As of 2017, clinic abortion services are not available in Nova Scotia, Prince Edward Island (PEI), Northwest Territories (NWT), Nunavut or Yukon, while there is only one clinic providing abortions in New Brunswick and Manitoba (Abortion Rights Coalition of Canada 2017). Hospital abortion providers are also particularly low in these areas, with one hospital each providing the procedure in Nova Scotia, PEI, NWT, Nunavut, Yukon and Manitoba (ibid). Due largely to activists' lobbying efforts, there are now three hospitals providing abortion in New Brunswick, though clinic abortions remain ineligible for public funding, and are thus inaccessible to large portions of the population.

One of the most significant findings among researchers in this area is identifying the sharp divide that exists between rural and urban access to abortion in Canada, where the bulk of services tend to be located in large urban centers (Ackerman 2016; Sethna and Doull 2012, 2013; Shaw 2006). As Sethna & Doull (2013) and Shaw (2006) have demonstrated, the clustering of abortion care in urban centers leaves rural and remote areas of the country largely underserved, creating disproportionate access barriers for women living in rural, Northern or coastal communities. In their recent Canada-wide study, Sethna & Doull (2013) found that nearly half (44.9%) of all participants surveyed travelled an hour or more to access abortion care in a clinic (N=1186), demonstrating that, for people living in Canada, travel is among the top barriers to accessing a safe,

timely and affordable abortion procedure.

During my interviews with activists, many drew attention to the long distances that people must travel to obtain abortion care in New Brunswick. This travel, they noted, is particularly challenging for communities who already experience marginalization due to their social location. During my interview with Joyce Arthur, chair of the Abortion Rights Coalition of Canada (ARCC), she described how people living in rural areas face disproportionate barriers to accessing care over those living in urban centers:

I think the biggest thing, really – and it’s a really hard and almost intractable problem – but it’s the rural/urban divide in terms of access. I mean, it’s quite a disconnect, because in most major cities, like Vancouver, Toronto, Montreal, access is just *excellent*. And in other cities it’s at least pretty good, or not bad. But as soon as you get outside of the major cities it becomes very difficult, and so many women have to travel long distances (Interview with Joyce Arthur 2015).

Here, Joyce identifies how New Brunswick’s regional access problems – something many of my participants consider one of the most significant barriers to care – are part of a larger trend in the distribution of abortion services across the country.²⁸ Because most abortion services are provided in large urban centers, those living outside of cities face unique challenges to accessing care, as they are often required to travel long distances to obtain their abortion. This trend is particularly visible in New Brunswick, which many of

²⁸ Joyce Arthur has been writing about this phenomenon for decades. In 1999, for instance, Joyce wrote an article for the Pro-Choice Action Network that names regional access as one of three mobilizing factors among Canadian pro-choice activists, alongside clinic funding and anti-abortion activity. According to her research, the geographic dispersion of Canada’s population (with 90% living within one hundred miles of the United States border), combined with a low rate of service provision in hospitals (at the time, approximately 1/3 of all Canadian hospitals performed abortions) created disproportionate access barriers for people living in northern and rural parts of the country (Arthur 1999). While scholars have recently helped bring visibility to the rural/urban divide, activists such as Joyce have for decades advocated for measures that would increase abortion access for rural communities in Canada.

my research participants consider a “uniquely rural” province. According to census data undertaken by Statistics Canada in 2011, New Brunswick has the second-most rural population density in the country, with 48% of residents living in rural areas of the province.²⁹ This has significant implications for abortion access. According to data collected by New Brunswick’s Department of Health between 2015 and 2016, approximately 31% of all patients who obtained an abortion at The Moncton Hospital (N=385) travelled some 151 kilometers from Saint John to access the procedure, with 18.5% travelling from Fredericton – some 175 kilometers – to obtain care (Government of New Brunswick 2017). Meanwhile, at the nearby Dr. Georges-L.-Dumont University Hospital Centre (N=447), approximately 40% of patients travelled from Saint John to access abortion, while another 16% travelled from Fredericton to obtain the procedure (ibid).

The third hospital providing abortion care in New Brunswick is the Chaleur Regional Hospital in Bathurst, a city situated in the northeastern region of the province. While nearly 50% of all patients who obtained abortion care at Chaleur Regional during this time (N=229) live within the city, another 37% reported travelling 100 kilometers or more – from Campbellton, Edmundston and Fredericton – to access the procedure (Government of New Brunswick 2017). As this data suggests, the regional distribution of hospitals providing abortion care in New Brunswick forces a significant portion of the population to travel long distances to access the procedure. Similarly, in their study mapping the distance that people travel to obtain clinic abortion care in Canada, Sethna &

²⁹ Statistics Canada defines “rural” areas as any territory falling outside of urban centres, with a population of 1,000 people, and with 400 people per square kilometer (Statistics Canada 2011).

Doull (2013) found that of all provinces, New Brunswick has the highest rate of patients who reported travelling over 100 kilometers to access care at abortion clinics—representing 73% of all New Brunswick respondents (55).

When I asked the former clinic manager, Simone Leibovitch, about patients who travelled to obtain abortion care at the Fredericton Morgentaler Clinic, she told me that a large proportion of patients travelled from Saint John, some 115 kilometers away from Fredericton. “But we had women from all over the province,” she added, “You know, like everywhere” (Interview with Simone Leibovitch 2015). In contrast, provinces such as Ontario, Quebec and British Columbia see a much lower proportion (0-12%) of patients travelling to access clinic procedures (Sethna & Doull 2013).³⁰ Simone, who now works as a counsellor at the Morgentaler Clinic in Ottawa, reminded me that even though the rate of travel is overall lower for patients in Ontario, communities in rural and northern areas of the province continue to travel long distances to access the procedure: “In Ontario, people think that it’s super easy... There’s women that travel from Thunder Bay [to Ottawa]. That’s not easy!” she told me. “But,” she added, “they don’t have to pay. So that’s the whole other huge difference, right?” (Interview with Simone Leibovitch 2015). While the barriers imposed by travel are reflected in rural communities across the country, in New Brunswick these barriers are made more challenging by the provincial government’s refusal to fund clinic abortions. As I demonstrate in later chapters, due to the regulatory constraints imposed by the *Medical Services Payment Act*, the costs of clinic abortions are offloaded onto patients themselves, many of whom incur

³⁰ Although the researchers do not readily provide a further breakdown of these statistics, the maps they generated for this study presents an intriguing visual of the spatial disparities of services in urban and rural areas.

significant travel expenses in order to access the procedure. This is not the case in other provinces, where provincial health plans cover the full cost of abortion procedures in both clinic and hospital settings. But in New Brunswick, where patients must pay out-of-pocket for clinic abortions, and where regional access to abortion services ranks among the lowest in the country, a two-tiered health system has emerged, in which those with financial means face significantly fewer barriers than those without.

The idea that Regulation 84-20 imposes a two-tiered health system upon patients seeking abortion care was common among my research participants, many of whom explicitly named the impact of social inequality on one's ability to access abortion in the province. During my interviews, I listened as activists described travel as not only an inconvenience or burden, but as a possibility that is bound by one's social location. As Shona Newton told me during our interview, access to care in rural areas of the province is "in general atrocious." She continued:

And that's not even abortion, that's just all reproductive health services. So, that's a unique issue that New Brunswick faces, because it is so rural and there isn't a lot of money. So, you have a lot of people who aren't able to access all sorts of healthcare, let alone reproductive justice, or reproductive healthcare (Interview with Shona Newton 2015).

Above, Shona points to the compounding issues of region, class and gender in determining one's ability to access to "all sorts of healthcare," including but not limited to abortion care. Making these sorts of connections is crucial for activism that seeks to move beyond advocating for abortion rights as such, to instead push for the conditions necessary for people to realize those rights. During my interviews with activists, nearly everyone engaged in the sort of contextualizing work that is central to this sort of work. Beyond the poor regional distribution of abortion services, they told me, the ability for

people to travel to access abortion is disproportionately challenging for those who are already made marginal by interlocking systems of oppression. Patients travelling outside their communities must arrange for transportation and pay out-of-pocket for associated travel expenses, including but not limited to childcare, time away from work, food, and accommodation. And due to Regulation 84-20, patients who seek care in clinic settings must also pay out-of-pocket for the abortion procedure itself.

As Megan Hill described during our interview, accessing an abortion can easily become “such a disruption in people’s lives” (Interview with Megan Hill 2015). She described this disruption in terms of travel, as well as the less-visible barriers that travel so often imposes upon patients:

So, even if you’re living in New Brunswick, if you’re like, in Miramichi, you have to drive to Fredericton or to Moncton, whatever. You need to get the time off work, you have to pay for gas, you have to have somebody come with you, you need to pay for all your meals, you know? If you have children, you have to pay for childcare [...] And it doesn’t have to be [a disruption]—like, it’s a medically necessary healthcare procedure. Yeah, so there’s a ton of barriers. And like, people don’t think about those things when they’re talking about abortion (ibid).

Here Megan highlights the importance of situating abortion access within the context of people’s everyday lives. In doing so, she unravels the complexity of travel, gesturing toward the many social and institutional relations that condition people’s ability to travel to access care. These are the barriers that “people don’t think about,” she told me.

Beyond their being excluded from everyday conversations about abortion, these experiences—the challenges of taking time off work, of paying for gas and childcare, of finding someone to drive you home after your procedure—are not represented within state and medical discourses surrounding abortion access. Megan was not the only one who suggested this. Jaden, too, told me how there are “so many things that people don’t

think would be barriers, but that are” (interview with Jaden Fitzherbert 2015). Talking explicitly about her privilege as an abortion rights activist and former clinic escort living in Fredericton, Jaden described how her connections and social location make it easier for her to obtain sexual and reproductive healthcare in the province. During this conversation, she stopped to consider those outside of her own circumstances:

Not everyone is that lucky. Like, what about the single mother who I spoke to last summer, who lived in a rural community, and the hospital there didn’t do them, and she couldn’t get to Bathurst or Moncton? What about people in any community that doesn’t have access to a hospital? [...] Because, you know, I can afford a hotel room, probably, but not everyone can (ibid).

In both excerpts, Jaden and Megan draw connections between the regional distribution of abortion services and the social forces that condition the possibility for patients to access those services. These connections, echoed by nearly all of my research participants, are reflective of a broader analysis that situates abortion access, as well as efforts to expand access, within the context of people’s everyday lives and experiences. While my participants are explicitly speaking to issues of abortion care, their analyses have largely been informed by the reproductive justice framework, which situates reproductive health and rights within a broader context of social, political and economic inequalities. At the same time, many of the activists I interviewed, in particular those involved with Reproductive Justice New Brunswick (RJNB), troubled their own use of the reproductive justice framework, expressing concerns over their complicity in co-opting the term to further a political agenda that is centered on abortion, rather than reproductive oppression more broadly. As I demonstrate in later chapters, one of the ways that activists navigated this tension was by framing their struggle in terms of access to basic healthcare, and by calling attention to the complex relationship between abortion access and systemic

inequalities. This understanding also helps to reveal a disjuncture between activists' knowledge about the social organization of abortion access on the one hand, and the knowledge undergirding the province's regulatory framework for abortion care on the other. While the former opens us up to the complexities of obtaining an abortion—demanding an analysis that is attuned to the intersecting dimensions of inequality that condition our lives—the latter flattens such complexities by assuming a normative subject whose access to care is not conditioned by her social location. As I show in the remainder of the chapter, this assumption has been prevalent throughout Canada's abortion policy history, resulting in a regulatory framework that prioritizes the experiences of white wealthy women (who face far fewer barriers to accessing care than those at the intersections of multiple oppressions), while simultaneously contributing to the culture of shame and stigma surrounding abortion. It is clear, then, that decriminalization alone has failed to integrate abortion care into Canada's publicly funded health system. Instead, women in Canada must “now travel here and there within their own country, bearing the burden of inequality of access to abortion services often in inverse proportion to their ability to undertake such travels” (Sethna et al. 2013: 48).

From Criminalization to Medicalization: 1869-1977

Early Abortion Regulation: 1869-1939

In Canada, the act of obtaining or providing an abortion was considered a criminal offense from the mid-nineteenth century until the 1988 Supreme Court decision that decriminalized the procedure. The first law restricting abortion in the country was inherited through the 1869 *Lord Ellenborough's Act*, which by British precedent prohibited abortion

without exception, subject to a punishment of life imprisonment (Johnstone 2012; Stettner 2016). Then, in 1892, the consolidation of the *Criminal Code of Canada* defined abortion squarely within a discourse of criminality, so that any attempts to procure a miscarriage or self-induce an abortion was subject to seven years imprisonment. Furthermore, persons found guilty of selling, advertising, or publishing information of “any medicine, drug or article intended or represented as a means of preventing conception or causing abortion,” were liable to two years’ imprisonment (McLaren 1978:323).³¹ For more than half a century, women in Canada facing unwanted or unplanned pregnancies risked their health and freedom to either self-induce a miscarriage or seek help from someone (whether a trained medical practitioner or not) who would agree to perform the procedure illegally (ibid). This law was altered by British precedent when, in 1938, a physician named Dr. Aleck Bourne announced he had performed a free abortion for a fourteen-year-old rape victim, with the consent of her parents (Hargreaves 2012).

As Johnstone (2012) notes, the Bourne Case was combined with a strong physician lobby group in Canada which, in 1939, influenced the federal government’s provision to permit physicians to perform abortions at their discretion, should they determine that a continued pregnancy would put the woman’s life at risk. As Stettner (2015: 35) helps make clear, these early criminal sanctions regarding abortion most often targeted physicians—in fact, records indicate that out of the less than two dozen abortion cases tried in Canadian courts during this time, not one woman was prosecuted for obtaining an abortion. Instead,

³¹ As this excerpt makes clear, the history of regulating abortion is interwoven with that of contraception and access to information regarding SRH. This early legislation, then, is indicative of Canada’s history of denying women reproductive autonomy through the gendered politicization of reproduction and sexuality.

the charges were most often placed upon medical practitioners. The 1939 case is of particular interest, as it marks the first of many attempts by the medical community to modify the federal law in order to grant physicians increased control over abortion-related decision making. In other words, this early attempt to liberalize the abortion law was primarily pursued not in the interest of women who sought abortion care, but in the interest of physicians who sought to provide that care. As Johnstone (2012) and Haussman (2001) have suggested, physician-centered reforms such as this have helped to maintain a hierarchy of power over women's reproduction, in which physicians, not women, are granted ultimate authority over reproductive decision-making. And although the 1939 provision enabled some women to legally terminate a non-viable pregnancy, in the years following, the complications of unsafe illegal abortions continued to be among the top reason for hospital emergency admissions among young women. It is estimated that in the year 1959 alone, there were some 33,000 illegal abortions performed in Canada (Rebick 2005: 35). In Shannon Stettner's edited collection, *Without Apology: Writings on Abortion in Canada*, Dr. Sterling Haynes reflects on the impact that criminalization had upon women's access to safe abortion procedures during this time (2016). Entering into practice in the 1960s, Haynes describes encountering numerous cases of complications following unsafe illegal abortions while working in the emergency ward of the Cariboo Memorial Hospital in British Columbia. As he writes, these abortions would often result in serious long-term complications for the women who sought them. The usual methods for "hotel-room abortionist[s]," Haynes recalls, was to insert slippery elm into the cervical canal and uterus. Upon coming into contact with the woman's blood, the slippery elm, full of bacteria and spores, would expand and dilate the cervix, forcing a miscarriage with "disastrous

results” (Haynes 2016:257). In 1965, one illegal abortion provider attempted to procure an abortion by shoving lye pellets up a young woman’s cervical canal and into her uterus. The woman suffered heavy bleeding, sepsis, and a severely burned vagina, cervix and uterus. Though she eventually healed, her traumatic abortion experience had the added effect of causing lifelong sterility (ibid). This, Haynes recalls, was the reality of a law that criminalized women who obtained abortions, as well as the physicians who provided them (ibid).

Organized Medicine’s Push for Therapeutic Abortions: 1966-1968

In the 1960s, physician concerns surrounding the abortion law began to grow as increasing numbers of women sought medical assistance in ending unwanted or non-viable pregnancies. During this time, the Canadian Medical Association (CMA) began deliberating over how best to protect its members – legally, politically and socially – from the increasing demand for safe abortions (Thomson 2004:10). In 1966, the CMA voted in favour of lobbying the federal government to decriminalize therapeutic abortions,³² which would enable physicians to perform the procedure without the risk of prosecution (ibid). In 1966, the governing bodies of both the CMA and Canadian Bar Association (CBA) adopted statements calling for a reformed abortion law that would decriminalize abortion under specific circumstances (Stettner 2012).³³ The positions of the medical community were also bolstered by public opinion—according to a 1967 Gallup poll, 71% of Canadians supported the liberalization of the abortion law under certain circumstances (ibid). In

³² The term “therapeutic abortion” is used here to indicate an abortion that is deemed medically necessary to ensure the health and life of the pregnant woman.

³³ It is perhaps worthwhile to note that, in this same year, the federal government introduced the *Medical Care Act*, which granted Canadian citizens universal healthcare in 1968.

response to these growing concerns, the House of Commons appointed the Standing Committee on Health and Welfare to consider several briefs and witnesses' calls for reforming Canada's abortion law. Operating from October 1967 to February 1968, the Committee heard briefs submitted by a broad range of public interest groups, including the CMA, the CBA, the National Council of Women, the Canadian Labour Congress, the Family Planning Federation of Canada, the Young Women's Christian Association, the Women's Liberation Group, and the Canadian Council of Churches (Stettner 2016: 42).³⁴ On December 19, 1967, the Committee released its interim report, which specified that the abortion law as outlined in the *Criminal Code* was lacking in clarity, and recommended that it be amended to allow for therapeutic abortions to be provided under the appropriate medical safeguards, in instances where a woman's life or health would be at serious risk should the pregnancy continue (Tatalovich 1996). This interim report coincided with recommendations put forward by the CMA to extend the conditions of legal termination to include cases of fetal health and sexual abuse (Thomas 1977). The contents of the Committee's interim report, combined with the recommendations of the CMA, held significant weight in future debates regarding the federal abortion law, ultimately leading to the amendment of the *Criminal Code* in 1969.

As many researchers have noted, male perspectives tended to dominate the abortion debate of the 1960s (Stettner 2012, 2016; Haussman 2001; Tatalovich 1996; Jenson 1997). This had the effect of marginalizing women's voices and perspectives of the abortion law, despite their being active at the time. While today's abortion debate is largely centered on the right for women to access a timely and affordable abortion, the 1960s debate, led by

³⁴ Dr. Henry Morgentaler also presented before the committee (Stettner 2016).

the medical community, was primarily centered on protecting the legal rights of physicians to perform the procedure (Haussman 2001). This medicalized, physician-centered representation of abortion went on to inform the liberalization of the abortion law, as well as its ultimate repeal in 1988, although it did so at the expense of a more holistic, women-centered framework of reproductive autonomy. While the 1969 amendment significantly improved access to abortion for women across the country, it did not grant women decision-making authority over the procedure, instead leaving it to the behest of a panel of physicians to determine the procedure's medical necessity. As the following pages make clear, the centering of physicians within the abortion debate throughout the 20th century helped to shape the current state of abortion access in Canada by shifting much of the jurisdiction over abortion-related decision-making into the hands of the medical community, rather than into the hands of those who required the procedure.

Parliamentary Debate: 1966-1969

While the medical community was establishing itself as a key player in the liberalization of the abortion law, the debate was met with contention on Parliament Hill. In the mid-1960s, a number of Private Member's Bills were introduced to legalize abortion on varied, albeit specific grounds: H.W. Herridge, MP for the New Democratic Party (NDP), introduced Bill C-136, which would allow abortions when the health and well-being of the woman or the fetus would be threatened if the pregnancy continued; Liberal MP Ian Wahn introduced Bill C-122, which would authorize hospitals' therapeutic abortion committees (TACs) to legally determine whether a woman's life or health would be threatened if a pregnancy continued, effectively permitting abortions to be carried out

under circumstances approved by TACs; and finally, Omnibus Bill C-195 was introduced by then-Justice Minister Pierre Trudeau, which included legislation that would authorize abortion when the health or life of a mother was likely to be endangered should the pregnancy continue (Tatalovich 1996). Though these bills never passed in the House of Commons, their contribution to the discursive production of abortion as a (conditionally) medically necessary procedure, coupled with the organizational efforts of the medical community, helped to create the conditions under which reforms to the *Criminal Code* would later become possible.

Once Prime Minister Pierre Trudeau was elected to Parliament in June 1968, the Liberal government was quick to reform the *Criminal Code* to reflect the recommendations of the medical community. Though Bill C-195 was defeated in the House of Commons in 1967, within two years the contents of this bill would be used in the creation of the identical Omnibus Bill C-150, introduced by Justice Minister John Turner in 1969. On its third reading, and after much debate, Bill C-150 passed in the House of Commons by a vote of 149 to 55 (Thomson 2004). With endorsement on behalf of the Senate, Omnibus Bill C-150 was enacted on August 26, 1969, effectively decriminalizing therapeutic abortions across Canada (Tatalovich 1996). The passing of Bill C-150 permitted women in Canada to obtain a “medically necessary” abortion by a licensed physician, at an approved hospital, after a TAC comprised of at least three physicians determined that a continued pregnancy would pose a threat to the woman’s life or health (Hargreaves 2012). It was thus at the

discretion of the medical community to determine who, when, and what constituted a medically necessary procedure (Jenson 1997).

As Shannon Stettner reminds us, “much of the impetus behind the 1969 amendments arose from a desire to clarify the circumstances under which physicians could legally perform an abortion” (2016: 42). In other words, the 1969 amendment was introduced as a way to primarily protect physicians against prosecution for providing abortions that they deemed medically necessary. By codifying abortion as at once a medical procedure governed by a team of physicians, and a criminalized practice mediated by the *Criminal Code*, Bill C-150 began to shift the regulation of abortion from the hands of the state to the hands of the medical community (Tatalovich 1996; Jenson 1997). This lodging of abortion within both the medical and criminal realm helped to preserve what Lorna Weir has referred to as the “political fiction [of] abortion [as] a criminal act necessitated under exceptional circumstances for health reasons” (1994: 225). It was thus “medical need, not feminist theory or rights jurisprudence” that motivated the 1960s abortion reformers in the Canadian context (Tatalovich 1996: 4). Confined to the realm of medicalization, physician claims to decriminalize therapeutic abortions fell short of addressing the complex relationship between abortion access, reproductive autonomy and women’s lived experiences. In fact, many physicians at the time were opposed to the full decriminalization of abortion, as well as the associated right of women to exercise full control over their reproductive lives (Hausman 2001). To be sure, this debate took place during an era in which motherhood was itself revered as a “benchmark of womanhood” (Stettner 2012: 152). This ideological image of womanhood – informed by conservative patriarchal, capitalist and white supremacist values, among others – was at stark odds with an analysis

that granted women full control over their reproductive lives. As a result, although Bill C-150 indeed led to increased access to abortion care, the bill itself did little to address the problem of reproductive autonomy.³⁵ Instead, it wedged abortion between a discourse of criminalization (that is, subject to legal sanctions under criminal law if performed or procured outside an approved hospital or without the approval of a TAC) and a discourse of medicalization, in which physicians were granted ultimate authority over women's ability to access the procedure. This rupture – between Bill C-150 and women's concrete reproductive needs – generated friction between the federal government, the medical community and local women's groups, who would soon call upon the state to repeal Canada's abortion law and ensure broad-based access to abortion for women across the country (Stettner 2012, 2016; Rebick 2005).

Women's Liberation, Women's Health & The Abortion Caravan: 1968-1970

While the decision to grant the medical community jurisdiction over women's reproductive health choices is somewhat indicative of the marginalized role that women – and feminists in particular – played in early Canadian abortion politics, I do not wish to suggest that women as a whole were absent from the early abortion debate, but rather that their voices were underrepresented within the dominant public discourse. For example,

³⁵ That Bill C-150 simultaneously increased access while also continuing to limit women's reproductive autonomy raises significant questions for those who are interested in transforming the social organization of abortion care. To be sure, the medical community's ability to successfully lobby for changes to the *Criminal Code* demonstrates the significant social and political influence that physicians have over the development of health policy in Canada. Thus, while the medical community fell short of addressing issues of reproductive autonomy, their lobbying efforts were indeed tactically useful in expanding access to abortion for many women across the country.

during the sexual revolution of the late 1960s and early 1970s, women's liberation groups were actively distributing information regarding birth control and abortion, and were also referring women to TACs with more liberal approval procedures. In 1968, the McGill Student Society published *The Birth Control Handbook*, which, like *Our Bodies Ourselves* (1970) in the United States, helped to empower and raise consciousness among women regarding issues of sexual and reproductive health (Rebick 2005). Similarly, women in consciousness-raising and self-help groups were exchanging tacit knowledge about their personal lives, as well as their bodies, health and sexuality, and exploring their genitalia – often for the first time – through self-examinations (ibid). These moments marked the emergence of an international movement for women's health, of which abortion access played a major part. Still, women's liberation groups were organizing at the fringes of the national abortion debate, and it was not until the passing of Bill C-150 that their collective voices were amplified in the national arena (Weir 1994).

This marginalization of women's perspectives in early abortion politics had direct implications for women's abortion experiences and feminist activism post-1969. Much of the direct action immediately following Bill C-150 stemmed from an upsurge of feminist activism in Vancouver, where many women's groups were already organizing around issues of reproductive health and rights. Groups such as the Vancouver Women's Caucus (VWC), which had grown concerned with the Bill's gendered and classed implications, mobilized around the intersections of class inequality and abortion access (Sethna et al. 2013: 35). The most significant demonstration led by the VWC was the cross-country abortion caravan, in which hundreds of activists travelled from Vancouver to Ottawa to protest the inadequacies of Bill C-150 and to call for the repeal of the abortion law. Before

leaving for Ottawa, members of the VWC sent letters to women's groups across the country in an effort to publicize the event and garner national support for their action. Once in Ottawa, approximately three hundred women gathered on Parliament Hill, with many marching into the Parliament Buildings to demand the law's repeal. One of the speakers at this first national abortion action was Dr. Henry Morgentaler, who, as feminist activist and caravaner Betsy Mary Wood recalls, was heckled by activists for "not being radical enough" in his politics (quoted in Rebick 2005: 41). The next day, the caravaners planned a second action, in which thirty women chained themselves to their chairs in the gallery of the House of Commons, in tribute to the direct action pursued a century before by British suffragists. Meanwhile, some two hundred women gathered again on Parliament, dressed in all black to mourn the deaths of women who had lost (and would continue to lose) their lives from complications following an unsafe illegal abortion (ibid).

Touted as the first national action of the Canadian women's movement, the abortion caravan was considered a watershed action for Canadian feminism in general, and the pro-choice movement in particular (Thomas 2004; Rebick 2005). To be clear, abortion was only one of many issues that women were taking up in their political organizing during these years, including but not limited to gendered wage inequality, childcare and domestic labour, as well as the broader movement for women-centered healthcare (Rebick 2005). Still, as many activists recall in Judy Rebick's *Ten Thousand Roses: The Making of a Feminist Revolution* (2005), abortion helped give many women a "common language" from which to analyze the hold that patriarchy, capitalism, the media, the medical community, and the state had over women's everyday lived experiences. At the same time, the caravan also helped reveal some of the political differences within the women's

movement during this period. This was particularly evident between Vancouver feminists, many of whom were involved in New Left and anti-war demonstrations, and feminists in Toronto, who were already experiencing internal political divides between socialist and radical feminists (ibid). The caravan brought together hundreds of women across the political spectrum. As one activist recalls, one of the major divisions among these women was whether they were fighting “for the right to abortion only, or [...] to smash a system” (Margo Dunn, quoted in Rebick 2005: 42). As I demonstrate in both this chapter and those to come, this debate – over whether to evoke a single-issue framework or a more holistic and intersectional one – is a tension that has continued to echo among pro-choice and reproductive justice activists in Canada.

The Royal Commission on the Status of Women: 1967-1971

Similar to the abortion caravan of 1970, the history of the Royal Commission on the Status of Women (RCSW) helps to capture women’s efforts to situate themselves within the public abortion debate, often politicizing their own lived experiences as a means of resistance. In 1971, the RCSW released a groundbreaking report recommending that women be granted control over abortion for the first twelve weeks of pregnancy (Jenson 1997: 297). The contents of this report clearly articulated the RCSW’s position on the abortion issue: specifically, that throughout the first trimester, women should be able to access an abortion without requiring a justification for their decision, and that qualified doctors should decide the necessity and viability of abortion only within the twelve to twenty-four-week period (ibid). In preparation for this report, the RCSW held hearings and public meetings, commissioned research reports, and gathered 480 briefs and some 1,000

letters of opinion from individuals and organizations across Canada between 1967 and 1968 (Rebick 2005; Stettner 2012). A nationally coordinated body, the RCSW was initiated under the government of Prime Minister Lester B. Pearson in 1967, following a campaign led by women in Ontario calling for a Royal Commission into women's issues (ibid). Among the problems that the RCSW helped to make visible were gender-based discrimination, unfair pay in the workplace, challenges around raising children, and barriers to abortion and contraception, as well as sexual and reproductive healthcare in general (Rebick 2005; Jenson 1997).³⁶

Shannon Stettner's (2012) archival research into the RCSW is particularly useful here. In it, she speaks of the Commission on the basis of women's efforts to convey and firmly establish authority over the issue of abortion. Through her exhaustive analysis of the 200 letters and briefs referencing abortion that were submitted to the RCSW in the late 1960s, Stettner provides an important contribution to the literature on women's abortion experiences as well as women's participation in Canada's early abortion debate. Countering Jenson's (1997) and Tatalovich's (2006) arguments that women's participation in the 1960s debates were either "absent" or "weak," Stettner (2012) demonstrates that the RCSW provided a forum for women to contribute to social change by sharing their political positions on abortion through acts of story-telling. As Stettner writes, "Diffused they may have been, weak they were not" (2012:155). In interrogating the common tendency among

³⁶ It is important to note that while the RCSW was emerging, local women's committees were already active in many provinces across the country. In Manitoba, for instance, a group of women set up a volunteer committee in 1967, which travelled around the province and held hearings where women were encouraged to share their experiences. According to Susanna June Menzies, who was active in the early Manitoba committee, many provincial committees submitted their own briefs to the RCSW, and then came together after the report was released in 1971 to help implement the recommended changes (quoted in Judy Rebick 2005: 23-5).

scholars to dismiss women's roles in early abortion debates, Stettner draws on the understanding of "the personal as political" and the notion that "individual voices can be powerful in shifting dominant understandings," (2012:154). Responding to Anne Enke's (2007) "encouragement to look for the women's movement in sites not usually considered political," Stettner reaffirms the domestic setting as a political space, "such that the act of a woman writing to the Commission while sitting alone at her kitchen table is evidence of feminist activism" (2012:155). As she suggests, the RCSW provided a "uniquely female space" for women to share their stories, experiences and perspectives, acting as the experts of their own lives and asserting their authority over the abortion issue (Stettner 2012:152). While women's voices may not have been centered in the drafting and passing of Bill C-150, it is wrong to assume that they were absent altogether. On the contrary, local consciousness-raising groups, provincial committees and the RCSW provided women with a platform from which to amplify their voices, placing women's perspectives on abortion firmly within the public arena.

Despite overwhelming support for increased abortion access within the RCSW, it is important not to oversimplify the nature of its submissions. As Stettner (2012) suggests, while most submissions spoke to a pro-choice perspective, there were others that demonstrated strong political positions against the decriminalization of abortion. Many women drew from their own lives in their submissions: their experiences of motherhood and maternity, their experiences as children, their professional experiences and education, as well as demographic characteristics, as justification of their authority and expertise. Others used their rejection or acceptance of religious or moral values to defend their perspectives. Still others "argued that their

authority over abortion stemmed from their identities as women; as the people most directly affected by unwanted pregnancies, at the very least they sought the greater involvement of women in the public arena or, more forcefully, total control over the abortion decision” (Stettner 2012:156). Some letters, especially those invoking women’s experiences with reproductive healthcare, signaled to the Commissioners that “the status quo not only was untenable, but pushed women to contravene laws— legal, social and religious” (ibid: 160). Poring through these stories, Stettner (2012) concludes that despite the oft-claimed absence of women in the early abortion debate, it is clear that women were neither silent nor uncritical of the relationship between gender relations – specifically the subordination of women to men – and women’s lack of authority over reproductive decision-making in Canada. It is thus “hard to imagine,” she writes, “that these voices did not contribute to the wider public dialogue, even if only as the undercurrent shifting dominant understandings of unplanned and unwanted pregnancies” (Stettner 2012:167).

TACs, The Morgentaler Clinic & The Badgley Report

The abortion caravan and the RCSW report mark two major moments in the history of feminist and pro-choice organizing in Canada. Soon after, in 1974, the Canadian Association for the Repeal of the Abortion Law (CARAL, later the Canadian Abortion Rights Action League) was founded in response to both the limitations posed by Bill C-150 and the criminalization and incarceration of renowned abortion provider, Dr. Henry Morgentaler (Hargreaves 2012). For over a decade, CARAL led federal lobbying campaigns to repeal the sections of the *Criminal Code* regulating abortion, lent support to

local and provincial activist groups, and helped secure funding to offset the costs of Henry Morgentaler's court cases (Rebick 2005; Weir 1994; 1995). Prior to this, in 1969, Morgentaler defied Canadian law by opening his first abortion clinic in Montreal. The police raided the clinic less than a year after it opened, charging Morgentaler with criminal offenses in 1971 (Hargreaves 2012). In 1973, Morgentaler issued a public statement announcing that, despite Bill C-150, he had continued to actively perform abortions outside of designated hospital settings, and without the approval of TACs. In his statement, Morgentaler estimated that he had performed over 5,000 surgical abortions under these conditions, and subsequently demonstrated his procedural technique on national television (Hargreaves 2012:19). Following this, Morgentaler's clinic was raided once more, with criminal charges laid against him. Although he was soon acquitted, the Court of Appeal reversed his acquittal in 1974. Morgentaler appealed this decision to the Supreme Court of Canada, which ultimately sentenced him to ten months imprisonment for defying the federal abortion law (ibid). Morgentaler's court battles continued during his incarceration, with two Quebec juries acquitting him of charges in 1975 and again in 1976 (Stettner 2016).³⁷

In response to growing public dissent surrounding the abortion law, the federal government appointed a committee in September 1975 to determine whether the parameters set in place by the *Criminal Code* were operating equitably across Canada (Thomas 1977). The three-member Committee on the Operation of the Abortion Law,

³⁷ It is worthwhile to note that, soon after the Parti Québécois came to power in 1976, its government defied federal law by granting prosecutorial immunity to all qualified abortion providers, regardless of whether they sought TAC approval or where they performed the procedure (Stettner 2015:49).

chaired by professor Robin F. Badgley, released its report in January 1977 (Stettner 2016). As outlined in its report, the Committee concluded that there were major inequities in the operation of TACs across Canada, including though not limited to broad variances in TAC approval procedures and patient requirements, delays in decision-making, lengthy wait-times averaging up to eight weeks, and varied interpretations of the term “health” (ibid; Thomas 1977). Recall that, with the introduction of the TACs, physicians were given full jurisdiction over what qualified as a medically necessary abortion procedure. Due to Bill C-150, it was left to the TACs to determine whether a continued pregnancy would pose a threat to the woman’s health—leaving the definition of “health” largely up to interpretation (ibid). While some committees were liberal in their interpretation of the law, many were fairly restrictive, while some rarely approved the procedure at all (Thomas 1977). In some cases, TACs required face-to-face interviews before approving women for their procedures (ibid). TAC requirements around procedural consent also varied among hospitals, and often depended upon the TAC’s interpretation of provincial laws surrounding the medical age of consent. In its report, the Committee found that more than two-thirds of the hospitals surveyed required that the woman’s husband consent to the procedure prior to approval (Dunsmuir 1998).³⁸ Combined with the fact that merely 20.1% of hospitals in Canada had established TACs, such requirements often created major delays in accessing abortion care, thus increasing the risks associated with the procedure (Rodgers 2008: 25). To be sure, the

³⁸ The Badgley Committee also found that several women were pressured into consenting to sterilization following their abortion—moreover, sterilization was, at times, a prerequisite to obtaining the abortion itself (Stote 2016:278). It is worthwhile to note that, in Canada, medical pressure to consent to sterilization, as well as abortion and birth control, have been disproportionately reported among Aboriginal women, revealing the complex relationship between colonization, white supremacy and reproductive oppression (ibid).

barriers to accessing an abortion within the TAC system were made disproportionately challenging for communities already situated at the margins of society.

As Haussman (2001) notes, there were no appeals processes set up within the TAC system, meaning that women who were denied procedures were forced to either carry a pregnancy to term, or to seek alternative abortion care outside of the TAC system. However, because abortions performed outside of approved hospitals were still subject to legal sanctions under the *Criminal Code*, women seeking care without TAC approval were subject to two years imprisonment (ibid). And while Bill C-150 granted eligible hospitals and physicians the ability to form TACs and provide abortions, hospitals and physicians were under no obligation to participate in the TAC program, nor to provide abortion services to approved patients (Hargreaves 2012). In fact, at the time, only one in five hospitals were reported to have had an active TAC (ibid). The patchy distribution of TACs within and across provinces meant that many women faced additional barriers – such as travel and associated costs – to accessing a therapeutic abortion in Canada. As Thomas (1997) notes, between 1970 and 1975, some 50,000 Canadian women are reported to have travelled to the United States to obtain an abortion. However, because the ability to travel in search of healthcare was – and continues to be – determined by one’s social location, the uneven geographic distribution of TACs had disproportionate impacts upon low-income women, as well as poor, young, single, racialized, Indigenous, disabled and otherwise marginalized women.

Together, the uneven distribution and operation of TACs meant that the ability for women to obtain a legal therapeutic abortion in Canada remained circumscribed by several variables beyond her control. As suggested earlier in this chapter, the TACs came into

formation only after the passing of Bill C-150, which granted the medical community increased control over abortion provision, while maintaining legal sanctions for procedures performed outside of the TAC-system. As Haussman (2001: 68) writes, Bill C-150 and its associated TAC system worked to maintain the role of physicians as gatekeepers, endowed with the authority to decide whether, where, and to whom an abortion would be granted. Unlike *Roe v Wade* (1973) in the United States, which legalized abortion based on women's liberty rights of privacy, Bill C-150 emphasized "the right of a pregnant woman to be provided with medical services according to a legal standard interpreted by a committee of doctors" (Kellough 1996:89). As the next section makes clear, women's experiences with the TAC system, made visible in part by the abortion caravan, the RCSW and the *Badgley Report*, helped create the conditions for future activism and advocacy centered on repealing Canada's abortion law, expanding access to abortion in clinics, and advocating for the necessary enabling conditions for women to exercise their right to care. In recalling this history, I return to the question of reproductive justice, exploring the role that this framework played among feminist pro-choice activists in the 1980s.

Contemporary History: Feminist Activism, Morgentaler & Canadian Federalism

Abortion clinics have long been a site of feminist struggle in Canada, particularly in the years leading up to and directly following the Supreme Court decision in *R v. Morgentaler* in 1988. While the state and the medical community dominated the public abortion debate well into the second half of the 20th century, the 1980s gave birth to what Lorna Weir (1994, 1995) considers a "new cycle" of pro-choice activism in Canada, much of which was centered on establishing, defending and expanding access to

abortions in clinics. In this section I explore several key moments in Canada's abortion history that took place during this decade. I begin with an overview of Dr. Henry Morgentaler's decision to open clinics outside of Quebec in direct violation of the *Criminal Code*, and the politicization that followed in response to his attempts to expand abortion care outside of hospital settings. In this same discussion, I explore the alliances that formed between Morgentaler and like-minded physicians on the one hand, and feminist pro-choice organizations such as the Committee for the Repeal of the Abortion law (CARAL) and the Ontario Coalition for Abortion Clinics (OCAC) on the other. Emerging from this alliance are three key themes, all of which remain significant for the contemporary movement for abortion access: 1) the implication of crisis-oriented activism for expanding access to abortion care; 2) the positioning of abortion clinics as material and symbolic rallying points for activism; and 3) the political differences between a single-issue platform that privileges abortion rights and a more broad-based framework of reproductive freedom and/or justice. Following this analysis, I present a brief overview of the Supreme Court decision in *R v. Morgentaler*, the impact this decision had upon the regulation and distribution of abortion services in Canada, and the ways that feminist activists have responded to the abortion problem post-1988.

Crisis, Clinics & Feminist Activism

In the 1980s, women's ability to access an abortion in Canada remained, as several of my research participants call it, "a matter of luck and privilege," distributed along lines of race, class, age, ability, region and more. As Weir's (1994, 1995) research demonstrates, this reality, made visible by the *Badgley Report* and the RCSW, led

feminists to construct Canada's abortion problem as a "crisis of access." The argument that women's ability to access an abortion was at a crisis point enabled pro-choice feminists to better articulate the relationship between structural inequalities and abortion access, calling attention to the ways in which the overlapping dimensions of "class, race, and region," among others, conditioned the possibility for women to obtain abortion care (ibid 1994: 261). Because abortion was regulated by both state and medical institutions, this same analysis helped feminists to challenge the "state-funded medical system that failed to provide adequate healthcare to citizens, thus violating the principles of the federal *Canada Health Act*" and making visible the "line of fault in state legitimacy" in regards to the universality of healthcare provision (ibid).³⁹ Seeking to reorganize this model of abortion care, many activists looked to Quebec, where Morgentaler had helped pave the way for expanded access to abortion in clinics and community health centres (ibid). Fighting for expanded access to abortion, these activists sought not only a short-term solution to the crisis of access in the form of clinic care, but also a change in the structural conditions organizing abortion access in Canada through a repeal of the abortion law.

At the 1982 annual general meeting of CARAL in Toronto, Morgentaler announced plans to establish the first abortion clinic outside of Quebec (Hargreaves 2012). At the time, clinics represented a challenge to the *Criminal Code*, as they were not

³⁹ Similarly, today's movement to expand abortion access in New Brunswick refers to the universality and accessibility principles of the *Canada Health Act* as a means to call into question the legitimacy of a provincial health system that restricts public funding for abortions in clinic settings. As I discuss in Chapter 5, members of RJNB, ARCC and FYF have framed the closure of the Fredericton Morgentaler Clinic, as well as the continued denial of public funding for clinic abortions, as a crisis of access.

considered accredited hospitals, nor did they require women to seek approval from a TAC prior to their abortion (Weir 1995). As Kellough (1996) writes, operating outside the TAC system, clinics helped to grant women reproductive autonomy by providing them with the opportunity “to define their own reproductive needs without subjecting their decision to the authority” of a panel of physicians (216). As a movement strategy, then, the establishment of illegal clinics addressed both structural and ideological problems: while providing much-needed abortion services, it would also help make visible the “crisis of access that was occurring in the hospitals” and the limitations of the TAC system (Kellough 1996:215-7). Shortly after Morgentaler’s announcement, the Ontario Coalition for Abortion Clinics (OCAC, then the Committee for the Establishment of Abortion Clinics) was formed, holding its inaugural meeting in September 1982 to begin planning its mobilization strategy for establishing a clinic in Toronto (Rebick 2005). By 1983, OCAC had approximately 3,000 members, an office and a part-time staff member (Weir 1995). Many of the founding members of OCAC had been working in the field of women’s health and care, and so were already acutely aware of the uneven access to abortion and the challenges put in place by the TAC system (Rebick 2005). As Carolyn Egan recalls, members of OCAC approached Morgentaler shortly after his announcement to discuss the possibility of establishing a clinic in Toronto. If he committed to this, they said, OCAC would in turn commit to building a “strong movement to fight for the repeal of the federal law and full funding for abortion clinics” (1998:17). He agreed, but first opened a clinic in Winnipeg, where a similar movement was happening among feminist activists, labour unionists, health workers and women working in the provincial NDP (Rebick 2005). By 1983, Morgentaler – with help from

his staff and allied activists – had established three abortion clinics across Canada: in Montreal, Winnipeg and Toronto (ibid).

Both the Winnipeg and Toronto clinics were raided the same year they were opened. Equipment was confiscated, and charges were laid against Morgentaler and his clinic staff members (Hargreaves 2012: 24-5). Thinking back on the raids in Winnipeg, Ellen Kruger recounts the “horror of [the police] parading seven women out and arresting them, women who had just had abortions, three of them still in recovery. It was horrible, horrible. The staff were all arrested. The clinic opened again, and there would be another raid. There were three raids in a short period. They’d confiscate the equipment, and Henry would order more” (quoted in Rebick 2005: 165). Judy Rebick, too, reflects on the climate of that first year, recalling how Toronto police would follow women as they left the clinic, harassing women seeking abortion care. “So we organized people to take the women to safe houses,” she writes, “The [clinic] escorts became a corps of support” (2005: 161). Then as now, abortion providers and activists were forced to come up with creative solutions to support and protect women seeking abortions in clinics.⁴⁰ As Egan describes, during this period, the abortion clinic became a “symbol of women’s resistance to an unjust law. It came to crystallize the battle between women’s liberation and those forces that oppose the emancipation of women” (1998:17). While the establishment of abortion clinics alone would not be enough to secure reproductive justice for

⁴⁰ There are striking parallels to be drawn between the stories of state-sanctioned harassment outside Morgentaler’s (then-illegal) abortion clinics during the 1980s and more recent stories of the harmful picketing strategies of today’s anti-choice movement, which often involve harassing women as they enter and exit abortion clinics. Today, many clinics continue to enlist volunteer clinic escorts to support and greet women, and to act as physical barriers between anti-choice protestors and those seeking abortion care.

communities across the country, its symbolic and material significance to the women's movement in the 1980s – particularly in relation to reproductive rights – is worth investigating further. The fact that clinics challenged both levels of the state – through federal criminal law and provincial health policy – helped to produce the abortion clinic as a symbol of feminist activism against state-sanctioned reproductive control (Weir 1994, 1995). In Weir's research, she demonstrates how feminist activists during this time understood clinics on the basis of their practicality, as material spaces that provided women access to abortion, as well as strategic and symbolic rallying points for political resistance and opposition to the status quo (1994: 255). The pro-choice movement thus took a two-prong approach to clinic-based activism, both by defending and expanding access to clinic procedures (as a material solution to the problem of abortion access), and by holding the clinic up as a symbol that inherently challenged the *Criminal Code* and TAC system (ibid).⁴¹

After the clinic raids, OCAC continued to build capacity within the pro-choice movement, holding mass demonstrations, marches, and rallies to push for the repeal of the abortion law and expanded access to reproductive healthcare. With the support of CARAL, OCAC's organizing efforts drew thousands of activists and allies onto the streets and into the campaign, generating a broad and diverse base of support for women's reproductive rights and health (Rebick 2005; Egan 2012). Central to OCAC's mobilization capacity was the organization's commitment to placing abortion within a

⁴¹ This bears a significant resemblance to the strategies used by activists today. For example, in New Brunswick, activists have rallied around the Fredericton Morgentaler Clinic and Clinic 554 to help curb the problem of access in the province and as means to challenge the provincial government's textual mediation of abortion under Regulation 84-20 of the *Medical Services Payment Act*.

broader discourse of “reproductive freedom,” which Weir (1994) attributes largely to the 1984 publication of Rosalind Petchesky’s *Abortion and Woman’s Choice: The State, Sexuality, and Reproductive Freedom*. Rather than maintaining a single-issue approach to organizing, members of OCAC called attention to the relationship between abortion access and systemic inequalities, making room for advocacy work around safe and effective birth control, access to culturally relevant, community-based and patient-centered healthcare, the right to funded childcare and paid parental leave, labour struggles and the right to employment, LGBT rights, issues around HIV/AIDS, the struggle against coerced sterilization, and the right to raise children in safe and healthy environments (Rebick 2005; Egan 1998, 2013; Weir 1994, 1995). This was important not only for generating a broad-based coalition of support, but also because, as Egan states, “The right to abortion, as important as it is, is meaningless unless all women have access to services that can make that right a reality,” (Egan 1998).⁴² While CARAL primarily stressed the “liberal argument that choice in abortion is a woman’s right,” members of OCAC disagreed with this emphasis, offering in its place an analysis that was more attuned to overlapping social relations of power (Haussman 2001: 73). As Carolyn Egan and Linda Gardner explain, OCAC’s members were “aware of the limits of the notion ‘choice,’” and sought instead to broaden their analysis to encompass “a number of interdependent struggles” in the fight for reproductive freedom (2016: 133). By emphasizing the concept of access, or what Haussman (2001: 73) refers to as the “‘choice-as-access’ or ‘choice-as-

⁴² As I discuss later in later chapters, similar analyses can be seen among many of the activists in New Brunswick following the closure of the Morgentaler Clinic in 2014. For instance, through their rallying cry “We have the law, we need the access!” activists helped bring visibility to the difference between an abstract or theoretical “right” to abortion and the concrete ability for people to obtain safe, timely and affordable care, regardless of their social location.

empowerment' model," OCAC was able to articulate choice as delineated by social relations of power, as well as the "willingness to fund and provide the services" locally (ibid). The language of access and reproductive freedom also enabled OCAC to link abortion to struggles faced by women of colour, women with disabilities, non-English speaking or ESL (English as a Second Language) women, as well as low-income women, young women and women living in rural and northern communities (Weir 1994, 1995). Yet then as now, the intersectional analysis put forward by left-leaning feminists did not come without tensions. Despite offering a multi-issue framework, the movement remained largely centered on the abortion issue, which was "for the most part not made with the active participation of women of color" (Weir 1994:262). Though discourses of access and reproductive freedom were central to many activists' analysis, and helped enable a broad-based movement to contest state control over abortion, as organizing principles, they were not evenly or consistently adopted within the movement (ibid:264).

Still, OCAC's multi-issue framework, combined with the political and cultural thrust of CARAL, helped produce a multi-faceted feminist movement that challenged an entire "regulatory system based on the criminal law of the federal state," (Weir 1994: 270). This approach generated broad public support in part due to the fact that the regulatory regime in question constructed multiple groups of women (that is, women across identity lines) as vulnerable at the hands of the state and the medical community (ibid).⁴³ The alternative that feminists proposed to the textually mediated abortions – that

⁴³ For example, several research participants from the AIDS Activist History Project (Carleton University) have discussed how they stood in solidarity with OCAC and other leftist pro-choice and women's health groups due to their overlapping struggles against the regulatory regime of the state and the medical community.

is, those authorized by the TACs under the *Criminal Code* – was one that both challenged “the ideology of abortion as a criminal act necessitated under exceptional circumstances for health reasons,” and “placed the decision for abortion in the hands of women” (Weir 1994: 255-6).⁴⁴ As the arrests of Morgentaler and his staff brought the abortion issue into the court system, feminist activists ramped up their campaign in an effort to change not only the law, but also the consciousness of the Canadian public with regards to abortion (Egan 1998).

Due largely to the influence of feminist pro-choice activists, Morgentaler’s understanding of abortion rights as an issue of reproductive freedom far surpassed that of the broader medical community at the time. His commitment to circumventing federal legislation by providing abortions without TAC approval helped to usher in a new model of abortion care that placed reproductive decision-making into the hands of women and out of the hands of the state and the medical community. This was met with enthusiasm by many feminist pro-choice groups, who tended to view clinics as necessary service providers, but also as symbolic rallying points for resisting state control over reproductive decision-making. Thus, the alliances that formed between feminist activists, Dr. Morgentaler and like-minded physicians during this time should be understood as part of a broader shift in the social organization of abortion politics, in which women’s voices and perspectives were entering more firmly into the public debate. Pro-choice

⁴⁴ This same argument can be made regarding the role that Regulation 84-20 played in New Brunswick between 1994 and 2015. During these years, Regulation 84-20 required a similarly ideological, textually mediated process that granted physicians authority over whether to declare a woman’s abortion medically necessary. Even today, abortions in New Brunswick remain textually mediated in that Regulation 84-20 creates the conditions under which some abortions are publicly funded while others are not.

feminist groups such as CARAL and OCAC were central to the establishment and defense of abortion clinics, while also playing a major role in galvanizing public support for the repeal of the abortion law. Through these actions, pro-choice feminists of the 1980s helped to shift the public discourse around abortion from one of criminalization and medicalization to one of access and reproductive freedom, in which abortion and clinics were understood to be socially and materially integral to women's reproductive health and autonomy.

The R. v Morgentaler Decision & Canadian Federalism

The enactment of the *Charter of Rights and Freedoms* in 1982 provided a significant opening for abortion-related policy in Canada. With the *Charter* in place, any law in violation of its provisions could be struck down by the Supreme Court. Armed with this, along with the *Badgley Report* and a vocal feminist movement, Drs. Morgentaler, Scott, and Smoling presented a case to the Supreme Court to repeal Canada's abortion law. On January 28th, 1988, the Supreme Court voted in a 5-2 judgment that Section 251 of the *Criminal Code* infringed upon Section 7 of the *Charter of Rights and Freedoms*, specifically women's rights to life, liberty and security of the person (Tatalovich 1997). Among the court justices was Bertha Wilson, the first woman justice in the Supreme Court, who framed the issue as a question of liberty and human dignity, arguing that the law violated the *Charter* by stripping women of the right "to make fundamental personal decisions without interference from the state" (Thomas 1997: 164). At last, abortion was decriminalized in Canada, and women were able to legally access the procedure in clinics.

While a landmark victory for reproductive health and rights in Canada, the

Morgentaler decision in many ways opened the floodgates for further controversy within the political arena. Among pro-choice feminists, the decision was indeed a victory, though an ambiguous one (Jenson 1997). While the decision won women the right to abortion by removing Section 251 from the *Criminal Code*, nothing preventative or enabling was put in its place (Tatalovich 1996). Despite Morgentaler's case that women's right to abortion be firmly enshrined in legislation, of the five-person majority, only Justice Wilson was receptive to this demand (ibid). As Kaposy and Downie (2008) have noted, "all of the justices who ruled that section 251 was unconstitutional nonetheless claimed that protecting the fetus is a valid objective of federal legislation, leaving open the possibility that a different and carefully crafted law against abortion might be constitutional" (281). To be sure, the Supreme Court's decision in *R v Morgentaler* transformed the institutional organization of abortion services in Canada. Due to this ruling, Canada is one of the few countries in the world without a federal law governing abortion. Instead, abortion was cast as a medical procedure, governed by the *Canada Health Act* (CHA), and falling under the jurisdiction of provincial and territorial health departments, medical associations and healthcare facilities. Provincial and territorial governments were quickly thrust into the spotlight to decide how best to regulate, implement and distribute abortion services within their jurisdictions. Without a federal abortion law mandating how abortion services were to be regulated, Canada has been left in what some refer to as a "policy vacuum" with regards to abortion (Johnstone 2012).

This shifting of abortion jurisdiction has led scholars such as Haussman (2001, 2005, 2010), Tatalovich (1997) and Palley (2006) to consider the impact of Canadian federalism on both the implementation of abortion policy and the ability for women to

actually access the procedure. As Palley writes, the “functioning of health-care service delivery in Canada is characterized by a competition between national fiscal power and the formal constitutional responsibility of the provinces to provide for healthcare” (2006:566). This tension is mediated by the CHA, which requires that provinces provide public funding for all medically necessary health services, and that the delivery of services meet the criteria set out by the CHA’s five core principles of public administration, comprehensiveness, universality, portability and accessibility (ibid). Although the federal government itself “cannot issue directives to the provinces concerning the delivery of healthcare,” it can withdraw public health transfers for provinces who they deem to be contravening the CHA (Haussman 2015: 177).⁴⁵

Thus, while *R v Morgentaler* (1988) was successful in decriminalizing abortion, it also opened a line of fault between the federal mandate for universal healthcare and the provincial regulation and provision of services. As Haussman (2015) has suggested, because Canada has failed to provide “a national, directly accountable regime for abortion funding and provision,” several provinces have enacted policies to restrict the circumstances under which an abortion may be considered eligible for public funding (Erdman 2007). Like New Brunswick, provincial governments in British Columbia, Manitoba, Prince Edward Island, and Nova Scotia moved quickly to restrict public funding for abortions provided outside of hospitals for non-medically necessary reasons

⁴⁵ As I demonstrate further in the dissertation, the threat of withdrawing public health transfers is one of several strategies used by activists, as well as past Federal Health Ministers, to pressure the New Brunswick government to repeal the anti-abortion provisions in its *Medical Services Payment Act*.

(ibid).⁴⁶⁴⁷ This move on behalf of provincial governments – made possible by the institutional coordination of publicly funded healthcare under Canadian federalism – has led scholars such as Haussman (2005) to argue that, without including “a mandate for funding or establishing clinics” at the provincial level, the *Morgentaler* decision has merely granted women theoretical access to abortion, rather than the necessary enabling conditions to obtain the procedure (74). Indeed, due to the makeup of Canadian federalism, the *Morgentaler* decision was, as Haussman (2015) suggests, layered onto “a system of policy decentralization in health,” leaving considerable political scope for provinces to limit access to abortion services within their jurisdiction (175). Since 1988, provinces have typically approached this in one of two ways: by making it “as difficult as possible for independent, non-hospital clinics to operate in the province,” and by restricting the conditions under which abortion care may be eligible for publicly funded health insurance (Haussman 2015: 176). As the next chapter makes clear, both approaches are visible in New Brunswick, where the line of fault between federal and

⁴⁶ One notable example is *Jane Doe 1 v. Manitoba* (2004), wherein a judge ruled that Manitoba’s *Health Services Insurance Act*, which “denied funding to abortion performed in private clinics,” was in violation of the *Charter of Rights and Freedoms*. In making their case, the plaintiffs argued that the regulation imposed by Manitoba resulted in women facing significant delays to obtaining an abortion in a hospital. While the judge agreed that forcing women to endure significant wait times to obtain a publicly funded abortion was in violation of the *Charter*’s guarantees of liberty and security of the person, the judgment was ultimately overturned by appeal in 2005 (286-7).

⁴⁷ To be sure, several provinces have since enacted legislation, policies and health service systems to ensure equitable and regional access to abortion care within their jurisdictions, including but not limited to the *Access to Abortion Services Act* (1996) in British Columbia and the Ministerial Guidelines on Family Planning (1996) in Quebec, which formally enshrined women’s rights to access universal abortion care.

provincial authority continues to structure the landscape of abortion care in the province.

Since 1988, pro-choice organizations in Canada have increasingly focused on lobbying provincial governments, demanding improved access at the local level, advocating for the approval of RU-486 or mifepristone (known colloquially as “mife” or “the abortion pill,”), and calling for the inclusion of clinic abortions within provincial health insurance arrangements (Weir 1994; Shaw 2013b; Spring 2014; ARCC 2005). As Hargreaves (2012) suggests, much of today’s Canadian pro-choice movement is centered on establishing abortion services as a provincially insured service to ensure regional and affordable access for those at the margins of society. In New Brunswick, this struggle has primarily focused on the combined effect of the province’s Regulation 84-20 (Schedule 2, para a.1) and Section 2.01(b), Chapter M-7 of the *Medical Services Payment Act*, which continue to deny public funding for abortions provided in clinics. While similar policies have since been struck down in provinces such as Nova Scotia, New Brunswick’s abortion restrictions lived on – under successive Liberal and Progressive Conservative governments – despite decades of local feminist activism, a ten-year court battle between Morgentaler and the provincial government (which closed only after Morgentaler’s death), recurrent pressure from the federal government, and the ongoing condemnation by pro-choice activists across the country.

Conclusion

As this chapter makes clear, Canada’s regulatory framework for abortion care has evolved significantly since the first law restricting the procedure was introduced in 1869. As a matter of federal criminal law, abortion remained one of the top reasons for hospital

emergency admissions among young women in the early-to-mid 20th century. During the 1960s and 1970s, organized medicine played a key role in the liberalization of the abortion law, which culminated in the enactment of Omnibus Bill C-150 in 1969. Yet while Bill C-150 decriminalized therapeutic abortions, it did so largely in the interest of protecting physicians against prosecution. With the TAC system intact, women could only obtain abortion with the approval of a panel of physicians who determined that the procedure was indeed medically necessary. Confined to debates over criminalization and medicalization, however, these early attempts to liberalize the abortion law ultimately failed to address the relationship between abortion, reproductive autonomy and women's lived experiences. In response, feminist activists organized *en masse* around the abortion issue in Canada, demanding an immediate solution to the crisis of access through the establishment of clinics and the repeal of the abortion law. It is due to the interventions of feminist activists, as well as the work of Dr. Henry Morgentaler and like-minded physicians, that the Supreme Court decriminalized the procedure in *R v Morgentaler* (1988).

In the years leading up to the Supreme Court decision, feminist activists found themselves divided over whether, and how, to evoke a single-issue platform for abortion rights or a multi-issue framework for "reproductive freedom." As I have demonstrated, further left-leaning and socialist feminists, such as those within the Ontario Coalition for Abortion Clinics (OCAC), sought to lodge abortion within a discourse of access, making important connections between abortion, systemic inequalities, and the broader fight for social and reproductive justice. However, faced with a crisis in the social organization of abortion care, this broader project was largely subsumed by activists' work around

repealing the abortion law and establishing clinics across the country. Then as now, abortion clinics have held an important space among feminist pro-choice activists, both as service providers as well as symbolic rallying points for social change. In the next several chapters of the dissertation, I take New Brunswick as a case study for understanding the important role that feminist activists play in expanding access to abortion care, as well as making visible the social relations that organize that care.

Chapter 4:

Constructing Abortion Access in New Brunswick, 1984-2014

Introduction

In this chapter, I begin to unravel New Brunswick's decades-long conflict over abortion clinics, detailing the historical, social and political circumstances that have led to the contemporary movement to expand access to abortion care in the province. As I demonstrate, the Fredericton Morgentaler Clinic has historically been a key site of social and political tension in New Brunswick. In the years leading up to the Supreme Court decision, as well as the decades following, the Morgentaler Clinic has served as a primary location for service provision in a province whose government authorities were overtly opposed to abortion. Like Morgentaler's earlier clinics, the Fredericton clinic also served as a rallying point for political organizing and resistance among both feminist and anti-abortion activists in the province. In writing up this history, I refer to interviews with past clinic managers and archival documents that I uncovered at the Provincial Archives of New Brunswick, including correspondence between the provincial government, the medical community, and factions of the pro-choice and anti-abortion movement. In addition, I build upon the important work of Lianne McTavish (2008; 2015), Katrina Ackerman (2012) and Rachel Johnstone (2012; 2014), whose research has provided critical insights into the social, political and legal history of abortion in New Brunswick.

During my research, several participants – especially older generations of activists and service providers – gestured toward these historical circumstances, speaking critically of past governments' role in restricting access to safe, timely, and affordable

abortion care. At the same time, members of RJNB, ARCC and FYF have all cited Regulation 84-20 – and, to a lesser extent, Section 2.01(b) – of the *Medical Services Payment Act* as major barriers to accessing an abortion in New Brunswick. Turning to the archives to get a better sense of the history of these policies, I explore how each was announced in the middle of intense public debate regarding abortion in New Brunswick, in direct response to Dr. Henry Morgentaler’s plans to build a free-standing clinic in the province. It is my intention to make this history more visible so that it may be used to inform contemporary struggles, and to continue to document the ongoing role that the state and the medical community have played in regulating, distributing and restricting abortion access in New Brunswick.

Premier Hatfield & Bill 92: Morgentaler Not Welcome in New Brunswick

When I began my archival research in New Brunswick, I did so with the intention of exploring New Brunswick’s abortion regulations post-1988, since Regulation 84-20 was enacted shortly after the Supreme Court decriminalized the procedure in *R v Morgentaler*. While a useful and logical starting point, this decision meant that I did not engage with the social and political climate in New Brunswick leading up to the Supreme Court’s decision, including the province’s 1985 addition to its *Medical Act*. I have since come across four scholars – Katrina Ackerman (2012), Rachel Johnstone (2012, 2014), Lianne McTavish (2008; 2015), and Kathleen D. King (2014) – whose historical work carefully traces the events leading up to the 1988 decision in New Brunswick. These sources have been central to my understanding of these events, and to my ability to trace the continuity (and shifts) in successive provincial governments’ stance on abortion

provision. In the following pages, I present a brief review of this literature, stitching together some of the historical circumstances leading to the Liberal McKenna government's amendment to the *Medical Act* (Bill 92) in 1989. In so doing, I situate this amendment within New Brunswick's active history of restricting access to abortions provided in clinic settings.

As pro-choice activism accelerated across Canada in the 1970s and 1980s, it also began to gain footing in the New Brunswick context. In the 1970s, organizations such as Planned Parenthood New Brunswick, the New Brunswick Advisory Council on the Status of Women, the Moncton chapter of CARAL, and the Committee for the Retention of Abortion Rights began to form, creating a vocal pro-choice faction in the province (Ackerman 2012). This local action, combined with Canada's growing pro-choice movement, the contents of the *Badgley Report*,⁴⁸ and Dr. Henry Morgentaler's moves to establish clinics outside Quebec, signaled a "potential realization of increased reproductive freedom for women, [which] was enough to spur politicians into action" in New Brunswick (Johnstone 2012: 83). Morgentaler's clinics created a particular degree of anxiety among the local anti-abortion community, which began applying increased pressure upon Conservative Premier Richard Hatfield to prevent Morgentaler from establishing a clinic in the province, and to end abortions in all cases unless a continued

⁴⁸ One of the report's findings was that women living in the Maritime Provinces had "less than half the access to abortion as women in central or western Canada, especially if they lived in rural areas of either New Brunswick or PEI" (McTavish 2015: 119-120). The committee also found that, apart from Nova Scotia, approximately two-thirds of people living in the Maritimes did not have a hospital eligible to provide abortions in their community, and that the Maritime hospitals that *did* provide abortions favoured residents living within a 60-mile radius (ibid). As a result, women in the Maritimes reported using "fake addresses to circumvent these regulations," or crossing international borders to obtain an abortion in Maine or New York (ibid).

pregnancy threatened the life of the child or mother (Ackerman 2012). Throughout the remainder of the 1980s and into the 1990s, abortion politics in New Brunswick centered on the possibility of Morgentaler establishing a clinic in the province.

The first time Morgentaler approached the provincial government about abortion was on January 25, 1983. In his letter to the attorney general, Morgentaler suggested that New Brunswick prevent “unnecessary legal battles by permitting women equal access to legal abortions” (Ackerman 2012: 84). This was one month after the Moncton Hospital (TMH) ended a six-month moratorium on performing abortions—an action resulting from increased anti-abortion pressure in the province (ibid).⁴⁹ At the time, TMH was performing two-thirds of the province’s reported abortions. The pro-choice movement responded to the moratorium by holding one of its earliest direct actions in front of the New Brunswick Legislature in 1983, calling upon the government to act on the province’s access problems. Between 1982 and 1984, some 299 women – predominantly young and single – were reportedly denied funding for abortions in the province’s TAC system (ibid). As Ackerman argues, the substantial decline in abortion access during the mid-1980s demonstrated that the “government’s opposition to Morgentaler and the strength of anti-abortion activism outweighed women’s needs for accessible services” (2012:100). In response to Morgentaler’s letter, the attorney general warned that the government would be willing to prosecute him should he choose to open a clinic in the province (ibid).

⁴⁹ Following TMH’s 1982 moratorium, the board of the New Brunswick Advisory Committee on the Status of Women adopted a motion outlining an explicitly pro-choice stance, arguing that women should be granted authority over abortion-related decision making in all circumstances, and that the government should readily offer information regarding women’s reproductive health options (Ackerman 2012: 82).

When Morgentaler approached the New Brunswick government in April 1985 to request help in establishing and funding a abortion clinic, Premier Hatfield was quick to “put in place measures that would block Morgentaler from effectively operating” said clinic (Ackerman 2012: 88). In this letter – which Morgentaler also sent to the *Globe and Mail* and *The Daily Gleaner* – he explained that a abortion clinic would be more cost-effective for New Brunswick’s taxpayers than expanding access to the service within the TAC system. Morgentaler also specified that his clinic would utilize the best equipment and techniques for the procedure, would provide counseling to all patients, and would effectively make abortion more accessible for women in the Maritime Provinces (ibid). In an effort to distance his proposed Fredericton clinic from the controversy surrounding those in Quebec, Winnipeg, and Toronto, Morgentaler urged New Brunswick’s Health Minister, Charles G. Gallagher, to officially declare the clinic a hospital space and establish TAC within the province (Ackerman 2012; McTavish 2015; Johnstone 2012). Due to the provincial government’s position on the abortion issue, however, such a declaration did not occur (ibid).

Facing pressure from the local anti-abortion movement, Hatfield’s government enlisted assistance from New Brunswick’s College of Physicians and Surgeons to amend the province’s *Medical Act* to prohibit abortions in non-hospital settings (as defined by the *Public Hospitals Act*), and enable the suspension of physicians’ licenses should they be found performing abortions outside of approved hospitals (Johnstone 2012). In June 1985, with the help of both the College and the New Brunswick Medical Society, Premier Hatfield’s government passed Bill 92, “An Act to Amend an Act Respecting the New Brunswick Medical Society and the College of Physicians and Surgeons of New

Brunswick.” Bill 92 effectively prohibited the provision of abortions in clinics by enabling the College to suspend members who performed such abortions. The bill also empowered the province to revoke Dr. Morgentaler’s medical license should he attempt to establish and practice in a clinic (Ackerman 2012; Johnstone 2012; McTavish 2015). According to Ackerman’s research, the Hatfield government avoided taking a public stance on abortion provision in the province, choosing instead to emphasize the role of the Medical Society in writing and passing Bill 92 (Ackerman 2012: 95). As McTavish suggests, the 1985 amendment would not have been possible without the assistance of physicians in leadership positions in the province, further demonstrating the key role of the medical community in developing abortion policy during the 20th century (2015: 118).

The Hatfield government’s 1985 amendment to the *Medical Act* was the first of many attempts to deter Morgentaler from establishing a clinic in the province. As illustrated above, this reactive move by the provincial government – influenced by a vocal anti-abortion movement and made possible by the help of the medical community – occurred in direct response to Morgentaler’s proposal to establish a clinic in the province. Thus, before it was even established, the space of the Morgentaler Clinic had ignited social and political debate in New Brunswick surrounding the legality of, and desire for, abortions provided in clinics. As I demonstrate further in this chapter, successive governments in New Brunswick have since sought to regulate clinic abortion care through the province’s

Medical Act.

Regulating Abortion in the Aftermath of *R v. Morgentaler* (1988)

As I have shown, the landmark decision in *R v. Morgentaler* (1988) meant provincial governments and local health authorities were forced to grapple with how to implement, regulate and, in many cases, restrict abortion services in their regions. While some provinces were quick to announce and implement their policies, others were slower to respond. In New Brunswick, then-Premier Frank McKenna approached the abortion issue with a certain degree of caution, suggesting that the federal government was still responsible for implementing a national law to fill the legislative gap produced by the *Morgentaler* decision. An article published by *The Telegraph Journal* (1988) documents the Premier's attempts to shift attention back to the federal government. In it, McKenna suggested that both levels of government would remain in "very close contact" going forward, and that New Brunswick's Health and Community Services Minister, Raymond Frenette, would soon announce the province's position on the matter (ibid). It was less than a week after abortion was decriminalized, and New Brunswick was one of the only provinces that had yet to announce its plans for abortion provision. While the provincial government was deliberating on how best to regulate abortion in the wake of the Supreme Court decision, local organizations continued to lobby the government on both sides of the abortion debate.

In early February 1988, Morgentaler wrote to Health Minister Frenette to offer his assistance in improving abortion access in New Brunswick by establishing a clinic in the province, as well as providing training for physicians, nurses and counsellors interested in

providing the service (Morgentaler 1988). In his letter, Morgentaler drew on the work of feminist activists by outlining a number of advantages to providing abortions in clinics rather than hospitals, including advanced modern techniques and equipment, timeliness of access and decreased delays, reduced costs per procedure, and the staffing of well-trained medical personnel who, as he stated, “have chosen to work in this field, who have empathy for this type of patient and are, therefore, more likely to provide an atmosphere of support and warmth” for those seeking abortion care (ibid).⁵⁰ Morgentaler also suggested that the provincial government should take any steps necessary to ensure that women are not forced to travel outside the province to obtain what he refers to as an “essential medical service,” noting that many New Brunswick women had opted to circumvent the province’s TAC system by travelling to his Montreal clinic to obtain the procedure (ibid). Morgentaler did not receive a response from Frenette until days after New Brunswick’s policy was announced. In his response letter, Frenette wrote that the province had “no interest in considering [Morgentaler’s] offer,” as it was not aligned with the policy adopted by the New Brunswick government (Frenette 1988a). Frenette closed this letter in a definitive manner: “I trust this makes the Government’s position clear to you” (ibid).

New Brunswick announced its abortion policy on February 12, 1988. In his announcement, Health Minister Frenette suggested that he had taken the matter of abortion “under serious consideration,” having met with members of Cabinet, the Minister of Justice James Lockyer, representatives of the New Brunswick Hospital

⁵⁰ It is worthwhile to note that many of these advantages are being named by contemporary feminist pro-choice activists as reasons to publicly fund abortions provided at Clinic 554.

Association, the New Brunswick Medical Society, the College of Physicians and Surgeons, hospital representatives, as well as the general public (Frenette 1988b). That Frenette met primarily with members of the medical community in determining the province's abortion policy further demonstrates the sociopolitical climate surrounding abortion at the time. This was an era in which women – whether pro-choice activists or those who sought abortion care themselves – were largely absent from the institutional discourses dominating the abortion debate, and were effectively marginalized from abortion-related decision-making.⁵¹ Without the power to legislate abortion under criminal law, Frenette's statement read, the provincial government “strongly urges the Federal Government to act quickly and decisively” to formulate a new law to end the “uncertainty and inconsistency” regarding provincial abortion mandates (ibid). Suggesting that the province had limited options following the *Morgentaler* decision, Frenette offered New Brunswick's new abortion policy as follows:

Consequently, no abortion in the Province of New Brunswick will be recognized as an insured procedure unless determined to be medically required by the physician and performed by a specialist in gynecology or obstetrics in an approved hospital. Furthermore we have been legally advised that under the Public Hospitals Act, regulation 84-212, the province has the legal authority to insist that a second medical opinion be obtained as to the need for the operation (Frenette 1988b).

As suggested earlier, the regulatory shift brought forward by *R v. Morgentaler* meant that abortion was no longer a matter of federal criminal law, but of provincial health policy. Without the possibility of criminal sanctions, New Brunswick's government sought alternative means for regulating a procedure that was deemed immoral and socially

⁵¹ This is one area that has dramatically shifted over the past three decades, although it is clear that the standpoint of women and activists still do not carry the same weight as medical and state authorities.

undesirable by conservative and anti-abortion factions in the province. In addition, the conditions set into place by the government's new abortion policy help to reveal women's marginal role in abortion-related decision-making, as well as the authority bestowed upon the state and the medical community to regulate women's reproduction by restricting access to abortion services in the province.

The day following Frenette's announcement, the province's policy made the front page of *The Telegraph Journal* in a headline titled "Women must prove abortion vital." As the story read, "With a few modifications, the province has opted for the status quo in determining under what circumstances a woman is entitled to an abortion" (Richardson 1988). As Richardson suggests, New Brunswick had essentially replicated the very law that the Supreme Court had struck down months earlier. Rather than criminal sanctions for services provided outside the TAC system, however, the provincial government simply opted to refuse public funding for abortions that did not adhere to similar – though slightly altered – guidelines (ibid). A comparable critique was made by then-president of CARAL, Norma Scarborough, who, in a letter to New Brunswick's Members of the Legislative Assembly, wrote that the government's new policy had failed to meet its legal obligation by introducing "impediments to access and the same delays, health risks and unfairness so criticized by the Supreme Court" (Scarborough 1988). Scarborough's letter further criticized the provincial government for seeking to indirectly regulate abortion, despite the Supreme Court ruling, which established that only the federal government had the authority to do so.

However, the provincial government's public records demonstrate a different conception of the Supreme Court ruling. Responding to public criticism, Minister of

Justice Lockyer clarified that New Brunswick's policy went well beyond the status quo, in that it did not prohibit abortions along lines of criminality: "All we're saying is that if abortions are to be performed, they be done in hospitals that are currently doing them and that appropriate health steps are taken to ensure that it is a proper procedure" (quoted in Richardson 1988).⁵² With the absence of a federal mandate on abortion service provision, New Brunswick – like other provinces at the time – was able to articulate its regulation as a matter of health and safety, while simultaneously restricting the conditions under which abortion could be considered an insured service. These restrictions, as I have shown, were made possible by the line of fault that was opened by the Supreme Court decision of 1988, which, while central to expanding access to abortion in many parts of the country, simultaneously shifted regulatory authority over abortion to provincial and territorial governments. In the months following the Supreme Court decision, the McKenna government moved quickly to restrict access to abortion by establishing a regulatory framework which, in a striking resemblance to the newly-abolished TAC system, denied women reproductive autonomy by restricting their options for care and requiring that they seek physician approval prior to accessing a publicly funded procedure. As in the years leading up both to Bill C-150 and *R v. Morgentaler*, the political debate surrounding the regulation of abortion was dominated by the state and the medical community, with Dr. Henry Morgentaler and his clinics at the center of the

⁵² It is worthwhile to note that the provincial government continues to cite these same safeguards as reason to not fund abortions provided in clinic settings.

controversy.

The Birth of Regulation 84-20

Shortly after the provincial government's policy was announced in February 1988, Premier Frank McKenna made headlines when he told reporters that he would give Morgentaler the "fight of his life" should he try to establish an abortion clinic in the province (Meagher 1988). Without elaborating, the Premier affirmed his belief that the government could "successfully resist the establishment of abortion clinics in New Brunswick" (Lavigne 1988). While affirming that there was nothing preventing Morgentaler from setting up shop in the province, Justice Minister Lockyer called upon the federal government to fill the policy vacuum created by the Supreme Court decision. "There is no prohibition," he said, "to prevent anybody from doing anything" in regards to abortion (ibid). The next day, Morgentaler wrote to Premier McKenna, remarking on the government's refusal to engage in meaningful conversation around the advantages of clinics over hospital abortions. In his letter, Morgentaler restated the dangers of restricting abortion access, and asked that the government reconsider his proposal to establish a clinic in the province. "I can assure you," he wrote, "that in spite of your uncomplimentary comments, I am still ready and willing to help your Minister of Health to establish high-quality abortion services in a clinic for the benefit of the population of New Brunswick" (ibid). Despite ongoing resistance from the government, Morgentaler

continued his efforts to expand abortion access for women in New Brunswick.⁵³

Morgentaler brought his first legal challenge to the province in 1989, when he called upon the provincial government to issue reimbursement for the three abortions he had provided for New Brunswick women in his Montreal clinic. At the time, the only legislation regulating abortion in New Brunswick was Bill 92 – Premier Hatfield’s 1985 amendment to the *Medical Act* – which restricted abortions performed outside of registered hospitals, but provided no mandate regarding abortions performed out of province (Johnstone 2012). When the court found this policy invalid for abortions provided out of province, the McKenna government quickly moved to promulgate an analogous regulation that would “fill the legal loophole” in Bill 92 (ibid: 85).⁵⁴ The amendment was written into the *Medical Services Payment Act* under Regulation 84-20 as follows:

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.

The effect of this amendment was that abortion would not be funded by New Brunswick’s health insurance plan unless it was performed in a hospital by an OB-GYN

⁵³ In April of that year, for example, then-executive director of the Toronto Morgentaler Clinic, Dr. Andrea Knight, travelled to New Brunswick to meet with representatives from local activist and advocacy groups to discuss the possibility of opening a clinic in either Saint John or Fredericton. According to an article published in *The Telegraph Journal*, Dr. Knight expressed concern regarding New Brunswick’s abortion policy, citing procedural delays and travel time as key challenges impacting women seeking care in the province (Tunney 1988).

⁵⁴ As I learned through my research participants, Dr. Julia Hughes and Dr. Karen Pearlston, Dr. Morgentaler was never reimbursed for these services, despite having won the suit in *Morgentaler v. New Brunswick (Attorney General)*.

and approved by two physicians as medically necessary. Today, this same regulation continues to restrict access to abortion in New Brunswick by denying funding for clinic abortions. As was the case with Premier Hatfield's Bill 92 four years prior, Premier McKenna's promulgation of Regulation 84-20 occurred against the backdrop of a controversial public debate surrounding Morgentaler's plans to establish a clinic in the province. The juxtaposition of these events – as well as those outlined in the following section – has led many scholars, activists and advocates to criticize the McKenna government for its overt anti-abortion policies which, as McTavish (2015: 123) suggests, “effectively maintained the 1970s TAC system after it had been deemed both ineffective by the Badgley Report and unconstitutional by the Supreme Court of Canada.” This continuity between the TAC system and post-1988 abortion policy in New Brunswick, in which abortion services are theoretically available yet conditionally accessible, is what many activists in my research have referred to as “the status quo,” or the upholding of regressive policies that regulate women's reproduction by setting parameters around what is considered a medically necessary, and thus socially acceptable, abortion. As was the case in the 1970s and 1980s, it was physicians, not women, who were granted decision-making authority over publicly funded abortions in New Brunswick. As I explore further in the dissertation, this power that physicians wielded over abortion during these years led many women to seek care outside the province's public funding model, forcing them to pay out-of-pocket for services provided at the Fredericton Morgentaler Clinic. This system, mediated by Regulation 84-20 of the province's *Medical Services Payment Act*, organized abortion in such a way that access to a safe, timely, and affordable procedure was – and remains – a matter of luck and privilege, conditioned not only by the

possibility of obtaining physician approval, but also by one's location in social relations of inequality. In the remainder of this chapter, I continue to explore the state-led opposition to the Fredericton Morgentaler Clinic that occurred during these years. As I demonstrate, like the clinics that Morgentaler established prior to decriminalization, the Fredericton clinic represented both an important space for the provision of care, as well as a symbolic rallying point for social change in the province.

Establishing the Fredericton Morgentaler Clinic & Section 2.01b

After years of dispute with the provincial government, Morgentaler finally established his abortion clinic in Fredericton in 1993. Shortly after the clinic opened in June 1994, the McKenna government responded by invoking Hatfield's Bill 92, which enabled the College of Physicians and Surgeons to suspend Morgentaler's license and prohibit him from performing abortions in the province (Ackerman 2012). However, the opening of the clinic also came on the coattails of *R v. Morgentaler* [1993], in which the Supreme Court held that Nova Scotia's abortion law and regulation – which bore a striking resemblance to New Brunswick's Bill 92 and Regulation 84-20 – were unconstitutional, as their primary objective was to “prohibit abortions outside hospitals as socially undesirable conduct” (Fine 1993). In reaction to Morgentaler's plan to open a clinic in Nova Scotia, the provincial government passed legislation in 1989 that denied insurance coverage for abortions provided outside hospital settings, declaring such procedures illegal and subject to hefty fines (Haussman 2015; Johnstone & Macfarlane 2015). When Morgentaler announced that he had already performed seven abortions at his clinic in Halifax, he was charged under the province's *Medical Services Act* and

prohibited from performing abortion in the province until the charges were heard in court (Hargreaves 2012: 28). In 1990, a Nova Scotia judge ruled the regulation unconstitutional after the court found that the province was attempting to legislate abortion under federal criminal law (ibid). Nova Scotia appealed the decision, which brought the case to the Supreme Court of Canada which, in 1993, ruled in favour of Morgentaler's right to establish clinics in the province (ibid). While the Supreme Court refused to engage with the *Charter of Rights and Freedoms* arguments put forward in *R v. Morgentaler* (1988) – focusing its ruling instead on the separation of powers between provincial and federal governments – the Court did note that Nova Scotia was essentially replicating the very in-hospital requirements that led to the abolishment of the TAC system years earlier (Johnstone & Macfarlane 2015: 104). Despite Morgentaler's successful ruling in Nova Scotia, other provinces – most notably New Brunswick and Prince Edward Island – continued to restrict access to abortion by denying coverage for clinic care under their provincial health insurance schemes (ibid).⁵⁵

This Nova Scotia case was used as precedent in Morgentaler's appeal to the Court of Queen's Bench of New Brunswick in 1994, in which he called for the appeal of the College's decision and the overturning of Bill 92, which banned abortion providers from practicing outside hospital settings. Although Morgentaler's court challenge was

⁵⁵ It is worth mentioning that Nova Scotia has recently received national attention for having some of the most significant access barriers in Canada, following the changes to abortion policy in New Brunswick and Prince Edward Island post-2014. For instance, until February 2018, women in Nova Scotia still required a physician referral prior to obtaining an abortion procedure in the province's only hospital offering the service (Bundale 2017; Nova Scotia Health Authority 2018).

successful, the McKenna government responded by promulgating Section 2.01(b) into its *Medical Services Payment Act*, which reads as follows:

Notwithstanding any other provision in this Act, the medical services plan shall not provide payment for... entitled services furnished in a private hospital facility in the Province.

Together, Section 2.01b and Regulation 84-20 have had the combined effect of denying public funding to clinics providing medically required abortion care, as well as to women seeking abortion care outside of hospital settings. As then-clinic manager, Allison Brewer, expressed in her interview with Kathleen D. King (2014), the enactment of Section 2.01(b) demonstrates the provincial government's unwavering persistence to prohibit Dr. Morgentaler from practicing abortions in New Brunswick. She continues: "That was the brilliance of Frank McKenna. That was the Machiavelli of Frank McKenna. It amazes me that even today no one has been able to break that, and tear it down" (Allison Brewer, quoted in King 2014: 4). Because of these regulations, thousands of women have been forced to pay out of pocket for their abortions at the Morgentaler clinic between 1994 and 2014, when the clinic was forced to close due to financial instability.

As the previous pages demonstrate, attempts to expand abortion access in New Brunswick have been stifled by the provincial government and the medical community, with support from local conservative and anti-abortion forces, since Morgentaler first expressed interest in building a clinic in the province. Taken together, these three policies – Bill 92, Regulation 84-20 and Section 2.01(b) – are illustrative of New Brunswick's decades-long struggle between pro-choice feminist activists and their allies on the one hand, and regulatory institutions responding to anti-abortion pressure on the other. While

the Hatfield government's passing of Bill 92 may have helped deter Morgentaler from establishing a clinic in the province prior to 1988, it remained a critical – though ultimately flawed – tool for Premier McKenna's challenge to the Fredericton Morgentaler clinic in 1994. However, by writing Regulation 84-20 and Section 2.01(b) into the province's *Medical Services Payment Act*, the McKenna government was able to frame its anti-abortion stance as a matter of provincial authority over the delivery of healthcare, despite the Premier's overt public hostility toward Dr. Morgentaler. That in 2017 these policies are still cited by the provincial government as reason to continue denying public funding to abortions performed in clinic settings is, as I demonstrate in later chapters, a regressive practice that serves to reproduce New Brunswick's long history of restricting access to safe, timely, and affordable reproductive healthcare.

Operating the Fredericton Morgentaler Clinic: 1994-2014

When the Fredericton Morgentaler Clinic opened its doors in 1994, it was located at 88 Ferry Avenue, in a reconditioned house on the north side of the Saint John River.⁵⁶ In 1998, the clinic was forced to relocate when the shopping mall next-door expanded, purchasing the clinic's building in the process. According to then-clinic manager Alison

⁵⁶ The Saint John River divides the city of Fredericton into two distinct regions, with the downtown core located on the city's south side. In my interviews with Abbie Moser (member of FYF) and Tabatha Armstrong (former clinic escort at the Morgentaler Clinic and active member of RJNB), they described the city's north side as more rural and conservative than its southern counterpart. For instance, Abbie, who attended Leo Hayes High School on the north side, noted several differences between her experience and those of her friends who attended Fredericton High School (FHS) on the south side, including problems with the school's sexual health curriculum and greater stigmatization of feminist and social justice issues. While an in-depth analysis of Fredericton's regional differences is outside the scope of this study, these short examples are illustrative of the complex relationship between access, stigma and geography, a theme that will be picked up in more detail in the final substantive chapter of the dissertation.

Brewer, locating a new site for the clinic proved quite challenging. Not only did they have to navigate restrictive city by-laws, but many real estate agents also refused to sell Morgentaler property, given the province's notorious hostility toward the physician (King 2014: 5).⁵⁷

When the clinic moved to 554 Brunswick Street in the south side of Fredericton, its proximity to the downtown core, as well as George Street Middle School, sparked controversy within the community (King 2014). Shortly after the move was announced, the *Fredericton Daily Gleaner* – whose editor, Tom Crawler, was explicitly opposed to abortion – published a scathing editorial criticizing the clinic's "high profile" location, suggesting it was "insensitive to school children and their parents, as well as the Catholic parish of [the nearby] St. Dunstan's Church" (King 2014:5). This sentiment was not uncommon within the community. In fact, on the day the clinic reopened in its new location, the George Street Middle School announced it would be suspending classes for the day (ibid). As Brewer describes, the decision to close the school "seemed political [...] it seemed like a real slap in the face. It was as if they wanted to make a point about the clinic being a dangerous place, being unsuitable for school-aged children, that it was some sort of public hazard" (ibid: 7-8). To be sure, the idea that the Morgentaler Clinic needed to be kept out of sight from the greater Fredericton community – and children in

⁵⁷ I chose not to include Alison Brewer in this study, as she was not involved in the recent resurgence of pro-choice & reproductive justice activism in New Brunswick. As such, I rely on research conducted by Kathleen D. King (2014) to provide a sense of the socio-political climate surrounding the Morgentaler Clinic during its early years.

particular – is illustrative of the climate of shame, stigma and fear surrounding abortion in the province.⁵⁸

While anti-abortion protestors were active at the clinic's original location, their presence grew after the clinic moved to the south side of the city. As Lianne McTavish (2008) has suggested, anti-abortion protestors likely felt bolstered by successive provincial governments, all of which continued to uphold the anti-abortion policies promulgated by the McKenna government. Speaking from experience, McTavish recalls how several anti-abortion protestors carried placards that read "Not with my tax dollars," a sentiment that reinforced – and brought visibility to – the government's position on the funding debate (2008: 29). In 1999, McTavish approached then-clinic manager Judy Burwell, offering to organize a group of volunteer clinic escorts to "greet and protect women as they entered the building" (2008: 25). In my interview with Judy, she described how McTavish – then a professor at the University of New Brunswick – recruited volunteers from the University, gathering some twenty-seven people for the first volunteer meeting at the clinic. "Lianne [McTavish] was great," Judy remembered, "she organized it, she set it up—who was coming, what the shifts were. They came in from 7am to 9am, or 9am to 11am, until everybody was in the clinic" (Interview with Judy

⁵⁸ While I am particularly concerned with the New Brunswick case, it is worthwhile to note that the politicization of the Morgentaler Clinic, combined with the culture of shame, stigma, and fear, was rapidly evolving across North America throughout the 1990s. During this period, anti-abortion activists ramped up efforts to stigmatize and terrorize abortion providers and women seeking abortion care by aggressively picketing outside of abortion clinics, picketing doctors in their homes and committing violence in the form of arson, firebombing and shootings. This included but was not limited to the firebomb that destroyed the Toronto Morgentaler Clinic in 1992; the shooting of Dr. Garson Romalis in his home in Vancouver in 1994, the shooting of Dr. Hugh Short in his home in Ontario, the shooting of Dr. Jack Fainman in Winnipeg, and the fatal shooting of Dr. Barnett Slepian in Buffalo, New York by infamous anti-abortion protestor James Kopp (Brodie 1992; Lochlin 2016; Saurette and Gordon 2013).

Burwell 2015). During these morning shifts, clinic escorts would stand at the front and back doors of the clinic, waiting for women to arrive. Once there, they would shield them from protestors, initiating pleasant conversation as a means to “normalize an otherwise unpleasant situation” (McTavish 2008: 30). When I asked former clinic manager Simone Leibovitch whether the clinic had looked into establishing a bubble legislation to deter such protestors, she shook her head, reminding me that it costs a significant amount of money to implement. “They have one in Toronto,” she told me, “But you know why that happened? Because [protestors] blew up the clinic” (Interview with Simone Leibovitch 2015).⁵⁹ When I asked whether she thought it would take something that extreme to enact bubble zone legislation in Fredericton, Simone shrugged while saying, “It always does. It doesn’t surprise you, does it?” (ibid).

The small yet vocal group of anti-abortion protestors, who confronted and shouted at patients as they entered the clinic, brought a particular kind of visibility to the Morgentaler Clinic—a visibility that continued until its closure in 2014. Many of my research participants described the negative impact this had on patients, many of whom would enter the clinic in tears after being subject to anti-abortion harassment. “Every Tuesday!” Simone told me, “Our clinic day was Tuesday. And every Tuesday there were protestors. Every. Single. Tuesday” (Interview with Simone Leibovitch, 2015). When I asked her to describe the protestors, Simone responded: “...they’re extremely annoying, and very loud, and very invasive, and very ignorant of respecting people’s personal space. It really impacted our patients in Fredericton” (ibid). All the clinic escorts I

⁵⁹ Here Simone is referring to the fire bomb which, on May 18th, 1992, destroyed the Toronto Morgentaler Clinic. There were no injuries sustained from this event, though the perpetrator remains unknown.

interviewed shared similar stories of protestors approaching patients on their way into the clinic, and the anxiety, shame, fear, and anger that patients so often experienced as a result. During my interview with Allison Webster, former assistant manager of the Morgentaler Clinic and current counsellor at Clinic 554, she described how patients would phone the clinic before their appointment, worried about anti-abortion presence outside the building:

Patients would even call us and say “I don’t think I can come in. I see those people.” And we would just try to talk them through it. And I think in the five years that I was there we probably did have like, one or two that just didn’t come back, because they just didn’t want to walk through, you know? (Interview with Allison Webster 2015)

For patients who did walk through, the clinic escorts were there to ensure their safety and well-being. Several clinic staff emphasized this during our interviews. As Allison told me, clinic escorts were there “for the *patient*, not to deal with the antis... [they would] walk with the patients, [and] just try to surround the patient with a bit of love to counter-act the hate and the negativity” (Interview with Allison Webster). All of the clinic escorts I interviewed described their role similarly: they were there to spread positivity, to shield patients from the anti-abortion protestors, and to make a tangible difference in their abortion experiences. Yet sometimes escorts’ work expanded beyond the clinic: during my interview with Jaden Fitzherbert, she told me how she would sometimes drive patients to and from bus stops, hotels and the clinic. She described how emotional these experiences could be; how patients would sometimes confide in her, sharing intimate details about their lives and the circumstances of their decision. These acts – from being physically present for patients to helping them navigate their trip to the clinic – were part of the everyday reality of working as a clinic escort. “You know, I have privilege,” Jaden

told me, “and I might as well use it for something. And if it can even make one person who’s had an abortion feel better, then I’ve done exactly what I’m supposed to do” (Interview with Jaden Fitzherbert 2015).

In 2001, the role of clinic escorts became even more crucial, as the New Brunswick Right to Life opened the Mother and Child Welcome House – known now as the Women’s Care Center – directly next door to the Fredericton Morgentaler Clinic. In my interview with Judy Burwell, she laughed as she described how the Right to Life group invited her to their press release, where they announced their plans to “change women’s minds [about abortion] and provide a service for women who were suffering” (Interview with Judy Burwell 2015). In many of my interviews, participants described how the Mother and Child Welcome House acted as a hub for anti-abortion protestors who not only picketed the clinic, but also frequently attempted to lure patients into their building to dissuade them from obtaining an abortion. According to their website, the Women’s Care Center provides free pregnancy testing, complimentary ultrasounds, as well as “compassionate care and support” (Women’s Care Center 2018). The first night I arrived in Fredericton, I walked down Brunswick Street, passing the Women’s Care Center and what is now Clinic 554 along the way. I remember feeling struck by the sharp contrast of these two buildings. To my right sat the clinic, with its brick, bunker-style architecture and thick windows (which I would soon learn were bullet-proof), fortified by metal bars. To my left was a white, classical revival style house, with battery-powered candles flickering in each window. A plaque to the right of the front entrance read: “this house stands near sacred ground where the lives of hundreds of New Brunswick children have been taken while in their mothers’ wombs.” In the front window was a display

featuring exaggerated models of fetuses in different gestational periods, foregrounded by four wooden letters that read: “LIFE.” From a distance, the Women’s Care Center appears warm, inviting, and women-centered. Its advertised services, its name, and its proximity to the Morgentaler Clinic combine to create the optics of a legitimate medical clinic offering compassionate care and support for pregnant women. However, a closer look at the space reveals it for what it is: a crisis pregnancy centre run by New Brunswick Right to Life, specifically designed to prevent women from accessing abortion.⁶⁰ Though the challenges facing the Morgentaler Clinic during these years went well beyond the actions of anti-abortion protestors, the prominence of New Brunswick Right to Life has helped to maintain abortion as a visible site of social and political conflict in Fredericton specifically, and New Brunswick more generally.

During my interviews with Simone Leibovitch and Judy Burwell, they expanded upon several challenges that they experienced while managing the Fredericton Morgentaler Clinic. Of course, they said, there was the devastating impact of provincial funding restrictions, and ongoing conflicts incited by anti-abortion activists. But it was also challenging to simply find a physician who would work for the clinic. When Judy

⁶⁰ The Women’s Care Centre is an example of a “crisis pregnancy centre” (CPC), which, functioning under the guise of a medical clinic or counselling centre, are strategically located near abortion clinics across Canada and the United States. Operated by anti-abortion organizations such as the Right to Life, CPCs actively spread misinformation about abortion to pregnant women in a concerted effort to stigmatize, shame, and prevent women from obtaining the procedure. Despite purporting to offer unbiased medical advice, most people who volunteer at CPCs have “no formal medical or mental health training,” relying instead on claims “for which no scientific support exists, such as the notion that abortion is linked to breast cancer, to a higher risk of miscarriage in future pregnancies, and even to infertility” (Stettner 2016: 52). In a recent study, the Abortion Rights Coalition of Canada (ARCC) identified 180 CPCs across Canada, noting that of the 166 CPCs with websites, 96% were religiously affiliated, while merely 24% disclosed this affiliation (2016: 2). Furthermore, 68% of those with websites had charitable tax status, despite CPCs being unregulated by the Canadian government (ibid).

managed the clinic in the early 2000s, there were no doctors in New Brunswick willing to work there. During those years, a physician from Montreal would fly in every two weeks to provide abortion care for one day—"clinic day," as referred to by staff and volunteers. This continued to be a challenge throughout the ten years that Simone managed the clinic: "We could never get a doctor to come and practice there," she told me, "They were afraid! And I don't blame them. I don't. Our doctor went through hell" (Interview with Simone Leibovitch).⁶¹

Beyond physicians, Simone and Judy each spoke of how challenging it was to simply convince community members to come to the clinic. For instance, when Judy and Lianne McTavish asked Margaret-Ann Blaney – the New Brunswick Minister responsible for the Status of Women during the late 1990s and early 2000s – to visit the Morgentaler Clinic for a meeting, she mused about having to "put a paper bag over [her] head" before stepping foot inside (interview with Judy Burwell 2015). Needless to say, Blaney did not take them up on the meeting. Still, when I asked Judy about the support she felt from the community, she prefaced her response by reminding me how much she loved working there: "I mean, our staff that came in were great. The women who came in were so appreciative to be welcomed in an atmosphere that was not judgmental. So, it was perfect in that sense," she told me. But "it was discouraging," she continued, "the lack of support from the medical community and people in general. You know? Just like,

⁶¹ Here Simone is referring to a New Brunswick physician who worked for the Morgentaler Clinic while also operating their own family business out of Saint John. In 2007, this physician lost their family practice and ceased their work with the Morgentaler Clinic due to intense anti-abortion pressure, harassment and threats. While this case does not appear in the literature, both Simone and Judy discussed the events during our interviews, remarking on how far the anti-abortion community will go to deny women access to a medically necessary service.

the lack of understanding” (ibid). Similarly, Simone recalled the isolation she experienced while working at the clinic:

We were [...] under nobody’s scrutiny. Nobody. Not the College of Physicians and Surgeons. Nobody gave a damn, right? They didn’t even do public health inspections. Nothing! It’s like we weren’t there—like we were an *enigma*. We weren’t funded by the province. The College of Physicians and Surgeons sort of knew we were there... we were on our own! We were responsible to Henry, and the management in Toronto [...] we were regulated by the National Abortion Federation, which the province of New Brunswick could care less about, right? We could have run a place that was filthy, unregulated, dirty! Nobody in the province would have said one word or known (Interview with Simone Leibovitch 2015).

Simone, who is now a counsellor at the Morgentaler Clinic in Ottawa, described how “totally different” it is to be working at a clinic that is not at odds with the provincial government; where abortions are funded by provincial health insurance, and where most patients simply “don’t know anything about not having access to free abortions” (ibid). This contrast in Simone’s experiences is particularly helpful for revealing the unequal distribution of abortion among provinces, as well as the ways in which this distribution shapes people’s experiences with, and conceptions of, access to abortion in Canada. Still, despite what Simone refers to as the clinic’s enigma-like presence in Fredericton, its supporters, from staff to volunteers, from feminist activists to Dr. Morgentaler, continued to show up for those in need of care—at the clinic, in the streets, and in the courts.

“It was the Fight of his Life:” Morgentaler v New Brunswick

In 2002, after more than ten years of operating the clinic in Fredericton, Dr. Henry Morgentaler announced that he would be launching a court case against the provincial government for refusing to fund clinic abortions. “I accuse the government of New Brunswick of being sexist, male chauvinists [and] of victimizing and oppressing

women,” Morgentaler stated, “By not paying for abortions, the New Brunswick government has been saving money on the misery of women” (quoted in Moulton 2003:700). On July 16th 2003, Morgentaler commenced his action against the province. In this suit, he argued that the province’s *Medical Services Payment Act* infringed upon women’s fundamental rights and freedoms guaranteed by section 7 and 15 of the *Charter of Rights and Freedoms*, thus denying pregnant women “equal benefit and protection of the law without discrimination based on sex and social condition” (*Morgentaler v. New Brunswick* 2004:4). In addition, he argued, the regulations in question created an arbitrary distinction between entitled and non-entitled abortion services, resulting in the “denial of equal benefit and protection of the law to pregnant women seeking to exercise reproductive autonomy” and as such was inconsistent with the provisions laid out in the *Canada Health Act* (ibid:6). In response to Dr. Morgentaler’s lawsuit, the provincial government introduced a series of procedural delays and stalling tactics, which extended the case for nearly ten years, until Morgentaler’s death in May 2013.⁶² “[That] was what they were waiting for,” Jaden Fitzherbert told me during our interview, reminding me that Morgentaler was nearly 80 years old when he took the province to court in 2003. “That was why they stalled the lawsuit for so long,” Jaden continued, as she shook her head and lowered her voice, “Because they knew he was going to die soon” (Interview with Jaden Fitzherbert 2015). Jaden was not alone in this assumption—in fact, it was one that was common among my research participants, in particular those who had worked or

⁶² The court battle officially closed in 2014, when the Morgentaler family was no longer able to continue funding the years-long case.

volunteered at the clinic prior to its closing. For instance, Judy Burwell told me how “horrible” it was during those years:

Henry was paying out hundreds and hundreds of thousands of dollars for the women of New Brunswick. And the government had their staff there who could just sit and think up ways to—you know, he’d win something, and they’d appeal it. That would be another nine months, you know? [...] And it should have been a clear case of, “Go to court. This is wrong.” He’d won all the other times. He’d always won. But New Brunswick just set up roadblock after roadblock. [...] And basically, I mean, Simone has probably said this, but they were just waiting for Henry to die. That was it (Interview with Judy Burwell 2015).⁶³

As Judy suggests above, Morgentaler had fought and won similar court cases in the past, including *R v. Morgentaler* (1993), in which the Supreme Court of Canada found unconstitutional the regulation of Nova Scotia’s *Medical Services Act* that prohibited and denied funding for abortions provided in clinic settings (Hargreaves 2012). By the time he launched his case against the province of New Brunswick, Morgentaler had also successfully – though certainly not without challenge – opened five other abortion clinics across Canada, all of which provided publicly funded abortion care to their patients. New Brunswick alone has stood strong and unrelenting in what Simone has referred to as its “vendetta” against Morgentaler and his clinic (Interview with Simone Leibovitch 2015). “For some reason,” she told me, “the name of Morgentaler – although he’s a little old dead man now – seriously seems to strike fear in the hearts of politicians” (ibid). As Dr. Karen Pearlston recently told me, in the end, Premier McKenna followed through on his

⁶³ Here Judy is not only speaking to the high financial costs of Henry Morgentaler’s court battle with the provincial government of New Brunswick, but also to the clinic’s pattern of helping to offset the costs of care for women who could not afford to pay out-of-pocket for their abortion. Although I was unable to source financial documentation of this latter commitment, it was corroborated by all of my participants who worked or volunteered at the Fredericton Morgentaler Clinic.

promise: “He said he’d give Morgentaler the fight of his life. Well, it *was* the fight of his life” (personal communication, December 2016).

To be sure, local and national pro-choice groups were also active throughout the extensive court battle between Morgentaler and the province. “It wasn’t just Henry,” Simone reminded me during our interview, “It was a whole women’s movement” (Interview with Simone Leibovitch 2015). Judy shared similar insights: “He didn’t do it alone, you know? There were a whole lot of people that carried him along” (Interview with Judy Burwell 2015).⁶⁴ There were letter-writing campaigns, petitions calling for changes to the *Medical Services Payment Act*, and meetings held between clinic staff, physicians and representatives from the Department of Health (McTavish 2015). During my interview with Joyce Arthur, she described her involvement in advocating against New Brunswick’s access problems during the early 2000s. After the Abortion Rights Coalition of Canada (ARCC) formed in 2005, she told me, they helped write press releases and position papers, initiated letter-writing campaigns to the provincial government, and supported Simone and Judy “in any way [they] could” (Interview with Joyce Arthur, 2015). For example, both ARCC and the Pro-Choice Action Network (PCAN) published papers challenging New Brunswick’s refusal to fund clinic abortions, describing the government’s actions as in violation of the *Canada Health Act* as well as

⁶⁴ During my interviews with Simone and Judy, they both acknowledged that Morgentaler’s fame likely caused resentment on behalf of many feminist pro-choice activists, who also fought tirelessly for the decriminalization of, and expanded access to, abortion care in Canada.

women's constitutional rights to life, liberty and security of the person (Abortion Rights Coalition of Canada 2005; Arthur 1999).

There have also been multiple attempts by the federal government to hold provinces accountable for denying public funding for clinic abortions. In 1995, Federal Health Minister Diane Marleau sent a notice to all provinces addressing the divergent interpretations of the CHA, in particular regarding private abortion clinics. This letter made clear that the refusal to fund clinic abortions violates the CHA by creating financial barriers to accessing abortion care (Marleau 1995). In it, Marleau also stated that the federal government would withhold health transfer payments for any province that continued to restrict public funding for clinic abortions (*ibid*). Despite New Brunswick's noncompliance, transfer payments were never withheld. In 2005, Federal Health Minister Ujjual Dosanjh initiated a dispute avoidance resolution (DAR) action against New Brunswick under these same guidelines. Then-New Brunswick Health Minister Elvy Robichaud declined to participate in the action, stating publicly that New Brunswick would not bow to federal pressure on the abortion issue. The DAR was effectively dropped when the Conservatives won the federal election in 2006. That year, the new Minister of Health, Tony Clement, announced that the federal government did "not intend to pursue the matter of abortion funding at the New Brunswick clinic," stating that the issue was "off the radar." There have been no further attempts by the federal government to hold New Brunswick accountable for violating the CHA, despite Prime Minister Justin Trudeau's public commitment to women's rights in the area of reproductive health and

abortion care (Abortion Rights Coalition of Canada 2007; Ackerman 2012; Johnstone 2012; McTavish 2015).

The End of an Era and the Birth of a Movement

I arrived in Fredericton on September 10, 2015. It had been nearly a year and a half since the Morgentaler Clinic announced it was closing. Since then, I continued the pattern of poring over news articles, social media and websites to document the struggle in New Brunswick, all the while meticulously recording notes on themes I saw emerging from this data. I quickly became intrigued by the ways that activists were framing the issue as a matter of access to basic healthcare, rather than an issue of reproductive rights. I was curious, also, about how they were using the concept of reproductive justice to situate abortion in the context of people's diverse lived experiences. Galvanized by the closure of the Fredericton Morgentaler Clinic, I made note of the central role that the clinic played in activists' demands for access. It was not enough, they argued, to expand access to abortion within the hospitals. The clinic needed to be saved, and it was up to the provincial government to repeal the regulatory framework denying public funding for abortions provided in clinic settings. Equipped with this preliminary research, I set out to interview activists, advocates and service providers who were centrally involved in the struggle to expand abortion access in New Brunswick.

The day after I arrived in Fredericton, I met Tracy Glynn in Café Loka, an independent coffee shop where Reproductive Justice New Brunswick's (RJNB) founding meeting was held in March 2014. I asked Tracy what it was like when the Morgentaler Clinic first announced it was closing, and how RJNB formed in response to the news. She mentioned that she had heard about the pending closure from Judy Burwell weeks before

it was announced. “It was devastating,” she recalls, “I just thought of the struggles people were going to have to get abortions” (Interview with Tracy Glynn 2015). The clinic had been providing over 60% of the province’s annual reported abortions at the time of its closure. It was also the only site in Fredericton – the province’s capital city, home to 60,000 students enrolled at the University of New Brunswick and St. Thomas University – where people could access an abortion. Despite the impact of the clinic’s closure, the uneven distribution of abortion care had long been a problem in New Brunswick, Tracy reminded me. Now, with one of the province’s three sites set to close, even more patients would be forced to travel to access care—a barrier that is particularly challenging for young, low-income and rural communities (Interview with Tracy Glynn, 2015).

Like Tracy, others who were closely involved with the clinic realized how big of an impact its closure would have on the community. During my interview with Jaden Fitzherbert, she recalled what it was like the night before the clinic closed:

Simone got all the escorts, she asked us to come to the clinic the night before the formal announcement was made. And that was when she told us. We all kind of knew. It was an in secret with all of us that obviously Henry [Morgentaler] had been paying for procedures. Like, *we* knew, but the public didn’t. And it had always been a question after he passed about, you know, how is the clinic going to continue doing that? [...] But it was like we got hit with a ton of bricks. We all kind of went silent. [...] And Simone told us that, no matter what happens, the clinic as-is isn’t going to be saved. Because it had to close, right? (Interview with Jaden Fitzherbert, 2015).

As Jaden describes, while those who were closely connected to the Morgentaler Clinic were aware of its financial challenges, and were wary of a future without Dr.

Morgentaler, the news that it would be forced to close shocked people across the Maritimes. Due to New Brunswick’s funding restrictions, Morgentaler, with limited financial help from the National Abortion Federation (NAF), had been subsidizing

abortion care for low-income women since the clinic first opened in 1994. But he also poured his money into court cases, where he fought provincial governments seeking to bar women from accessing abortion care in clinics (including those in New Brunswick, Nova Scotia, Manitoba and Québec) and helped to cover the more than \$100,000 in flood damages at the Fredericton clinic in 2008. When Dr. Morgentaler passed away in 2013, the issue of funding became insurmountable. During my interview with Simone, she discussed how challenging it was to run a clinic in such precarious conditions:

I mean, we had staff to pay. We had equipment—and medical equipment is very expensive. Every time it broke, it was Toronto that was paying to get it fixed. It wasn't our clinic. I know because I know the bank account. We didn't have the money. You know, if we needed a new ultrasound machine, Toronto bought the ultrasound machine. You know, you're talking \$50,000. And I don't think people really got that at all, about how much money... like, if a woman is paying \$700 for an abortion, it's not going very far when it comes to paying staff, and utilities, and heat, and everything! And then we had [the] flood... (Interview with Simone Leibovitch 2015).

After Dr. Morgentaler's death in 2013, the pattern of funding abortions for low-income patients, combined with the financial burdens Simone describes above, continued to place strain upon the Fredericton clinic. Despite the important role it played within the community, the clinic model was never sustainable in New Brunswick. The combined effect of the province's *Medical Services Payment Act* and Morgentaler's commitment to never turn away a patient in need helped set into motion a model of care that depended on Morgentaler's personal funds and the revenue made from the Toronto clinic. In other words, due to the province's funding stipulations, the provincial government had for decades offloaded the costs of clinic abortion care – deemed a medically necessary service under the *Canada Health Act* – onto Morgentaler, the National Abortion

Federation (NAF), and patients with financial means.⁶⁵ In Simone's mind, there was no option but to close the clinic. "There's no money!" she told me during our interview, shaking her head as she spoke. "We couldn't keep helping women and paying for people's abortions. We couldn't do it" (Interview with Simone Leibovitch 2015).

And so, in the weeks before the clinic's closure was made public, Tracy Glynn, along with Judy Burwell and Elizabeth Blainy,⁶⁶ decided to form the Ad Hoc Group for NB Reproductive Justice, which would later become RJNB. Their close relationships with Simone meant they had been made aware of the clinic's financial situation well before the announcement. Tracy describes the committee's early formation below:

We felt really defeated. Judy's been involved in the fight for decades... I don't think one of us really thought a group would come together. But I think Elizabeth suggested that we form this ad hoc committee, and that it be focused around reproductive justice, not just abortion rights. Which was something I was really happy about, because that links to all the other things I'm working on (Interview with Tracy Glynn 2015).

As many participants described, the decision to focus the messaging around access and reproductive justice provided space for talking about the ways in which systemic inequalities interact with people's ability to access abortion in New Brunswick. For Tracy and others, this meant being explicit about how barriers such as Regulation 84-20 were particularly burdensome for those experiencing multiple social relations of oppression. In addition, the above excerpt reveals how Tracy – like many others I interviewed – was surprised by the amount of support that was generated in response to the clinic's

⁶⁵ During my interview with Simone, she described having to request funding from NAF to help subsidize abortion care for low-income patients. She estimated that, for a \$700 abortion procedure, NAF would send \$100 to the clinic to help cover the costs of the procedure.

⁶⁶ Elizabeth Blainey is a longstanding reproductive rights and justice activist in New Brunswick and former member of RJNB. She was not available to participate in this study.

announcement. After all, the restrictions set in place by Regulation 84-20 were not new. For decades, people on the ground had been pushing for the provincial government to loosen its grip on reproductive control. There were court cases launched by Dr. Morgentaler; there was political agitation and lobbying undertaken by past generations of activists, including Judy Burwell, Simone Leibovitch, Lianne McTavish, Julia Hughes and Joyce Arthur; there were initiatives led by Federal Health Ministers Diane Marleau (1995) and Ujjal Dosanjh (2005), compelling the province to adhere to the *Canada Health Act* by funding abortions provided in clinics. However, these pockets of action never managed to gain the momentum necessary to transform the provincial government's approach to abortion provision. Many of my research participants gestured toward this in our interviews, suggesting that the clinic's closure both exacerbated and made visible the province's decades-long abortion problem. "Access was always an issue," Tracy told me during our interview, "But when [the clinic] announced its closure, we knew it would be even more difficult for people" (Interview with Tracy Glynn 2015). And so, Tracy, Judy and Elizabeth put out a call for action, and in early March 2014, some fifteen to twenty-five community members gathered for RJNB's founding meeting at Café Loka. Representatives from local groups and organizations, including the Fredericton Sexual Assault Centre (FSAC), staff and volunteers from the Morgentaler Clinic, professors and students from the University of New Brunswick (UNB) and St. Thomas University, high school students and members of the Fredericton Youth

Feminists (FYF) came together to begin organizing in the wake of the clinic's closure.

Conclusion

During my interviews, activists would often describe the provincial government's complicity in upholding the province's decades-old regulatory framework for publicly funded abortion care. Since this framework emerged, activists, advocates and like-minded service providers have demanded that the province repeal Regulation 84-20 and Section 2.01b of the *Medical Services Payment Act*, which continue to organize service provision in New Brunswick. This chapter helps to reveal the social and political circumstances through which these measures were enacted—specifically, that both were promulgated in the middle of intense public debate around Dr. Henry Morgentaler's plans to establish a clinic in the province. In conversations with activists, they would often mention the social, political and material ramifications of the province's historical vendetta against Dr. Morgentaler, drawing clear lines between today's access problems and the government's historical commitment to maintaining the status quo. Indeed, that the government has continued to uphold these regressive anti-abortion policies is in part indicative of the abstract and authoritative character that people so often tend to attribute to texts (D.E. Smith, 2015). As D.E. Smith has described it, the tendency for people to abstract texts from people's everyday practices is part of what gives texts their magical, reified, and static quality (ibid). Exploring the history of texts, as well as the ways in which they work extra-locally to coordinate people's everyday experiences, is thus useful for producing research that seeks to disrupt and transform the status quo. For instance, as this chapter reveals, by codifying anti-abortion ideology into the province's *Medical*

Services Payment Act, Premier Frank McKenna helped set into motion a two-tiered health system, which has systematically denied women access to clinic abortions since the Morgentaler Clinic opened its doors in 1994. As many of my participants have argued, attending to this history helps to reveal that Regulation 84-20 and Section 2.01b are derived not from medical best practices or evidence-based policy, but from an overtly anti-abortion ideology, leftover from the days of criminalization.

In the next chapter, I discuss how the clinic's closure amplified past demands for the repeal of Regulation 84-20, ushering in a new wave of feminist pro-choice activism in the province. Similar to activists in the 1970s and 1980s, contemporary activists in New Brunswick have explicitly framed their struggle as a matter of access. This discourse of access, as I elaborate on further in the dissertation, has been used by activists as a way to demonstrate that, in New Brunswick, the ability to obtain an abortion is organized not only by the province's *Medical Services Payment Act*, but also by the uneven distribution of services in the province, as well as the intersecting and interlocking social relations of power and inequality undergirding Canadian society.

Chapter 5:

“We Need the Access:” A Story of Activism in New Brunswick

Introduction

When the Fredericton Morgentaler Clinic announced it would be closing its doors in 2014, many of my research participants felt as though New Brunswick had fallen into a state of crisis. Abortion access, restricted by provincial regulations and provided in only two hospitals across the province, would significantly weaken with the closure of the Maritimes’ only abortion clinic. While New Brunswick has long been considered among the worst provinces for abortion access in Canada (Sethna and Doull 2013; Shaw 2006), the closing of the clinic helped spark an organized, grassroots movement to resist, reshape and transform the social organization of abortion care in the province. In this chapter, I recount the events that unfolded in New Brunswick between May 2014 and January 2015, both from my own perspective as an activist and researcher, and from the perspective of the activists and service providers who played a key role in the movement. I begin by describing how members of the Fredericton community came together to form Reproductive Justice New Brunswick (RJNB), a grassroots feminist collective dedicated to expanding abortion access in the province. I then highlight several key moments of collective action that occurred during this period, illuminating the unrelenting work that activists undertook to bring transformative change to the landscape of abortion care in New Brunswick. In both sections, I explore the relationship between clinic care, access and reproductive justice, demonstrating how activists rallied around the clinic to bring immediate solutions to the crisis of access, as well as regulatory transformation to the province’s *Medical Services Payment Act*. In this same discussion, I demonstrate that

while activists' discourses of access and reproductive justice provided significant openings for activism, these same discourses have been a site of tension and negotiation within the movement. In general, activists have used the concept of access to draw attention to the complex relationship between service provision and systemic inequalities in the context of New Brunswick's public funding model. However, though activists' analyses reflected many of the core principles of reproductive justice, the crisis in which they found themselves led them to focus their organizing around expanding abortion services, rather than ensuring the necessary enabling conditions for the achievement of reproductive justice.

In the final section of this chapter, I explore the political confrontation that took place in the weeks leading up to the provincial elections in 2014, and the role that activists played in ensuring that abortion became a key election issue. I then turn to Liberal Premier Brian Gallant who, once elected, announced that his government would be eliminating all barriers to abortion access in the province. Though this marked a historic moment in New Brunswick's abortion policy history – culminating in the amendment to Regulation 84-20 and the expansion of hospital abortion care – the Gallant Liberals' failure to repeal Regulation 84-20 and Section 2.01b of the *Medical Services Payment Act* means that clinic abortions continue to be ineligible for public funding in the province. As I explore further in the chapter, these moves on behalf of the provincial government have created a semblance of access in the province, ultimately weakening the momentum that activists had worked so hard to generate. As I argue, the series of events that unfolded in New Brunswick demonstrates the usefulness of attending to activist accounts when developing policies around sexual and reproductive health, as well as the

ongoing need for broad-based reproductive justice organizing in the province and across Canada.

Crisis, Access & Inequality: A Catalyst for Activism

Forming out of Crisis, Acting out of Necessity

When I asked my research participants to describe what it was like when the Fredericton Morgentaler Clinic announced its closure, nearly everyone described it as a catalyst for activism. This was the only abortion clinic in the Maritimes, many of them would remind me. It was performing 60% of the annual reported abortions in New Brunswick. It was the only space in Fredericton, a university town, where women could access abortion care. But there was also something unique about the space of the clinic, they told me. The kind of care that was provided there was compassionate, patient-centered, and judgment-free. Beyond service provision, the clinic also served as an information hub for reproductive health and rights, as well as a gathering space for progressive groups in the Fredericton community.⁶⁷ As a social artefact, the Morgentaler Clinic also represented a rich history of struggle between Dr. Henry Morgentaler and feminist pro-choice activists on the one hand, and the provincial government, sectors of the medical community, and the anti-abortion movement on the other.

During my interview with Allison Webster, the assistant manager of the clinic, she

⁶⁷ For instance, in my interview with Sorchá, she described how, months before the announcement, members from the FYF organized a tour of the Morgentaler Clinic to learn more about the problems with abortion access and healthcare provision in New Brunswick. She recalls being floored by what she and others discovered, from the impact of Regulation 84-20 to the deep-seated culture of shame and stigma in the province. After their tour, FYF formed what Sorchá refers to as an alliance with the clinic, offering mutual support whenever possible and/or necessary (Interview with Sorchá Beirne 2015).

described how a wave of shock pulsed through the Fredericton community in the days following the clinic's announcement. This sense of shock ultimately led to RJNB's founding meeting:

So, there really was this groundswell of outrage and fear! Like, "What the hell are we going to do," you know? It was actually here [at Café Loka]. A bunch of us got together. It was a snowy March day. There was probably like, fifteen of us. And we had our first meeting to try to make a plan and to take up the reins, so to speak. And we didn't decide on "RJNB" or anything like that officially, it was sort of an ad-hoc committee [...] It's really been evolving since that first meeting here, where we were just like, "We need to get something going" (Interview with Allison Webster 2015).

That visceral sense of "need[ing] to get something going" was a common thread among my research participants, especially those who were involved in RJNB's formation. Community members were outraged and devastated, but they were also prepared to organize. Jaden Fitzherbert, who volunteered as a clinic escort, illustrates this below:

It was like this light went off immediately. We were all just like, "What can we do?" Immediately. "What can we do to help and to save the clinic?" [...] And I think even though it was devastating, it was a catalyst. It lit a fire under this whole movement that I didn't even know existed in New Brunswick (Interview with Jaden Fitzherbert 2015).

For Jaden, the closure of the Morgentaler clinic acted as a catalyst for feminist organizing around abortion access. It "lit a fire" in people, inciting a level of support and solidarity that even those involved with the clinic did not know existed. However, as I demonstrated in the previous chapter, New Brunswick has for years been a site of struggle over abortion. For decades, the "status quo" had a hold on the province: abortions were conditionally funded in certain hospitals, and paid for out of pocket at the Fredericton clinic.⁶⁸ It was not comprehensive access, but it was enough to *not* generate

⁶⁸ The "status quo" is a concept that is often used by activists, advocates, service providers and journalists in New Brunswick to describe the provincial government's conservative and

national, organized outrage. Jessi Taylor, former spokesperson for RJNB, elaborated on this during our interview:

But when the clinic closed, that was a huge catalyst for the entire community. Even though work had been ongoing, and work had been done by activists for years in Fredericton... the closing of the Morgentaler Clinic was a big catalyst for a lot of people. So many people had used the service or knew someone who had used the service, or knew someone that had been in a situation where they'd considered using the services. And just the situation of, I think sometimes we get used to not having enough in New Brunswick. And it just becomes normal life. But having something extra taken away from people, I think, was a big game changer (Interview with Jessi Taylor 2015).

As Jessi makes clear, New Brunswick has a long history of social and political struggle over abortion access. Still, the clinic's announcement shifted the character of that struggle. Jessi describes it as a "game changer" and a "huge catalyst" for the community. It was as if the clinic was being taken away from the people of New Brunswick, who, in Jessi's view, are already used to "not having enough."⁶⁹ Its closing meant one less space where abortions would be provided in New Brunswick. As so many of my participants made clear, this was not just any space that was being taken away. Clinic care, so valued by abortion advocates, would no longer be an option in New Brunswick. The Morgentaler Clinic had played a vital role in the province's reproductive healthcare

restrictive position on abortion care throughout history, as well as the tendency for this position to go relatively unquestioned – or at least, unchallenged – by much of the general public.

⁶⁹ Discussions around New Brunswick residents "not having enough" were common in my interviews with activists, who frequently referenced New Brunswick's significantly low number of physicians, which has left approximately 50,000 people without a family doctor in the province. Others, such as Jula Hughes, Sorcha Beirne, Megan Hill, and Abbie Moser cited the unevenness of sexual health education across the province, emphasizing that youth in rural areas are particularly disadvantaged when it comes to sexual health education and access to contraception. Still others referenced New Brunswick's unemployment rates, which have sent many young people to seek work out of province, as well as the influence that wealthy, conservative business owners (most notably the Irvings) have over provincial policy and leadership.

system. The numbers alone demonstrated this: more than half of all patients seeking abortion care in the province did so at the Morgentaler Clinic. This meant that its closure would significantly restructure the way abortion services were provided in New Brunswick. Without a clinic providing abortions in Fredericton, patient experiences were sure to change.

While many of my research participants considered the clinic's closing to be a catalyst for activism, Simone drew firm, causal lines between the two: "Unless the clinic closed, nothing was going to change in New Brunswick. Nothing," she said during our interview. As Simone described it, the clinic's closure provided the necessary pressure for the provincial government to finally pay attention to the problem of access. It also provided an opening for grassroots mobilization:

The clinic closing was the impetus for RJNB. It was the impetus for the crowdfunding thing. It was the impetus for getting [Dr. X] there.⁷⁰ [...] From my perspective, I think the biggest thing was just the group getting together and saying, "Well, the clinic is closing, so now what are we going to do?" So, if the clinic hadn't closed there wouldn't be this group of people that would have gotten together to do anything, right? And so that started it... people I think had something to fight for then (Interview with Simone Leibovitch 2015).

Before the clinic closed, there were small pockets of pro-choice activism in New Brunswick. But from where Simone stood, there was not an organized base propelling that movement forward. It took the clinic closing to spark that. As Joyce Arthur describes in an interview with the *Toronto Star*, because New Brunswick's access problem had received so little attention in recent years, it was challenging to "get people to understand

⁷⁰ "Dr. X" is a pseudonym for the physician who moved from Vancouver to Fredericton to open Clinic 554. This pseudonym was and continues to be used by the activists who organized for the opening of Clinic 554.

how serious a problem this was,” even among abortion rights activists (Arthur, quoted in MacDonald 2015). Similarly, as Lianne McTavish writes, with the closing of the clinic, “the reality of the restricted access to abortion in New Brunswick’s hospitals came back into the spotlight,” and “forced politicians and others to address a longstanding situation and renewed lobbying efforts both for and against funded abortion care” (McTavish 2015:125-6).

While the clinic’s closure was a catalyst for change, it also marked a deep loss for reproductive healthcare in the province. Closing the clinic was devastating, Simone told me. And the decision to do so was not easy. For years, she and others had invested their “blood, sweat and tears” into the clinic (Interview with Simone Leibovitch 2015).

Hundreds of people relied on its services each year. But operating without the appropriate financial resources ultimately led to significant challenges. Like others I interviewed, Simone was firm in her belief that the clinic had to close. For decades, the Morgentaler Clinic had acted as a band-aid solution to a systemic problem in the province’s organization of abortion care. Finally, as Julia Hughes and others have suggested, the government would be forced to grapple with the access barriers imposed through the

Medical Services Payment Act:

[For years] it was easy to get away with not taking a positive position on access to reproductive health, because the clinic was here [...] The clinic not being available would put, I would imagine, some pressure on government to rethink what was essentially an ideological position, not one that was grounded in real public policy making (Hughes, quoted in CBC News 2014)

Similarly, Tracy described the clinic’s closing as “kind of a blessing in disguise” (Interview with Tracy Glynn 2015). It was a material loss to the community, but it also helped mobilize a grassroots movement to demand better access to care. As Julia describes above,

the provincial government's ongoing refusal to fund clinic abortions is not grounded in medical best practice or evidence-based policy, but rather an ideological stance that sets arbitrary boundaries between abortions provided in hospitals and those provided in clinics.⁷¹ As described in Chapter 3, this arbitrary distinction was used by several provinces across Canada to restrict the provision of abortion care in the aftermath of the 1988 Supreme Court decision.

Even in the wake of the Fredericton clinic's closure, New Brunswick's Progressive Conservative Premier David Alward remained silent on the issue of abortion access. Instead, he directed media attention toward Health Minister Ted Flemming. Following the clinic's announcement, Flemming issued a public statement indicating that the women of New Brunswick would "continue to have access to medically necessary abortions in the province with the approval of two physicians," and that the ongoing lawsuit filed by the late Morgentaler prevented the department from commenting further on the matter (Government of New Brunswick 2014b).⁷² Shortly thereafter, Minister Flemming was featured in Atlantic's CTV News as stating that New Brunswick's *Medical Services Payment Act* held a position that was "consistent with what the province has had for some time," leading many to suggest that the government would continue to uphold the status quo with regards to abortion, despite resistance from activists and advocates on the ground (Bissett 2014a; CBC News 2014b). What is perhaps most significant in the Department of

⁷¹ To be sure, this distinction is also indicative of the government's patriarchal stance on self-referred abortions, as Regulation 84-20 also required women to seek approval from two physicians prior to obtaining the procedure.

⁷² The Morgentaler court case was dropped on April 15, five days after the Department of Health released its statement. In the coming months, the PC government would continue to affirm their stance in defense of the status quo.

Health's statement – as well as Alward and Flemming's subsequent comments – is what is left unsaid: specifically, the refusal to acknowledge the fact that the clinic providing most of the province's abortions was closing due to lack of government funding, as well as the absence of a proposal for ensuring access to the procedure going forward.

On May 14, 2014, Reproductive Justice New Brunswick (RJNB) announced its formation on the front lawn of the New Brunswick Legislative Building in downtown Fredericton. Kathleen Pye, then-spokesperson for RJNB, addressed the media:

In light of the imminent closure of the Fredericton Morgentaler Clinic [...] New Brunswick women are at a crisis point. [...] We urge the government to repeal its outdated and unjust abortion rules and to ensure New Brunswick women have the same access to health care services as women in the rest of Canada (Pye, quoted in Reproductive Justice New Brunswick 2014b).

A factsheet was posted to the group's website that day, detailing the historical, social and political context of New Brunswick's abortion restrictions and access problems. This text communicated to the world that the Morgentaler Clinic was closing due not to a lack of demand, but to restrictions set into place by the province's *Medical Services Payment Act*.⁷³ It also explained that New Brunswick was the only province where clinic abortions were available but not publicly funded, and the only province that continued to impose "regulatory constraints on access" (Reproductive Justice New Brunswick 2014f). In response, a group of local feminist activists and advocates had come together to form RJNB, a collective that was "advocating for a publicly funded and comprehensive

⁷³ Factsheets were also distributed by hand (at rallies and demonstrations, on University campuses, on the streets) and circulated online (through social media, news media and RJNB's website) to increase public awareness about the impact of New Brunswick's anti-abortion regulations.

reproductive health system” that would include “full abortion access on a self-referral basis in all regions of New Brunswick and in both official languages” (Pye, quoted in Reproductive Justice New Brunswick 2014b).

The central role that activists, advocates and clinic staff played in framing the clinic’s closure is striking when compared to the media stories decades earlier, which centered almost entirely upon Dr. Morgentaler and the provincial government. When the clinic closed in 2014, both local and national news stories covered the issue predominantly from the perspective of feminist pro-choice activists, featuring quotes from Simone Leibovitch, Jula Hughes, Jaden Fitzherbert, Kathleen Pye, and former clinic manager Alison Brewer. As in the past, the public discourse surrounding abortion care in New Brunswick centered on the relationship between abortion access, the Morgentaler Clinic and Regulation 84-20. However, unlike past debates in the province, in which the voices and perspectives of grassroots activists often took a backseat to those of the state and the medical community, the discourse coming out of New Brunswick in 2014 was led by clinic staff, volunteers, activists and advocates. As I discuss further, the ongoing amplification of these voices has been the result of a groundswell of feminist activism that sought both an immediate solution to the crisis of access in the province, as well as a transformation in the province’s regulatory framework for abortion care.

Organizing Against the “Crisis of Access”

As the previous section makes clear, the closure of the Morgentaler Clinic helped catalyze a local, grassroots movement dedicated to expanding abortion access in the province. From the moment the clinic’s announcement went public, activists and

advocates began to mobilize a discourse that was centered on the crisis of access in New Brunswick. The clinic's closure, they argued, would weaken abortion access in a province where abortion was already heavily regulated, making it more challenging for women – especially those who experience multiple and interlocking relations of oppression – to access safe, timely and affordable abortion care. This notion of crisis arose many times during my interviews with activists. As Alison described, RJNB was formed out of a period of crisis: “This was crisis mode,” she told me, “It was like, ‘We’ve gotta do something. We can’t just sit on our hands and just see this go away.’” (Interview with Allison Webster 2015). While each research participant discussed the clinic's closure as having negative implications for abortion access, six participants explicitly framed this as a period of crisis, including Allison Webster, Hannah Gray, Maggie Fitzgerald-Murphy, Tracy Glynn, Sorchá Beirne and Marilyn Merritt-Gray, who are all current or former members of RJNB. As they described it, although the clinic's closure signaled a crisis of access, it also ushered in a wave of crisis-oriented, feminist pro-choice activism. During my interviews, several participants described how the crisis of access impacted the internal politics and decision-making processes of RJNB. In this way, the “crisis” was present not only in the social organization of abortion care, but also in the social organization of RJNB itself. As I elaborate further in the chapter, one of the ways this manifested was in the decision to use “reproductive justice” in the collective's name, while narrowly focusing on the issue of abortion. Other organizing aspects that activists felt were impacted by the crisis of access included the collective's early internal structure – hierarchical rather than horizontal – as well as debates between liberal and third wave

feminists, the relationship between RJNB and the Fredericton Youth Feminists (FYF), as well as decisions regarding the collective's organizing strategies.

However, despite the visceral sense of crisis that so many of my participants mentioned, as Tracy Glynn reminded me, abortion access has *always* been a crisis in New Brunswick. The clinic's closing not only compounded that crisis; it also made it more visible. "I think we were really thrown into this crisis mode," Tracy told me, "Even though the crisis existed before with the lack of access... no one had really seen that" (Interview with Tracy Glynn 2015). To be sure, the clinic's closure brought forward a new wave of tangible access issues in the form of service provision. However, as Tracy and others have suggested, it also brought renewed visibility to the province's decades-old anti-abortion regulations. Articulating the current struggle as one of crisis, while also locating that crisis within New Brunswick's historical socio-political context, provided a platform for activists to make concrete demands of the state while also revealing its complicity in denying women access to care. In this way, the closure of the clinic not only brought forward a material crisis in the social organization of abortion care, but also acted as a symbolic rallying point for activists in their struggle against the state and the medical community.

This double significance of the Morgentaler Clinic's closure bears striking resemblance to earlier iterations of feminist pro-choice activism in Canada. As I have shown, feminist activists in the 1970s and 1980s challenged the textual mediation of abortion through the *Criminal Code of Canada* – which granted medical and state authorities control over reproductive decision-making – through a rhetorical tool that Lorna Weir refers to as a "crisis of access." According to Weir (1994), the "crisis of

access” discourse helps to reveal how feminist activists conceived of abortion clinics as both material spaces for providing abortion care, as well as strategic and symbolic rallying points for “political resistance to the state system of reproductive control” (255). Weir (1994) considers the material and symbolic significance of abortion clinics, as spaces that challenged the institutional coordination of abortion by providing care outside the bounds of the *Criminal Code*. Historically, the very existence of abortion clinics clashed with – and resisted – a socio-political landscape in which legal, therapeutic abortions could be procured or provided only in hospital settings, and only with the approval of a therapeutic abortion committee (TAC). This same analysis lends itself well to the New Brunswick case, where the Fredericton Morgentaler Clinic operated for twenty years in tension with the province’s *Medical Services Payment Act*. As I have shown, this act serves as a regulatory mechanism that prohibits funding for abortions provided in clinics and, up until 2015, placed conditions upon publicly funded abortions provided in hospital settings. When the clinic announced its closure, it too became a material and symbolic rallying point for activism, as a space that could help curb New Brunswick’s access problem, while also challenging the provincial government’s textual mediation of abortion services under the *Medical Services Payment Act*. As in earlier decades, the “crisis of access” in New Brunswick helped to catalyze a movement that centered its struggles on the social relations coordinating that crisis, calling upon the state

and the medical community to re-organize abortion services in a way that would prioritize women's reproductive autonomy.

Access, Social Inequality & Reproductive Justice

Another similarity that I have found between the contemporary movement for abortion access in New Brunswick and the history of feminist pro-choice organizing in Canada can be located in activists' discourses around abortion access and reproductive justice. As I have shown, leftist feminists in the 1970s and 1980s, such as those involved in the Ontario Coalition for Abortion Clinics (OCAC), mobilized around a framework of reproductive freedom to make connections between abortion access, structural inequalities, and a broader vision for social justice. In so doing, members of OCAC advocated not only for the establishment of abortion clinics and the repeal of the abortion law, but for a number of other social justice issues impacting communities at the margins, lending organizing power to struggles faced by women of colour, women with disabilities, young women, low-income women, and those living in rural and northern communities (Weir 1994, 1995). During my research, activists offered a strikingly similar analysis, though were hesitant to identify their organizing as explicitly "reproductive justice" work.⁷⁴ Still, they told me, focusing on access provided them with a framework for understanding abortion as a complex site of inequality in the gendered,

⁷⁴ As I learned through my research, most activists who were involved in the struggle in New Brunswick — and, as a result, the majority of my research participants — are white, middle-class and cisgender. Approximately half are below the age of 40. Many identify as queer or gay. Several identify as people with disabilities. Given this demographic makeup, I was not surprised when several of my participants prefaced their responses by acknowledging the gaps between their work and the broader project for reproductive justice.

classed and racialized politicization and distribution of reproductive healthcare. Tracy elaborates on these links below:

So, I think with the clinic closing, the action centered right away around access. And not making it solely an abortion rights issue, too... and I think Jessi said it in a meeting, about how healthcare “shouldn’t be based on luck and privilege.” And I really like that statement, because it speaks so well to like—that’s the healthcare system we have right now! It’s based on luck and privilege! Like, if you’re lucky enough to be born in an area where there’s abortion access and with a family that can support you, all of these things! [...] And I think the language around access, too, *is* more about reproductive justice, where you get to talk about access to healthcare for *everyone*. Like, universal, comprehensive reproductive healthcare access (Interview with Tracy Glynn 2015).

Like Tracy, many of my participants conceptualized “access” in terms of the ability for *everyone* to obtain safe, timely, affordable and non-judgmental abortion care in a context that makes sense for them, their family and their community. This definition of access indeed mirrors many key aspects of the broader framework for reproductive justice. As Marlene Gerber Fried argues, there is a conflicting relationship between state-sanctioned rights and the ability to access those rights. Without concrete *access* to abortion services, she argues, “the legal right to abortion is empty, and choice an abstraction” (1990:6). This perspective is visible in much of the organizing that took place in New Brunswick following the clinic’s announcement, where the rallying cry quickly became, “We have the law, we need the access!”

By focusing on access, members of RJNB, ARCC and FYF sought to articulate their struggles beyond the narrow scope of abortion rights, in order to address how interlocking dimensions of inequality condition the possibility for people to actually obtain an abortion in New Brunswick. For instance, during my interview with Hannah Gray, a former spokesperson for RJNB, she used the example of mifepristone to explain

the questions that come into view when looking at medical abortion through a framework of access and reproductive justice:

So, with medical abortions everyone is excited about it. But then our reproductive justice stance is also like, well, how much is this medication going to cost? Who is going to prescribe it? What about people who get turned away the first time? What about the follow-up care? What are the obligations of doctors? What are the obligations of pharmacists? How are we actually going to approach this in a way that is culturally appropriate? (Interview with Hannah Gray 2015)

For Hannah, taking a reproductive justice approach to abortion helps broaden the scope of struggle by making distinctions between theoretical rights to healthcare and the ability for people to obtain that care in a way that makes sense for them, regardless of their social location. This framework directs us beyond the individualizing narrative of state-based rights, and toward the relations of ruling that deny equal access to those rights. As stated by ARCC board member Peggy Cooke, “It’s not just about abortion; it’s about who gets the right to control their bodies and the resources to do that,” (as quoted in Hodge 2014). In New Brunswick, this struggle has most often been foregrounded by the ways in which Regulation 84-20 places barriers on people’s ability to obtain safe, timely, affordable and non-judgmental abortion care within their community, or in the location of their choosing. As many of my research participants noted, these barriers are particularly challenging for people who experience intersectional oppressions, including but not limited to class, race, sexuality, age, ability, ethnicity, immigration status, religion, family dynamics and region. Similar to leftist feminists in the 1980s and 1990s, the contemporary movement to expand abortion care in New Brunswick has used the language of access to frame the abortion issue as connected to broader social relations of

power and privilege—relations which are themselves in need of transformation.

At the same time, however, the use of the reproductive justice framework has been a complex site of tension and negotiation among activists in New Brunswick. While the discourse of access is expansive, inclusive and attentive to the intersections of reproductive health and structural inequalities, it has still primarily been mobilized as a means to reveal and transform the unequal distribution of abortion care in the province. On the other hand, the reproductive justice framework was developed by women of colour working against the grain of the single-issue pro-choice and reproductive rights movements, which have historically centered the experiences of white, middle-class, able-bodied and cis-gender women. As discussed in Chapter 2, reproductive justice organizations across the United States and Canada have organized along identity lines to approach reproductive health, rights and justice in ways that address the unique needs of their communities, carving out spaces from which to reflect upon, critique, work through, and ultimately dismantle the systems that perpetuate reproductive oppression within their communities (Ross 2006; Siliman et al. 2004). In addition, many of those within the reproductive justice movement have expressed concerns regarding the co-optation of the reproductive justice framework, especially among activist groups that would have traditionally identified as pro-choice, and whose organizing efforts are focused primarily on the achievement of abortion rights and accessibility (Danforth 2010; Ross 2006:18–19).

Discussions around co-optation and the difference between abortion access and reproductive justice emerged frequently in my interviews. In fact, almost all of my research participants, especially those involved in RJNB, expressed concern over the

movement's use of the reproductive justice framework, both in their organizing and their namesake. Hannah elaborates on this below:

I think the biggest tension is from... concerns about whether or not we're living up to it. I think the name of reproductive justice—we took over accidentally. I think people maybe didn't research it as much as we wanted to. We kind of adopted the idea. And then we realized that it's kind of appropriated (Interview with Hannah Gray 2015).

Similarly, Tracy Glynn expressed how she was initially supportive of the collective's reproductive justice namesake, but recognized the tensions that the framework had within the movement. Part of the reason for the name, as she described it, was to consciously break away from a more liberal feminist agenda centered on abortion rights. Opting for "Reproductive Justice New Brunswick" meant centering an anti-oppression framework within their organizing. "I was really happy about that," Tracy said, "because that links to all the other things I'm working on" (Interview with Tracy Glynn 2014). At the same time, Tracy told me, there were challenges in determining what reproductive justice work meant in the context of RJNB's organizing:

It was something that we all realized, too, that we didn't know a lot about—that we also needed to educate ourselves on. And to realize that we were very limited, no matter... like, it was always a struggle to figure out if we should be putting our resources and energies on the abortion struggle right now, or should we be talking about all these other things (Interview with Tracy Glynn 2015).

Part of the challenges that Tracy and others describe can be traced back to how RJNB formed during a period of crisis. During my interviews, activists recalled how they were forced to respond quickly to the Morgentaler Clinic's closure and, as a result, had less time to grapple with the political implications of identifying as a reproductive justice collective while centering their work around abortion access. Allison Webster expanded on this during our interview, describing her desire for the collective to "grow into its

name” after the abortion issue was resolved. “We’re definitely aware that abortion access *isn’t* reproductive justice,” she told me, “it just happens to be a really pressing issue for us in New Brunswick right now” (Interview with Alison Webster 2014). Hannah also acknowledged this, mentioning that RJNB continues to focus on abortion access because “that’s really what our history is, and it’s so important [in New Brunswick] right now.” (ibid).

In several of these conversations, members of RJNB mentioned that they hoped to “grow into” their name, referencing their commitment to solidarity work and to expanding the collective’s scope within the community. For example, many of my research participants spoke of the collective’s support for and solidarity work with groups like New Brunswick for Midwives, TransAction New Brunswick and AIDS New Brunswick (all of whom have similarly advocated against systemic inequalities in New Brunswick’s healthcare system), as well as local and national struggles surrounding sex work, colonialism, the environment, homelessness and drug use. During my interview with Tracy, she highlighted the importance of connecting these struggles:

So, for example, RJNB supported the Red Head residence in Saint John [...] that was already affected by the oil industry. It’s a proposed site of the Energy East pipeline terminal. So, we sent out a statement in support of their march back in May, and some of our members went to the march, and in that way we’re able to connect the struggle for environmental justice to the struggle for reproductive justice. And I think we’re also all educating ourselves, too, on what that is. And looking at how, for example, oil refining and the oil industry affect reproductive health. And then also with the feminists or the activists within our own circles who aren’t engaged in environmental activism, they also learned about how Red Head – I mean, some hadn’t heard of Red Head before! – but how they’re struggling. And yeah, just about environmental health issues, too. Sometimes we think these issues are so separate! (Interview with Tracy Glynn 2015)

Despite tensions and anxieties over the co-optation of the reproductive justice framework,

many members of RJNB have used their platform to stand up and speak out against issues beyond abortion and reproductive healthcare. Still, debates over how much energy and how many resources to put into this work have not been uncommon, as the collective has grappled with how best to orient itself within the broader socio-political landscape. Younger activists tended to be the most apprehensive about this. For example, Sorcha Beirne told me that she chooses not to identify as a reproductive justice activist. “Because I’m not,” she affirmed, “and I don’t that anyone who’s involved [in the movement] is. It’s unfortunate that that name has been appropriated” (Interview with Sorcha Beirne 2015). While discussing why the movement might not be engaging in reproductive justice work, Sorcha reflected on some of the challenges of organizing around broader initiatives. Rather than change its name to reflect the collective’s mandate for abortion access, she told me, members of RJNB sought to incorporate a broader range of issues into their work. The problem, as several participants have described, was that the collective lacked the resources and capacity to do so effectively, especially given the crisis of access in the province.

Within their work, activists involved in RJNB, FYF and ARCC continue to use the language of access to illustrate how structural inequalities condition the possibility for women to obtain safe, timely, and affordable abortion care in New Brunswick. When my research participants spoke of abortion access, they did so in a way that captured a constellation of interrelated struggles. Though the movement focused on ensuring access by saving the Fredericton Morgentaler Clinic and lobbying the government to repeal Regulation 84-20 and fund abortions provided in clinics, these were far from the movement’s only strategies for expanding abortion access in the province. As I show in

the next chapter, activists have also sought to expand the regional distribution of abortion services, especially among rural communities, which are disproportionately underserved when it comes to abortion. Also included within activists' demands for access is for hospitals to enlist physicians who can provide abortions beyond fourteen weeks gestation, and to put an end to the two-appointment requirement for abortion procedures. For activists, access to abortion also means ensuring care that is culturally appropriate, non-judgmental, and available in both French and English. It means investing in a comprehensive, evidence-based sexual and reproductive health education curriculum. And it means actively working to end the culture of shame, stigma, and secrecy surrounding abortion. All of this, activists argue, must be done with the context of people's diverse lived experiences in mind. As I have learned through my research, it is not possible to achieve comprehensive access to safe, timely, and affordable abortion care without also attending to the intersecting and interlocking dimensions of inequality that structure the possibility for people to exercise self-determination—that is, to make healthy and informed decisions regarding their reproductive health and lives.

Exposing New Brunswick's Access Problem: Direct Actions & Crowdfunding

As I have shown, once the Morgentaler Clinic announced its closure, activists in Fredericton moved quickly to bring local and national attention to the crisis of access in New Brunswick. In the following section, I highlight several key moments of grassroots, collective action that took place in the province during the spring and summer of 2014. Throughout, I explore how activists from RJNB, FYF and ARCC intervened in, and made sense of their interventions into, the social organization of abortion care in the

province. Finally, I demonstrate how activists were not only engaged in political struggles against the state – through efforts to transform the province’s regulatory framework – but were also working outside the province’s public funding model to bring clinic abortion care back to New Brunswick.

Rally for our Right to Accessible Abortion

It was early in the afternoon on Thursday, April 17, 2014. One week had passed since the Morgentaler Clinic announced it was closing due to lack of funding. In those seven days, members from the Fredericton Youth Feminists (FYF) – with help and support from members of RJNB – organized a large demonstration in downtown Fredericton, where hundreds of people gathered outside the New Brunswick Legislative Building to demand the right to accessible abortion care. As I pored over photographs posted to the event’s Facebook page later that day, I was struck by that same “sea of red” that Sorcha Beirne would later describe in our interview: community members in red coats, hats and scarves, their hands clutching red posters, placards with red lettering, and wire coat hangers adorned with notes – many written in red marker – communicating the importance of abortion access in New Brunswick. At the edge of the crowd, a banner read “WE HAVE THE LAW, WE NEED THE ACCESS. #NBProChoice.” This message was at the core of the organizers’ demands. On their Facebook event page, the FYF encouraged attendees to use the language of access when creating signage for the rally. “It’s not so much a pro-life/pro-choice debate (though they are closely related!),” they wrote, “Try to keep your signs focused on access!” The group recommended two key

slogans: “Two doctors = too many, two hospitals = not enough,” and the widely popular “We have the law, we need the access!” These slogans, alongside the hashtag #NBProChoice, soon spread beyond Fredericton, as cities across Canada organized solidarity rallies to demand abortion access for the people of New Brunswick.⁷⁵ In a press release issued by ARCC, Joyce Arthur described how the rallies were “challenging the New Brunswick government to do the right thing – safeguard women’s lives by improving access to abortion” (Abortion Rights Coalition of Canada 2014b). On RJNB’s website, activists urged their supporters to contact New Brunswick’s Premier and Health Minister, to sign the petition demanding funding for the Morgentaler Clinic and the repeal of Regulation 84-20, to write editorials in support of abortion access in New Brunswick, to tweet using the hashtag #NBProChoice, and to submit photographs of people holding signs of solidarity to the NBProChoice web page (Reproductive Justice New Brunswick 2014g).⁷⁶ While the Morgentaler Clinic’s announcement brought visibility to New Brunswick’s access issue and served as a catalyst for activism, the Rally for our Right to Accessible Abortion helped to jumpstart a movement dedicated to transforming the organization of abortion care in the province.

I met Sorcha Beirne in Ottawa more than a year after she helped organize the Rally

⁷⁵ Solidarity rallies were held in Toronto, ON (April 17), St. John’s, NL (April 18), Halifax, NS (April 19), Ottawa, ON (April 26), Montreal, QC (April 26) and Charlottetown, PEI (May 8).

⁷⁶ The petition was created by a handful of social work students as a “social action project.” It was hosted by change.org, and gathered 12,000 signatures by April 14, and 13,790 signatures by the time the petition was closed. The website hosting the petition described how New Brunswick’s abortion law was in violation of both the 1988 Supreme Court decision and the *Canada Health Act*, noting how it “discriminates against all women, especially those of lower socio-economic status, as well as women who are sexually assaulted.” The aim of the petition was to pressure the provincial government “to fully fund abortions at the Morgentaler Clinic in Fredericton, and repeal the provincial law restricting abortion payment (Regulation 84-20, Schedule 2(a.1) of the Medical Services Payment Act)” (Curtis, Opacic, and Mee 2014)

for our Right to Accessible Abortion.⁷⁷ When I asked how she came into the movement for abortion access, she described the strong ties that FYF felt to Simone, who they had established a connection with in the months leading up to the clinic's announcement. "She was this idol to us—she ran the Morgentaler Clinic!" Sorchia told me. When the clinic held a press conference to announce its closure, members of FYF organized a gathering outside to express their support for the clinic. "We managed to get a large group of people within like, twelve hours' notice," Sorchia told me, "And that's why we were kind of like, 'Well, we could probably get a bigger group out and get angry about this!'" (Interview with Sorchia Beirne, 2015). Sorchia began organizing the rally that day:

So, I went home and I posted on the Youth Fem Facebook group – and everyone was at school still, so no one could even respond to me – but basically, "Should we organize a rally? I think we're gonna organize a rally!" And I messaged Hannah, and I was like, "Hannah, I think I'm gonna organize a rally." And she was like, "I think that's a great idea." And I took a nap. I think I made a Facebook group, or a Facebook page, and I took a two-hour nap. And I woke up, and then it was just—it was done. It was just organized. I think five hundred people at the end of the day, or within 24 hours, had said they were planning on coming. Which in Fredericton is bonkers (Interview with Sorchia Beirne 2015).⁷⁸

Like Sorchia, every activist I spoke with who was present at that first rally framed it as somewhat of an anomaly in Fredericton. While the city is home to a fair amount of social and political action, the support that this specific action garnered within the community – and across Canada – brought renewed energy to activists in New Brunswick. While many

⁷⁷ While the April 17 rally was collectively organized by the Fredericton Youth Feminists, many of my research participants described the key role that Sorchia Beirne and Hannah Gray played in planning and executing this action.

⁷⁸ While the final count varies among my research participants, there were reportedly between five hundred and seven hundred people in attendance at the rally on April 17, 2014. It is worthwhile to note that this was the first large-scale demonstration organized by members of FYF.

of my participants were surprised at the level of community support, they also discussed how exciting, empowering, and hopeful it was that “that many people showed up and that many people cared” (Interview with Sorchá Beirne 2015). During my interview with Hannah, she described the rally as “monumental” and “the most empowering day of [her] life” (Interview with Hannah Gray 2015). “And it also changed the language, totally,” she told me, “This was not fighting with the antis anymore” (ibid). This sense of going beyond the “pro-choice versus pro-life” framework theme arose in many of my conversations with activists. This is not about morality or the sanctity of life, they told me. This struggle is about the right for everyone to have access to safe, timely, and affordable abortion care without the fear of shame and stigma, and without the barriers imposed by the province’s *Medical Services Payment Act*. At the rally, this message resonated loudly throughout the crowd, as community members called upon the provincial government to bring New Brunswick in line with the rest of Canada by funding clinic abortions and repealing Regulation 84-20.

In the week leading up to the rally, members of FYF, RJNB and ARCC mobilized people on social media, distributed information on New Brunswick’s access problems, organized speakers, reached out to politicians, and took interviews with local and national media to publicize their action and demands.⁷⁹ With the provincial elections on the horizon, the FYF decided to extend an invitation to each of the provincial party leaders, asking them to speak on behalf of their party at the upcoming rally. This would provide

⁷⁹ The speakers list included Dr. Colleen MacQuarrie, Kathleen Pye, Sorchá Beirne, Marilyn Merritt Gray, Hannah Gray, David Coon (Provincial Green Party Leader), Dominic Cardy (Provincial NDP Leader), Brian Gallant (Provincial Liberal Leader) and Marie-Claude Blais (Provincial Minister responsible for Women’s Equality).

activists with the opportunity to assess each party's stance on the abortion issue, and to "show the difference between the parties who care and the parties who either won't show up, or will show up and make a fool of themselves," Sorchá told me (Interview with Sorchá Beirne 2015).⁸⁰ Out of all four leaders, the Progressive Conservative Premier David Alward was the only one who did not appear at the rally that afternoon. And while the leaders of both the NDP and Green Party expressed their full support for the repeal of Regulation 84-20, Liberal leader Brian Gallant was less clear on his party's stance, calling instead for a "review process" into the barriers imposed by the regulation. His words were met with frustration, as chants of "NOT ENOUGH!" resonated through the crowd, foreshadowing the discord that would soon arise between activists and the Liberal party following the provincial election (Interview with Shona Newton 2015).

As the rally drew to a close, hundreds of demonstrators approached the steps of the Legislative Building, fastening their posters and coat hangers to the gate, which was set out earlier that morning in an attempt to prevent people from entering the building.⁸¹ Images of the gate, overtaken by colourful lettering and harrowing messages clinging to wire coat hangers, circulated across social media as a striking representation of how important this issue was to New Brunswickers. One of several demonstrations held in the aftermath of the clinic's announcement, the Rally for our Right to Accessible Abortion mobilized more support and more bodies than any of my research participants had

⁸⁰ This recalls A.K. Thompson's writings on direct action as "effective research practice and pedagogy," in which political confrontation becomes an active site for the production of knowledge (2006:101).

⁸¹ Sorchá, who also helped organize FYF's counter-rally at the annual March for Life in Fredericton, noted that neither security guards nor gates were present at anti-abortion gatherings in town—though both were in place for the rally on April 17.

expected. For those who had been organizing around this issue for years – including Simone, Judy, Julia and Marilyn – although it was inspiring to watch as a younger generation of activists continued their struggle to bring abortion access to New Brunswick, it was also frustrating that the struggle was still not over. The night before the rally, Hannah received a phone call from Simone, who was gathered in her home with Judy, Julia, and a former physician from the Morgentaler Clinic. “We’re in your corner,” Simone told her, “We’ve been where you’ve been. You’ve got this” (Interview with Hannah Gray 2015). This moment meant the world to Hannah, who had for years drawn inspiration from these women, and the movement they represented (ibid). At the same time, it acted as a visceral reminder of the decades-long struggle over Regulation 84-20 in New Brunswick. For those who had been involved for years, the Fredericton Morgentaler Clinic represented a struggle that was never fully won, despite ongoing resistance in the courts and on the streets. For the newer wave of activists, the clinic’s closure helped to shine a light upon the province’s regressive abortion policies, and acted as a catalyst for further mobilization. Looking back on the April rally, Sorchá considers how much of an impact it had on the social organization of abortion access and activism in the province:

So, I kind of knew that like, people were paying attention, but I didn’t know that the rally itself would have that kind of impact. And I think part of it was that it was very—it reached out to a lot of levels of people. So it was very social media-based, and so a lot of young people jumped on board. Like, a lot. Which is not normal for Fredericton, either. [...] We had reached out to other activist groups. There were a lot of older activists there. [...] And I think the fact that so many people came just made a lot of people realize that this was an important issue, this was a big issue. I think it kind of kickstarted a lot of the activism (Interview with Sorchá Beirne 2015).

As Sorchá describes, the Rally for our Right to Accessible Abortion helped to kickstart a

wave of political resistance to the social organization of abortion care in New Brunswick. Within a week, the organizers of the rally had mobilized hundreds of people to gather in downtown Fredericton, where they demanded the repeal of Regulation 84-20 and the full funding of clinic abortions. This momentum would continue into the coming months, as members of RJNB and FYF organized Twitter campaigns and local rallies, mobilized on social media, and continued to agitate for access to safe, timely and affordable abortion care.

#SaveTheClinic Campaign

Less than three months after FYF organized the Rally for our Right to Accessible Abortion, RJNB launched its #SaveTheClinic campaign. With the Morgentaler Clinic's closure on the horizon, local activists took it upon themselves to ensure that clinic abortion care would remain an option for women in the Maritimes. When I interviewed members of RJNB, several people described how the #SaveTheClinic campaign began as an offhand comment made among friends in the wake of the clinic's announcement. It was a year after Dr. Morgentaler had passed away, and clinic staff, volunteers, and communities members gathered to share stories and commemorate his life and work. They were wrapping up the evening, Alison told me, when someone said, "What if we just tried to raise enough money to buy the clinic? Is that bananas? Is it so crazy that it just might work?" (Interview with Alison Webster 2015). She continued:

So, it was on the heels of this really amazing, supportive night, just thinking about Dr. Morgentaler's legacy. So, we brought it to the collective and we talked to the doctor that is in the clinic now, because they had expressed interest in coming, but couldn't afford to buy a half a million-dollar

building! So it just sort of snowballed and like... before we even really knew what we were doing... we sort of just leapt into it!” (ibid)

On July 4, 2014, RJNB launched its crowdfunding campaign on FundRazr.com, to help

“ensure the people of New Brunswick have access to safe abortion on demand.”

(Reproductive Justice New Brunswick 2014a). In a video posted to RJNB’s website,

Simone Leibovitch and then-chair of RJNB, Kathleen Pye, announced that the collective

hoped to crowdfund enough money to extend the lease at 554 Brunswick Street, and to

establish a new, comprehensive health clinic that would offer a range of services,

including abortion care (Pro-Choix NB Pro choice 2014). The video, which received over

600 views and was circulated across social media platforms, also included an overview of

New Brunswick’s access problems, pointing to the province’s *Medical Services Payment*

Act as a key barrier to abortion care (ibid). “We have a lot of hope,” Simone added near

the end of the video, “We’re doing this because we see this building becoming a very

useful part of the city and of this province, providing a place where women don’t have to

feel ashamed or embarrassed about decisions they have every right to make” (ibid).

Although a clinic would indeed help expand access to abortion care in New

Brunswick, members of RJNB also acknowledged that its establishment was another

“bandaid solution” to the province’s regressive abortion policies. As described on their

crowdfunding site, the new clinic would help to “give the people of New Brunswick a

fighting chance to access their rights under the Charter of Rights [sic] and the Canada

Health Act” (Reproductive Justice New Brunswick 2014a). This idea – that Clinic 554

was a temporary solution to a larger, more systemic problem in the social organization of

abortion care – was present in many of my discussions with activists. While a new clinic

would not transform the province’s regulatory mechanisms, it would help to offset the

crisis of access in New Brunswick, picking up on the important work that the Morgentaler Clinic left in its wake. The success of the campaign would also demonstrate the importance of, and support for, abortion clinics in the province, providing a platform for people across the world to act in solidarity with New Brunswick. Within a matter of weeks, RJNB had successfully raised over \$100,000—enough to enter into a lease agreement with the owner of 554 Brunswick Street, and to begin their plans to establish a health clinic where the Morgentaler Clinic once stood.

As part of their #SaveTheClinic campaign, RJNB organized a rally to decry the provincial government's inaction, demand the repeal of Regulation 84-20, demonstrate the importance of public funding for clinic abortions, and garner support for their crowdfunding initiative. Held on July 18, the #SaveTheClinic rally was smaller than many of my research participants had hoped, with 482 Facebook followers and between 200 and 300 attendees. Still, video footage of the rally captures a series of powerful speeches made before hundreds of enthusiastic attendees in downtown Fredericton (Capitol Films Inc. 2014).⁸² The rally began with a march from the Morgentaler Clinic to the Legislative Building, where community members flooded the streets with signs reading "Save the Clinic," "Repeal 84-20," and "It's Our Right, It's the Law, JUST FUND IT!" while chanting "ACCESS NOW!" and "Hey hey, ho ho, 84-20's got to go!" (ibid). At the legislative building, Sorchá addressed the crowd before opening the floor to each of the provincial party leaders. In her speech, Sorchá reprimanded the provincial government for remaining silent on the issue of abortion access, and for forcing hundreds

⁸² Among the speakers were Sorchá Beirne, Marilyn Merritt-Gray, Federal Green Party Leader Elizabeth May, David Coon, Dominic Cardy, and a Provincial Liberal representative who spoke on behalf of Brian Gallant.

of people across Canada to stand up for New Brunswickers' rights to abortion care:

\$100,000 out of our own pockets trying to fund access to abortions. That's not our job, that's the government's job, according to constitutional law and according to the Canada Health Act. And we're going to say it over, and over, and over, until we make change! ... We're going to change access in New Brunswick because we *have to*! We have the law, we need the access! (Sorcha Beirne, quoted in Capitol Films Inc 2014).

Sorcha's passion resonated through her speech, as she directed attention to the unrelenting work of activists, advocates and community members who were fighting for social change in the face of government silence and inaction. It had taken the collective work of people across the country to help fund abortion access in New Brunswick—a responsibility that the government had abandoned, despite stipulations set into place by the *Canada Health Act* and the 1988 Supreme Court decision.

Like Sorcha, Marilyn Merritt-Gray also criticized the provincial government's inaction in her rally speech, calling upon community members to stand up against the province's restrictive regulatory framework:

This is my province and your province and we need to work together to repeal 84-20! But we need to go beyond that! [...] My vision of New Brunswick doesn't match at all what Premier Alward and Minister Flemming's is [...] Reproductive health is a basic, fundamental, core element of women's and family's health. This province is failing us (Merritt-Gray, quoted in Capitol Films Inc. 2014).

When I spoke with Marilyn about her speech, she described how she intentionally emphasized the power of collective action and the strength of women seeking abortion care. She told me how she refused to believe that New Brunswick was a backwards province. While much of the population is indeed conservative and religious, positioning the entire province as backwards contributes to the erasure of communities that are working to resist and transform structures of oppression and inequality in New

Brunswick. Rather than focus on New Brunswick's "backwards" identity, Marilyn told me, we should focus on the influence of people in power, what their traditions and views are, and "how tightly controlled things are politically and within the health system" (Interview with Marilyn Merritt-Gray 2015). In her speech, Marilyn countered this narrative by declaring the power of resistance and the strength of collective action: "We are strong and powerful, and we want change [...] Say it with me: *I have power!*" (Marilyn-Merritt Gray, quoted in Capitol Films Inc, 2014). When Marilyn said this, she told me, she was also pointing toward the strength of women who seek abortion care, rupturing the victimizing narrative that pro-choice activists often fall into:

As RJNB, we had started a message around poor or disadvantaged or vulnerable women. So, that image of women being weak, it's just not my own personal experience with looking after women in recovery. The whole violence against women area has taught that that messaging – when we start with the victim – is not constructive. It's a social construction and it doesn't serve women well. And it really doesn't, you know, the qualitative work is about survival and reclaiming, so it's a story of strength, really, and resistance." (Interview with Marilyn Merritt-Gray 2015)

By refusing these narratives – of New Brunswick as backwards and of abortion-seeking women as victims – Marilyn, like others I interviewed, seek to move beyond ideological or speculative accounts of the social world, to instead interrogate the complicity of the provincial government and the medical community in denying equal access to healthcare. While it is important to identify how markers of inequality shape access to abortion, activists' decision to emphasize women's strength and resistance can be understood as a practice of reclaiming agency and empowerment in the face of state-mandated reproductive control.

When the #SaveTheClinic campaign ended on September 25, RJNB had received \$131,366 from 1,506 contributors—enough to cover the costs of the lease while

continuing to agitate for the repeal of Regulation 84-20 (Reproductive Justice New Brunswick 2014a). As several of my research participants mentioned, donations began to skyrocket on the heels of Elizabeth Renzetti's *Globe and Mail* article published on July 14. In it, Renzetti exposed New Brunswick's access problems, decried Liberal Leader Brian Gallant's call to "review" Regulation 84-20, and enthusiastically promoted RJNB's fundraising campaign—all on a national media platform. "Right now," Renzetti wrote, "in a country where all provinces and territories (and the people in them) are supposed to be equal, the women of New Brunswick are distinctly second-class citizens when it comes to controlling their biological destinies" (Renzetti 2014). The response was immediate. According to Simone, RJNB raised more than \$60,000 the day after that article was published. Jaden, too, remembers how fast the donations started to pour in:

And then Kathleen did that *Globe* interview during our #SaveTheClinic campaign, and it just blew up [...] I had to work that night and I didn't end up going in, because I stayed up all day just texting and watching. Like, "It went up by \$5,000! It went up by \$2!" And then it hit \$100,000 and we were just flooded. (Interview with Jaden Fitzherbert, 2015).

This was an exciting and emotional time for activists. Below, Alison describes what it felt like to see all of the donations and words of encouragement from people across Canada:

The outpour of support that we got was just *amazing*. I mean, the highlight of my life, for sure. Friends, strangers, people literally all over the country, you know? Like, a five-dollar bill coming in an envelope with a note saying, "I wish I could give more." Like, ah! I could just cry about it again (Interview with Alison Webster, 2015).

Whenever I speak with activists about the #SaveTheClinic campaign, our conversations often revolve around direct actions and fundraising—the rally, the gala, the social media

presence.⁸³ Each time I hear people recount these stories, I also notice this familiar sense of awe, accomplishment and empowerment resonating through their words. Throughout my interviews, many activists described how proud and empowered they were to have been part of the #SaveTheClinic campaign that summer. Within months, and in the face of government inaction, a small group of grassroots activists had brought national attention to the crisis of abortion access in New Brunswick, and had coordinated a successful fundraising campaign to help establish a new clinic to fill the gap in access left behind in the Morgentaler Clinic's wake. Jaden elaborates on this below:

Who thought that anyone would want to give a bunch of feminists a hundred grand to save a clinic in rural New Brunswick, right? Everyone across Canada kind of stood up, and they did the job that the government hasn't been doing, and still isn't doing. [...] The activists who were on the ground did amazing work. And it's all because of them (Interview with Jaden Fitzherbert 2015).

From mobilizing the public to organizing demonstrations; from taking media interviews to maintaining a social media presence; from initiating the fundraising campaign to monitoring the donations; from negotiating with the landlord to contacting a new physician—none of these actions would have been possible without the hard work of feminist, pro-choice activists and the support of their allies. Yet while these events

⁸³ As part of the #SaveTheClinic campaign, the FYF and RJNB organized a Pro-Choice Gala, held at the Crowne Plaza on the evening of July 25. The gala was a black-tie event, with live music, dancing, a vegetarian meal and a silent auction. Tickets were \$60 each. In my interview with Jaden, she described how David Coon and Dominic Cardy each bought tables for the event, and how people from across Canada were wiring money to fund tickets for those who could not afford them, including several members of RJNB and the FYF (Interview with Jaden Fitzherbert 2015). When I spoke with Sorchá about the Gala, she recalls having raised approximately \$5,000 that evening. "But it was also kind of like, a way [...] to celebrate all of the work that had been put in," she added, "I mean, we were raising money and we got people to speak a little bit, but mostly it was just a fun night for people who had worked so hard over the last few months" (Interview with Sorchá Beirne 2015).

certainly demonstrate the strength and capacity of activists – as well as their integral role in expanding access to abortion throughout Canada’s history – they also help to illustrate the provincial governments’ complicity in regulating and restricting access to abortion services post-1988. As Abbie Moser told me during our interview, though it was exciting to see the support for the #SaveTheClinic campaign, it was also distressing to know that in 2014 – nearly three decades since abortion was decriminalized in Canada – activists were still forced to take it upon themselves to ensure access to abortion (Interview with Abbie Moser 2015). This sense of frustration was reflected in many of the comments made by donors on the crowdfunding website. As one person wrote, “Just doing individually what a caring and just government would have made unnecessary” (Anonymous, 17 July 2014). Another comment notes that it is “Embarrassing that private support is necessary for what should be public access, and that our system is so clearly discriminating against women” (Anonymous, 15 September 2014).

In my interview with Max Arsenault of Clinic 554, he described the #SaveTheClinic campaign as “one of the most successful fundraising campaigns in [Canada’s] history” (Interview with Max Arsenault 2015). As I sit here writing this chapter, Jaden Fitzherbert has just posted a three-year anniversary memory to her Facebook page: “The day our fundraising campaign to save Fredericton’s abortion clinic reached \$100,000 will forever go down as one of the best days of my life [...] I will forever be thankful to all the amazing people who donated and all the amazing people who I worked with on this. I still can’t believe we did this” (Jaden Fitzherbert 2017). Sitting on the same corner of Brunswick Street as the Morgentaler Clinic, Clinic 554 has, since January 2015, continued to provide abortion care one day a week as part of its

patient-driven, sex-positive, gender-celebratory, anti-racist and feminist model of care (Clinic 554 n.d.). Today, clinic abortion care remains in New Brunswick due to the dedication of feminist, pro-choice activists who refused to see access to abortion deteriorate across the province. As the #SaveTheClinic rally demonstrated, activists in New Brunswick worked both within and outside of the province's regulatory framework, by lobbying for the repeal of Regulation 84-20 while also organizing for the establishment of a new, health clinic where the Morgentaler Clinic once stood.

A Shift in New Brunswick's Abortion History: Access, Elections & Regulation 84-20

In the final section of this chapter, I explore how activists in New Brunswick helped make abortion access a key issue in the 2014 provincial elections, and how their lobbying efforts – combined with pressure exerted by several leaders in the political and medical community – helped to facilitate incoming-Premier Brian Gallant's commitment to remove barriers to abortion access in the province. While this indeed signaled a major shift in New Brunswick's abortion history, I demonstrate that Gallant's move to amend, rather than repeal, Regulation 84-20 enabled the government to remove *some* barriers to abortion access, while simultaneously upholding public funding restrictions for abortions provided in clinic settings. I conclude with a discussion of how members of RJNB, FYF and ARCC have made sense of the amendment to Regulation 84-20, as well as the impact this has had on activists' terrain of struggle.

Political Pressure & Provincial Elections

With the provincial elections on the horizon, activists moved quickly to turn New

Brunswick's access problem into a key election issue. Shortly after the Morgentaler Clinic made its announcement, activists began lobbying the provincial government, urging people to contact their local MPs, as well as Premier David Alward, Health Minister Ted Flemming, and Federal Health Minister Rosa Ambrose, to demand a commitment to expanding abortion access and repealing Regulation 84-20 in New Brunswick. In May, RJNB launched a month-long Twitter campaign to apply pressure to provincial party leaders, and to demonstrate the government's complicity in supporting and upholding the province's anti-abortion "status quo" (Reproductive Justice New Brunswick 2014e).⁸⁴ Over the course of several months, activists in New Brunswick lobbied the provincial government and party leaders; extended invitations for them to speak at direct actions and fundraising events; demanded that organizations hosting the provincial leaders' debates include questions related to abortion access; distributed an all-candidates survey to assess each party's support for abortion access in the province; and engaged in creative acts of political resistance both on the ground and via social media. In September, for instance, FYF launched their #VoteforAccess campaign on social media, featuring images of New Brunswick youth holding signs with powerful messages, such as "#VoteForAccess Because: Lives Depend on It," and "#VoteforAccess Because: I Can't" (Fredericton Youth Feminists 2014). As part of their campaign, members of FYF hung banners around downtown Fredericton reading "ABORTION ACCESS NOW," "VOTE FOR ACCESS," and "REPEAL 84-20."⁸⁵ In another demonstration, members of RJNB

⁸⁴ For instance, in the first week of their Twitter campaign, members of RJNB targeted the twenty-three New Brunswick MLAs who were present at the annual March for Life in downtown Fredericton.

⁸⁵ As Abbie Moser described in our interview, members of the FYF were featured on CTV for this action, and were nearly fined \$25,000 for posting a "political banner" during the provincial

gathered outside the Liberal party campaign launch in Fredericton, holding an “Abortion Access Now” banner and carrying signs with messages such as “No Vague Promises!,” “Show us Your Repeal Timeline!,” and “Counting on You, Brian [Gallant]” (RJNB blogroll, 25 August 2014), in a reference to Gallant’s call for a “review” of the province’s abortion restrictions.⁸⁶ At the same time, members of RJNB and the FYF were continuing to educate the public on what Regulation 84-20 meant for abortion access in the province. On September 12 – ten days before the election – they released a collaborative video breaking down the ways that Regulation 84-20 violated federal law. In it, they encouraged supporters to “know your rights, know your candidate’s stance, and vote!” (Reproductive Justice New Brunswick 2014b).

While activists were engaged in political agitation on the ground in New Brunswick, many members of the medical and political community were also helping to apply pressure to party leaders by advocating – both federally and provincially – for changes to the province’s public funding model. In May, for example, then-Health Minister Ted Flemming received letters from the New Brunswick Medical Society (NBMS) and the Society of Obstetricians and Gynaecologists of Canada (SOGC), which strongly recommended the removal of the province’s “two-doctor rule” and the provision of public funding for clinic abortions (Murdock and Blake 2014). As NBMS President Lynn Hansen wrote, “Our national policy specifies various points, some of which are not

campaign. While the group was ultimately not fined for their action, the contention surrounding their political activity led the administration at Saint Thomas University to ban the FYF from participating in a university-wide event on campus (Interview with Abbie Moser 2015).

⁸⁶ During my interview with Jaden Fitzherbert, she described how activists were banned from displaying their signs inside the event: “If we wanted to go in, we were not allowed to take in our signs, even though we had all pre-registered. So we sent a couple people in without their signs, and the rest of us stayed outside and talked to the media” (Interview with Jaden Fitzherbert 2015).

aligned with New Brunswick's regulation [...] We believe the current provincial system is at odds with what is recommended by the nation's doctors" (Hansen 2014:1). In an open letter addressed to then-Federal Health Minister, Rona Ambrose, several members of the Federal Liberal Party – including Dr. Hedy Fry (Liberal Health Critic), Carolyn Bennett (Liberal Women's Caucus), and Dominic Leblanc (Liberal House Leader) – condemned the provincial government's regulatory structure for potentially contravening the Canada Health Act (CHA), and requested that Minister Ambrose initiate a Dispute and Resolution process (DAR) to bring safe, timely and affordable access to the women of New Brunswick (Fry, Bennet, and Leblanc 2014). Similarly, members of the Federal NDP – including Libby Davies (NDP Health Critic) and Niki Ashton (Status of Women critic) – urged Minister Ambrose to work with the New Brunswick government to expand access to abortion care in the province, and to act quickly to ensure the enforcement of the CHA in New Brunswick as well as Prince Edward Island (New Democratic Party of Canada 2014). Meanwhile, as representatives across Canada were calling upon provincial and federal leaders to rethink New Brunswick's abortion regulations, Federal Liberal leader, Justin Trudeau, announced in early May that all Liberal MPs – regardless of their personal stance – would be expected to vote pro-choice on any legislation concerning abortion (Payton 2014).⁸⁷ While feminist, pro-choice activists were leading the discourse around abortion access in New Brunswick, their concerns – and, in many cases, demands

⁸⁷ It is worthwhile to note that Justin Trudeau's pro-choice stance has been met with cautious optimism by pro-choice feminists across Canada. For instance, while the federal government has undertaken measures to improve global access to reproductive health – such as the March 8, 2017 announcement that Canada would be contributing \$650 million over three years in funding for sexual and reproductive health and rights (Government of Canada 2017) – many members of RJNB continue to criticize the Trudeau Liberals for neglecting to hold the Gallant Liberals accountable for upholding funding restrictions for abortions provided in clinic settings.

– were bolstered by the support of political and medical leaders across the country, helping to apply pressure to party leaders and voters alike as the provincial elections drew nearer.

When I travelled to New Brunswick to conduct interviews, nearly a year had passed since the 2014 provincial elections. Through my conversations with activists, I learned that out of all four party leaders, the only two who expressed a firm commitment to repealing Regulation 84-20 were David Coon (Green) and Dominic Cardy (NDP). Since 2014, both leaders have been key allies in the struggle to expand abortion access in New Brunswick. They have spoken at rallies, donated to the #SaveTheClinic campaign, collaborated with activist initiatives and campaigns, and advocated among political leaders for the repeal of Regulation 84-20.⁸⁸ In fact, Marilyn-Merritt Gray volunteered for David Coon throughout the provincial election, acting as the point person on issues related to abortion access for the Green Party’s campaign. During our interview, Marilyn described how she and David worked together to ensure that the party platform clearly stated that the Greens stood in support of expanding access to abortion in New Brunswick. She continued:

[We wanted to] articulate that in the platform so that, you know, it’s part of that printed, public record. And I didn’t realize this at the time, but none of the parties actually did that. They said they’d be “pro-choice” or that they planned to facilitate those rights, you know, or enhance women’s access to “appropriate care,” but did not use the word “abortion” (Interview with

⁸⁸ In May 2016, for instance, David Coon presented RJNB’s petition to fund clinic abortions in front New Brunswick’s Legislative Assembly. The petition requested that provincial MLAs “support increased access to abortion services” by “repealing s.2.01(b) of the NB Medical Services Payment Act” and fund clinic abortions in community settings, beginning with Clinic 554 (Reproductive Justice New Brunswick 2016).

Marilyn Merritt-Gray 2015).

Indeed, while both the NDP and Green Party platforms include a commitment to repealing Regulation 84-20, the word “abortion” does not appear anywhere in the NDP platform, which instead describes the regulation as a barrier to “a woman’s right to choose” (New Brunswick New Democratic Party 2014:16). While this point was not raised by any of my other research participants, it remains a significant indicator of the ongoing stigmatization of abortion in New Brunswick, and of the resulting caution by political party leaders in the province. Meanwhile, the Liberal Party platform included reference to neither Regulation 84-20 nor abortion, and instead identified their commitment to “respect the Supreme Court of Canada and the rule of law” by “identify[ing] all barriers to a woman’s right to choose and eliminat[ing] them” (New Brunswick Liberal Party 2014:29).⁸⁹ As I illustrate in the final section of this chapter, this stance – first announced by Gallant at the Rally for our Right to Accessible Abortion in April – helped to situate Gallant as a “pro-choice candidate,” while also enabling him to circumvent a commitment to funding abortions provided in clinic settings.⁹⁰

⁸⁹ Candidates’ hesitancy around the issue of abortion access was further demonstrated by the results of RJNB’s All Candidates Survey on Reproductive Health, which asked candidates whether they would support the repeal of Regulation 84-20, and whether they would support the expansion of reproductive health care clinics providing publicly funded abortion care in community settings. While the majority of NDP and Green candidates responded in favour of both questions, many PC and Liberal candidates refused to respond to the survey—including David Alward, Brian Gallant, and Victor Boudreau (now-Health Minister of Gallant’s Liberal government in New Brunswick). Opting not to respond to the survey, Gallant instead emailed RJNB and Tracy Glynn to reaffirm his party’s position on identifying and removing barriers to ensure women’s right to choose in New Brunswick (Reproductive Justice New Brunswick 2014d).

⁹⁰ The pro-choice identity was one that Brian Gallant claimed for himself earlier that summer, when promising to “remove barriers” to access, and pledging that all 48 Liberal candidates running in the election would support and respect a “woman’s right to choose” in New Brunswick (Poitras 2014; Sims 2014). While Gallant’s pro-choice mandate was met with cautious optimism among feminist and pro-choice activists, it was met with hostility among anti-choice factions in

Two days before the provincial elections, cities across the country held rallies for the National Day of Action in Solidarity with New Brunswick and PEI: Equal Access Now! – organized by members of ARCC, together with local activists – to help bring visibility to the ongoing access problems facing women in Atlantic Canada. Once more, people across Canada were standing up to demonstrate their support for the struggles facing women in New Brunswick. The importance of these rallies is perhaps best summed up by Peggy Cooke, renowned pro-choice activist and former clinic escort at the Fredericton Morgentaler Clinic:

When I was living in New Brunswick and working at the clinic, you sometimes feel like you're alone and not a lot of people across the country know what's going on there. Now that people do, it's really important for people in the Maritimes to know people across the country are pulling for them (as quoted in Hodge 2014).

As suggested earlier, this theme – of people across Canada standing in solidarity with New Brunswick – arose throughout my conversations with activists. Many of my research participants described how appreciative they were of the far-reaching support they felt for their work—from the success of the #SaveTheClinic campaign to the many publications, blog posts and social media shares that helped place New Brunswick's access issues on a national platform. On the morning of September 22, I watched as my Twitter feed was overtaken by expressions of support and solidarity for New Brunswick residents as they headed to the polls—the words #NBProchoice and #VoteForAccess punctuating tweets by activists, advocates, allied organizations like OCAC (Ontario

the province. For instance, in the days leading up to the election, anti-abortion activists in Moncton and Fredericton distributed graphic pamphlets featuring an exaggerated image of what was claimed to be a five-month-old aborted fetus, along with the message “A vote for Brian Gallant and the Liberals is a vote for this” (Robinson 2014).

Coalition for Abortion Clinic) and LEAF (Women’s Legal Education and Action Fund), news sites like rabble.ca, and political leaders such as Niki Ashton and David Coon.

Unofficial election results were announced the next day: the Liberals had won with 42.7% of the vote—outracing the Conservatives by a margin of 8.1% (McHardie 2014).⁹¹

On September 24, Gallant’s officials announced they had already begun to assemble a committee of experts to review how best to expand abortion access in the province (Taber 2014). At RJNB’s collective meeting that evening, many members discussed their concerns with Gallant’s commitment to “review” barriers to access—a process they feared would delay the repeal of Regulation 84-20, as well as efforts to expand regional access to services. In response, activists spent the next few weeks monitoring the incoming government’s actions on abortion access, while continuing to apply political pressure for the immediate repeal of Regulation 84-20. During this time, members of RJNB were also arranging for the establishment of what would soon become Clinic 554, including managing the collective’s bank account and #SaveTheClinic funds, creating a contract between RJNB and the new physician, and drafting media releases, statements, and messaging for the clinic’s announcement. As many of my research participants have suggested, while the provincial government was reviewing how best to deal with the abortion issue, activists were implementing collective, grassroots solutions for expanding access to timely, affordable, and patient-centered abortion care.

⁹¹ While the NDP received 13% of the votes in the 2014 elections, the Green Party staggered behind at 6.6% (McHardie 2014). However, the 2014 elections signaled a historic electoral win for Green Party Leader David Coon, whose Fredericton South riding has consistently voted Liberal or Conservative. This was met with enthusiasm on behalf of feminist, pro-choice activists, who have gone on to collaborate with the MLA on a number of campaigns related to abortion access and reproductive justice.

Brian Gallant, Regulation 84-20 & Activists' Response

On November 26, 2014 – nearly four months after the Fredericton Morgentaler closed its doors – the provincial government announced its plans to expand abortion access in New Brunswick: “We have identified the barriers,” Brian Gallant stated before the press, “and are proceeding to eliminate them in order to respect our legal obligations under the Supreme Court of Canada ruling and the *Canada Health Act*” (quoted in Government of New Brunswick 2014a). The four barriers identified in the provincial government’s press release were as follows: 1) the two-doctor rule and specialist requirement imposed by Regulation 84-20; 2) problems with “timeliness of access” to abortion care; 3) issues surrounding the availability of “accurate and non-judgmental information” regarding abortion; and 4) the health system’s capacity to expand abortion services in the province (ibid). As a solution to these barriers, the government announced that it would be amending Regulation 84-20 effective January 1, 2015, and that officials would be working closely with the province’s two regional health authorities (RHAs) to “increase capacity and improve timeliness of access” in hospitals (ibid).⁹² Media coverage of Gallant’s announcement overwhelmingly framed this as a major victory for reproductive rights, describing how the Premier had finally “scrapped,” “lifted,” or “repealed” New Brunswick’s restrictive abortion regulation (Abortion Rights Coalition of Canada 2014a; Aslin 2014; CBC News 2014d). But while some considered this a major success for the movement, others remained skeptical of the government’s commitment to

⁹² As the next chapter makes clear, this latter step was actualized through Horizon Health Network’s expansion of abortion services within The Moncton Hospital (TMH).

eliminating “all barriers” to abortion access in the province. On the one hand, the political pressure exerted by activists, advocates and allied service providers was successful: the provincial government was making concrete moves to improve abortion access in New Brunswick. At the same time, the government’s announcement did nothing to address the problem of public funding for clinic abortions—a demand that had been central to feminist, pro-choice activism in the province for decades.⁹³

During my interviews, I asked members of RJNB, FYF and ARCC to respond to the provincial government’s amendment to Regulation 84-20. These discussions frequently revealed activists’ frustrations with the Gallant Liberals for creating the optics of a government that was pro-choice, progressive, and amenable to activists’ demands, while simultaneously leaving the province’s status quo for clinic abortions firmly intact. Beyond failing to remove all barriers to abortion access, Gallant’s announcement – and subsequent media coverage – led much of the public to believe that New Brunswick’s access problems had been solved. Alison expands upon this below:

So, a lot of people, especially those who traditionally voted and supported the Liberal party, were like “Yes! We won! This is amazing! We did a great job! Phew!” you know? But for those of us that are a) involved with the clinics directly, and b) that were really reading what the changes were, not just like “Oh, they made this great announcement, woo!” it was pretty clear to us that it really wasn’t going to change too much on the ground [...] It was clear that they weren’t budging on the clinic issue, which to me, and

⁹³ As outlined in Chapter 4, Schedule 2 (a.1) of Regulation 84-20 requires that abortion only be considered an “entitled service” under Medicare when “performed in a hospital facility approved by the jurisdiction in which the hospital facility is located” (New Brunswick Medical Services Payment Act, 2015). A similar restriction is coded into Chapter M-7, Section 2.01 of the *Medical Services Payment Act*, which restricts Medicare payments for “entitled services furnished in a private hospital facility in the province,” (ibid). Today, both regulations remain intact despite ongoing lobbying by activists in New Brunswick.

many other people in RJNB, was really the heart of what we were asking for, because it's better for patients (Interview with Alison Webster 2015).

While many people – including activists – were happy that the government was finally making moves to expand abortion access in New Brunswick, those who were involved in the movement knew that the struggle over clinic abortions was not over. As Tracy told me during our interview, activists “knew that [it] was going to be another battle” (Interview with Tracy Glynn 2015). The demand for publicly funded clinic abortions was, as Alison suggests above, “at the heart” of what RJNB, FYF and ARCC were asking for. Indeed, these were the provisions of the *Medical Services Payment Act* that forced hundreds of women to pay out-of-pocket for abortion care each year, setting into motion an unsustainable model of subsidizing services for low-income patients. As I have shown, although the clinic's closure resulted in a crisis of abortion access in the province, it also helped catalyze the movement to expand abortion access, while also bringing visibility to the province's restrictive regulatory framework. While this movement indeed brought about substantial changes to the social organization of abortion in the province, the government's piecemeal amendment to Regulation 84-20, as so many of my participants have suggested, upheld the province's status quo while also weakening the momentum that activists had worked so hard to generate. As Hannah described during our interview, rather than an ally in the struggle, the provincial government continues to be a “huge barrier” to ensuring safe, timely, and affordable abortion access in the province. “And they know what they've done,” Hannah continued, “They know they've created a law that's harder for us to fight. And created like, a semblance of access, so that it's harder for us to educate people on” (Interview with Hannah Gray 2015). By amending Regulation 84-20, the Gallant Liberals successfully positioned themselves as committed

to removing barriers to abortion, while simultaneously upholding regulations banning public funding for clinic abortions. Alongside the success of Clinic 554, the provincial government has ushered a return to the status quo in New Brunswick, where clinic abortions are available yet ineligible for public funding. Together, these acts have, as Hannah described, provided New Brunswick with a semblance of access, and the optics of a provincial government that finally transformed the organization of abortion care.

Conclusion

As I conducted research for this project, I was struck by the similarities that I saw arising between contemporary pro-choice organizing in New Brunswick and that which has come before in Canada. As I have shown, abortion clinics have and continue to be central to movements centered on expanding access to abortion. Both historically and today, feminist activists have constructed abortion clinics as at once medical spaces providing warm, compassionate, and medically necessary care, as well as symbolic spaces that act as rallying points for political organizing against the status quo. My research participants frequently spoke of the important role that the Fredericton Morgentaler Clinic played in New Brunswick, both as a service provider and a hub for community gatherings and information on sexual and reproductive health. When the clinic closed, it gave way to a crisis of access in New Brunswick. As this chapter demonstrates, it is because of the work of activists that that crisis is no longer as dire as it was during the spring and summer of 2014. Through their fundraising and organizing efforts, activists helped bring clinic abortions back to New Brunswick. While this was an important win and an example of the incredible power of collective action, the fight for

abortion access is not over in New Brunswick. As many of my participants told me, the establishment of Clinic 554, though a necessary and important win, is simply a band aid solution for the broader, systemic problem in the social organization of abortion in the province. The tensions between the push for immediate solutions to the crisis of access, and structural change in the textually mediated social organization of abortion, points toward another consistency between past and contemporary formations of pro-choice feminist organizing in Canada. Then as now, the establishment of abortion clinics was central to providing concrete access to services. And while historically such clinics operated outside the TAC system, and ultimately aided in the decriminalization of abortion in Canada, Clinic 554 continues to operate outside of New Brunswick's public funding model, rendering its services inaccessible to large portions of the population. As I learned through my research, the upholding of Regulation 84-20 was in part due to the crisis in which activists found themselves: struck with a crisis, activists were forced to make quick decisions about what to prioritize, and how to get their messaging out to the public. As a result, activists accomplished major successes in the reorganization of abortion services in New Brunswick, though the broader project to ensure funding for clinic abortions remains to be won.

When I spoke with activists about the scope of their struggle, they were explicit about fighting not for abortion rights, but for abortion access. During these conversations, activists often made connections between their definition of access and the broader framework for reproductive justice. Access, many told me, helps to unravel how complex the ability to obtain abortion care can be in New Brunswick, especially among those who experience multiple social relations of inequality. Activists would frequently speak of

access in terms of creating the necessary enabling conditions to ensure that people are able to obtain safe, timely, and abortion care in a context that makes sense for them, their families, and their communities. Activists tended to talk about access as a dynamic, open and ongoing process attuned to people's everyday lives, rather than a static and quantifiable goal to achieve. However, the richness of this definition tended to get lost in activists' organizing, which importantly focused around maintaining clinic care, repealing Regulation 84-20, and expanding the regional distribution of services, as I continue to unravel in the next chapter. This directs us toward two important and interrelated findings. First, the slippage between activists' definition of access and their use of the reproductive justice framework caused tensions within the movement. Second, this same slippage in part enabled the newly elected provincial Liberals to co-opt the language of access, hollowing it out to fit within their political agenda. For the provincial government, achieving access became a matter of amending Regulation 84-20 rather than repealing it, and, as I show in the next chapter, working with the province's regional health authorities to expand hospital abortion services. This co-optation helps to reveal a line of fault between the provincial government's representation of abortion access, and the ways in which abortion access is understood and experienced by activists, service providers, and, most importantly, patients. While the provincial government continues to affirm its commitment to women's "right to choose" (CBC News 2017), the decision to uphold Regulation 84-20 clearly demonstrates the government's complicity in maintaining the province's two-tiered approach to abortion service provision.

Finally, this chapter, as well as the one that follows, helps to demonstrate the important role that activists have played in developing concrete, evidenced-based

solutions for transforming the social organization of abortion in New Brunswick. Historically, feminist pro-choice activists have been central to efforts to expand access to abortion for people on the ground. In New Brunswick, it was activists who made possible the establishment of Clinic 554. It was also activists who fought to make abortion a key issue in the 2014 provincial elections. Activists are the ones who lobbied for change, and who pushed the provincial government into action. As I argue in this dissertation, if policymakers wish to create policies that reflect the diverse needs of women who seek abortion care, then it would be useful for them to engage in meaningful dialogue with feminist pro-choice activists, as well as other key stakeholders such as patients, service providers and community leaders. Additionally, despite tensions over co-optation and “living up to their name,” many of the activists that I spoke with are making important connections between reproductive justice, systemic inequalities and abortion access. The analyses that my participants have developed around abortion and reproductive justice can provide significant insights into the experience of accessing an abortion in the province, and would likely prove useful in the development of policies that enable people to actually obtain the services and information they need. Rather than hollowing out activists’ demands for access, the provincial government would do well to learn from the approaches that activists are taking in their work for change. In the next chapter, I explore how activists in New Brunswick have continued to struggle over the province’s semblance of access, unraveling the many barriers that remain under the province’s public funding model.

Chapter 6: Semblance of Access & Optics of Change: Reexamining New Brunswick's Public Funding Model

Introduction

As I write this in January 2018, it has been more than three years since Premier Brian Gallant announced that his government would be removing all barriers to abortion access in New Brunswick. As demonstrated in the previous chapter, this announcement came on the heels of a concerted grassroots movement to resist, reshape, and ultimately transform the social organization of abortion care in the province. During this time, feminist pro-choice activists, together with their allies, brought international visibility to the province's access problems; helped to make abortion a major issue in the province's upcoming elections; and successfully coordinated a fundraising campaign to bring clinic abortion care back to New Brunswick. In response to activists' demands for expanded access, the provincial government has since removed the two-doctor and specialist requirements from Schedule 2(a.1), Regulation 84-20 of the *Medical Services Payment Act*, and has worked with Horizon Health Network, one of the province's two regional health authorities, to bring abortion services to The Moncton Hospital. Yet although the landscape of abortion care has indeed expanded, the procedure continues to be restricted by two provisions in New Brunswick's *Medical Services Payment Act*, both of which exclude clinic abortions from the province's public funding model. In this chapter, I explore how activists in New Brunswick have continued to mobilize for the repeal of Regulation 84-20, while also advocating for the improvement of abortion care within the province's providing hospitals. Central to this discussion is the provincial government's mobilization of the optics of being committed to expanding access to abortion in the

province, while simultaneously upholding the very restriction that led to the Morgentaler Clinic's closure in 2014.

Since the re-emergence of the feminist pro-choice movement in New Brunswick, activists have consistently constructed abortion clinics as essential components to New Brunswick's health system, and as fundamental to any project for reproductive justice in Canada. As I have argued earlier in the dissertation, the scope of activists' struggle in New Brunswick must be understood within its historical context. Since 1988, feminist pro-choice activists have largely centered their struggle on the regional availability of abortion services, the coverage of clinic abortions under provincial and territorial insurance plans, and the ability for people to access safe, timely, affordable, and non-judgmental care within their communities. In New Brunswick, these struggles have overwhelmingly been located within and against the province's *Medical Services Payment Act*, which restricts publicly funded abortion services to hospital settings. However, in response to the provincial government's commitment to expanding abortion services within the province's hospital system – as well as its ongoing refusal to fund abortions provided in clinics – the activists with whom I have researched have recently shifted much of their attention toward the quality of care provided within the province's hospitals, while also addressing the access barriers produced by the province's hospital-only model. As I demonstrate in this chapter, this strategy, of demanding reforms within the province's hospital-only system, while also seeking to transform that system through the repeal of Regulation 84-20, has created significant challenges for activism. While advocating for the removal of barriers within the province's hospital system is indeed an important strategy for expanding access to safe, timely, and affordable abortion care, it

has had the added effect of shifting public attention away from New Brunswick's regulatory framework, as activists have been forced to divide their mobilization efforts between two distinct spheres. As a result, New Brunswick's regulatory framework has fallen further into the background of the public imaginary, contributing to what activists have referred to as the "semblance of access" in the province, as well as the "optics of change" on behalf of the provincial government.

This chapter is organized into three sections, each of which helps to illuminate the challenges that activists continue to confront in their struggle to expand abortion access in New Brunswick. The first section offers a brief sketch of New Brunswick's public funding model for abortion care. Here I begin to unravel the complex network of institutions that coordinate the social organization of publicly funded abortion care in New Brunswick, highlighting the expansive bureaucratic line of command that activists have encountered throughout their work. In this same section, I provide a brief overview of Horizon Health Network's decision to expand abortion services to The Moncton Hospital, and explore why activists consider this to be an insufficient solution to expanding access to hospital services in the province. In the next section, I offer critical insights into several of the barriers that activists have identified within New Brunswick's hospital-only system for abortion care, including multi-week wait times, early gestational limits, and the requirement that patients attend multiple appointments for a single procedure. In the final section of this chapter, I summarize activists' ongoing concerns regarding the regional distribution of abortion services in the province, situating these alongside activists' demands for safe, timely, and affordable access to abortion care. In closing, I suggest that although activists' struggle over clinic abortions has been stifled by

the government's decision to uphold New Brunswick's remaining abortion policies, their work to expand access within the province's public funding model provides important insights and lessons for future (and, indeed, ongoing) efforts to transform the social organization of abortion in the province.

A Brief Sketch of New Brunswick's Public Funding Model for Abortion Care

Tracing the Institutional Coordination of Hospital Abortion Services in New Brunswick

As I have shown, the landmark Supreme Court decision in *R v. Morgentaler* (1988) effectively transferred the regulation of abortion from a matter of federal criminal law to one of provincial and territorial health policy. While formally mediated by the *Canada Health Act* (CHA), the allocation and provision of abortion services – like other medically necessary procedures – falls under the jurisdiction of provincial and territorial health departments, regional health authorities, medical associations and local healthcare facilities. This web of institutional relations coordinating abortion services has led to the current “patchwork” landscape of abortion in Canada, with access to the procedure varying widely among provinces, territories, and regions (Eggertson 2001; Haussman 2015; Johnstone 2014; Johnstone and Macfarlane 2015). As a health procedure, abortion is mediated broadly by provincial and territorial health insurance plans – such as New Brunswick's *Medical Services Payment Act* – as well as the institutions that are responsible for administering and delivering healthcare both regionally and locally. In New Brunswick, this includes the province's two regional health authorities (RHAs), which are each responsible for managing, delivering and administering public health services in accordance with the province's *Regional Health Authorities Act* (Legislative

Assembly of New Brunswick 2002). Yet because the RHAs operate at an arm's length from the provincial government, activists in New Brunswick have recently divided their efforts between lobbying the state and applying pressure to the RHAs to both expand hospital abortion care and remove existing access barriers within the hospital system.

When Brian Gallant announced his commitment to expanding abortion access within the hospital system, local activists and their allies were quick to call for clarification into the provincial government's plan. In a press release issued shortly after Gallant's announcement, members of the Abortion Rights Coalition of Canada (ARCC) commended the provincial government for taking steps to expand service provision, while also calling for additional measures to ensure equitable access to care, such as recruiting more physicians to perform the procedure, expanding operating room (OR) times in hospitals, providing support for physicians and hospitals as they begin to establish and/or expand services, and ensuring that abortion is provided in at least one hospital in each region of the province (Abortion Rights Coalition of Canada 2014a).⁹⁴ Medical leaders across the province also expressed their support for expanding abortion access, while calling upon the government to ensure the appropriate resources to facilitate the expansion. As one representative from Vitalité Health Network noted, "Hospitals will need to streamline current procedures, requiring more staff and more operating room time," which, he added, would require additional resources and expenditures (Luc Foulem, quoted in CBC News 2014a). Similarly, in a statement issued by the New Brunswick Medical Society (NBMS), president Camille Haddad stressed the importance

⁹⁴ At the moment, abortion care is provided in three of New Brunswick's seven designated health regions.

of the government's commitment to "provide the necessary resources to the regional health authorities in order to increase the capacity of hospitals in New Brunswick to adequately perform these services" (Haddad, as quoted in CBC News 2014c). Dr. Karine Arsenault, a specialist in obstetrics and gynecology at the George-L-Dumont Hospital Center, agreed with Haddad, revealing that while many physicians within Vitalité welcomed the changes to New Brunswick's abortion policy, they were relying on the provincial government to ensure sufficient funding and resources to implement such changes on the ground (ibid).⁹⁵

As the above paragraphs illustrate, efforts to expand abortion services in New Brunswick are caught within a complex network of institutions. While abortion is mediated federally through the *Canada Health Act*, it is organized locally in New Brunswick by the Department of Health—specifically through the province's *Medical Services Payment Act*, which restricts public funding for abortions provided outside of hospitals. However, the actual implementation of abortion services *within* hospitals is further organized through a series of institutional relations, forming a complex line of command that includes but is not limited to the Department of Health, the RHAs, various hospital boards, advisory committees and individual physicians. Even within the RHAs, the bureaucratic line of command is expansive. In a recent meeting with a representative of Horizon Health Network, for instance, members of RJNB – myself included – learned that local hospital policies are determined by "various decision-makers," and that

⁹⁵ According to Brian Gallant's estimates, the government's plan to increase access would cost the province \$1.2 million in the first year, and up to \$700,000 the following year (CBC 2014d). However, the Premier did not reveal precisely how those funds would be allocated and distributed between the RHAs.

Horizon Health itself was not responsible for determining what physicians do and do not perform within their local facilities (personal communication 2017).⁹⁶ As described in Chapter 2, this network of institutional relations forms what George W. Smith (1990) has referred to as a politico-administrative regime, or a way of describing “how ruling is organized and managed by political and administrative forms of organization” (55). While a detailed explication of this specific politico-administrative regime is outside the scope of this study – and, indeed, points toward the need for future IE research into the everyday work of employees within these institutions – the rough mapping that I have presented here provides a starting point for understanding how efforts to expand abortion services within New Brunswick’s publicly funded health system must occur at multiple levels of governance and bureaucracy.

This complicated and expansive network of social relations creates challenges for those seeking to expand access to abortion care across the province. As the Horizon Health representative stated during our meeting, the size of Horizon Health – with some 12,000 employees across the province – means that “things don’t move very quickly” when it comes to implementing new policies, practices and services within the network’s hospitals (personal communication 2017). During my interviews, many research participants reported that the complex line of command for expanding abortion services within New Brunswick’s publicly funded health system made it difficult for activists to know precisely who was responsible for which decisions, and thus who to approach in

⁹⁶ This meeting centered around policies that activists have identified as barriers to accessing a safe, timely and affordable abortion at the Moncton Hospital, including gestational limits and what is colloquially referred to as the “two-appointment rule,” in which patients must book an initial appointment for their ultrasound, followed by a second appointment for the abortion procedure.

their advocacy and lobbying work. In many of my non-recorded conversations with research participants, they described their meetings with health representatives as an arduous game of “passing the buck.” When Horizon Health announced that they would be expanding abortion services within the Moncton Hospital, for instance, several members of RJNB reported being led from person to person – and institution to institution – to advocate for the expansion of hospital services *outside* the Moncton area. When members of RJNB met with representatives from the Department of Health to discuss the repeal of Regulation 84-20, they were told that it was representatives from the RHAs who informed the government’s decision to uphold funding restriction for clinic abortions (ibid). However, in recent meetings with representatives from Horizon Health and Vitalité, members of RJNB were assured that the RHAs had not advised the government on any matters related to Regulation 84-20 (ibid). This pattern of “passing the buck,” as activists have described it, works to obfuscate the social relations governing access to abortion care—presenting challenges for activists working to transform access, while also impeding people’s capacity to discern the very social relations coordinating their lives. This phenomenon is similar to what Viviane Namaste (2006) has referred to as an “administrative abyss” (166). While Namaste is specifically writing on how people become marginalized when the requirements of one institution excludes them from accessing another institution, this same concept may be used to express the complex, abyss-like network of institutions that activists have been forced to grapple with in their efforts to expand publicly funded abortion care in New Brunswick. In the following section, I continue to unravel this administrative abyss by examining the role that Horizon Health played in expanding access to publicly funded abortion care during the

spring of 2015.

Horizon Health Network and the Expansion of Hospital Abortion Services

When Premier Brian Gallant announced that the provincial government would be removing barriers to abortion access in New Brunswick, one of the key elements of his proposal included working closely with the regional health authorities (RHAs) to “increase capacity and improve timeliness of access” (Government of New Brunswick 2014a). Soon after the government amended Regulation 84-20, Horizon Health announced that it would begin providing abortion services in the spring of 2015.⁹⁷ When the announcement was first made, then-CEO John McGarry refused to verify which hospital would be providing the service, in an alleged attempt to deter anti-abortion activists from protesting outside the facility (CBC News 2015). In response, many activists critiqued McGarry for prioritizing anti-abortion ideology over access to care. Indeed, his hesitation reveals in part the strength of the anti-abortion movement in the province. Although the activists I have interviewed tend to frame the local anti-abortion movement as a “small yet vocal” group that is largely irrelevant to the contemporary struggle over access, the mere thought of the anti-abortion presence was enough for McGarry to temporarily withhold the location of Horizon Health’s abortion services. To be sure, McGarry’s hesitation is bolstered by the active history of anti-abortion movement in New Brunswick – and across North America – as well as the climate of shame and stigma surrounding abortion, in which a series of precautions must be made to

⁹⁷ Up until 2015, there were no hospitals within Horizon Health Network that provided abortion care.

ensure the safety and privacy of physicians who provide abortions, as well as the patients who obtain them. And while an in-depth examination of the local anti-abortion movement is outside the scope of this study, it is clear that the anti-abortion movement itself plays a significant role in the coordination of abortion access in the province.⁹⁸

Nearly a month after Horizon Health’s initial announcement, John McGarry disclosed that the network would be expanding abortion services to a single site—The Moncton Hospital (C. Smith 2015). In a series of internal emails obtained through the Right to Information Act by members of RJNB, and leaked by the *NB Media Co-Op* and *The Globe and Mail*, it was revealed that Horizon Health had originally intended on expanding abortion services to three sites – including Fredericton and Saint John – but opted against doing so due primarily to cost savings and infrastructural challenges (Grant 2015).⁹⁹ According to these documents, the Horizon Chief of Staff for the Saint John Area was in favour of setting up a family planning clinic in the Saint John Regional Hospital, which he estimated would perform approximately 300 procedures annually, or six procedures per week. At the same time, the Chief of Staff cautioned for the need to prioritize patient and staff safety and anonymity: “Indeed, when staff have been identified as providing abortions in our province, significant adverse events have occurred,

⁹⁸ Indeed, such coordination was active in the promulgation of anti-abortion policies by Premier Richard Hatfield in 1985, as well as Premier Frank McKenna in 1988 and 1994. Another example may be found in Dr. Barry, a local physician who is fervently opposed to what he refers to as “government-sponsored abortion on demand,” and who has for years used his professional status as a physician to protest both the liberalization of abortion policy and the acceptability of the procedure within the medical profession (Barry 2007; Ackerman 2015).

⁹⁹ Here, too, officials cited a concern over anti-abortion presence as reason to forgo service provision in the Saint John area. As John McGarry noted, Saint John is home to “a very significant Irish Catholic community, and it was quite a surprise to me that the hospital physicians would even entertain the matter. Times have changed of course” (Grant 2015).

including threats to doctors and the closure of practices” (ibid).¹⁰⁰ Still, in the coming weeks, planning for the Saint John clinic continued, with floor plans being drafted, cost estimates produced, and job postings written up in preparation for the expansion (Grant 2015). Meanwhile, John McGarry urged officials at the Dr. Everett Chalmers Regional Hospital in Fredericton to expedite the expansion and ensure that the service was operational as soon as possible (ibid).

As these leaked internal emails demonstrate, representatives from Horizon Health soon opted against the original three-site proposal, in favour of expanding abortion services to a single site in Moncton. The single-site option would, McGarry wrote, “balance access with cost,” and help the network remain “accountable to both patients and taxpayers” (Grant 2015).¹⁰¹ In response to this news, RJNB member Tracy Glynn published an article in the *NB Media Co-Op* releasing the above communications, in which she argued that the provincial government’s “attempt to save money by jeopardizing women’s health does not sit well with New Brunswickers who fought hard to repeal the province’s anti-abortion legislation” (Glynn 2015). When I asked my research participants about the Moncton expansion, they frequently described Horizon

¹⁰⁰ Here the Chief of Staff is likely referring to the physician who lost her family practice in New Brunswick due to relentless anti-abortion activity occurring outside her place of employment during the early 2000s.

¹⁰¹ John McGarry outlined a list of additional reasons for Horizon Health’s decision, including: the firm commitment of TMH’s clinical team to provide abortion care; the timely fashion in which services could be made operational at TMH; a minimum cost savings of \$500,000 annually; the inability for Horizon Health to afford the capital cost of implementing services in three sites; the potential for TMH to provide access to PEI residents, where abortion care had not yet been made available; opportunities for mutual support and collaboration with the Vitalité hospital in Moncton, where abortion services are already provided; development conflicts within the Saint John site; and the potential for conservative and religious backlash in the Saint John region (Grant 2015).

Health's decision as a move that "made no sense" in terms of actually expanding access. From their perspective, one of the most significant barriers to abortion access in New Brunswick is the lack of regional service provision across the province. While the expansion indeed increased the number of patients who could access abortion care in Moncton, they argued, it ultimately fell short of addressing the province's regional disparities in service provision. During my interview with Tracy, for instance, she remarked on how troubling it was that Horizon Health came so close to offering services in Saint John – one of the poorest cities in the country, she reminded me – yet opted instead for a single site in Moncton, one of the province's largest urban centers, and a region where abortion services were already offered by Vitalité Health Network:

I mean, to hear that they almost went ahead with it and then—just these musings about what Saint John people would think because they're conservative... while knowing that they would continue to struggle to access these services! (Interview with Tracy Glynn 2015).

As I described earlier in the dissertation, people living in Saint John – as well as communities in the Southwestern and Northern regions of the province – face disproportionate barriers to abortion care due to the distance they must travel to access the procedure. Above, Tracy expresses frustration with Horizon Health for not only yielding to economic and conservative pressure in the province, but also for their failure to expand abortion access in communities that need it most. As nearly all my research participants suggested, recent moves to expand abortion services in New Brunswick have fallen short of addressing the complex relationship between access and systemic inequalities, thus reproducing many of the same barriers to access that activists rallied against in the first place. Jessi Taylor expands on this below:

If you want something like an abortion service, you might not have access

because currently you can only get publicly funded services in two cities. Moncton and Bathurst. And Moncton and Bathurst already *had* services before Horizon started to also put more services in Moncton—which they claimed would be more cost efficient, but it’s not more cost efficient if you *already have that service [there]*. That’s like... buying cookie ingredients, and you already have butter and you need flour, but you bought more butter. That’s not helping your flour problem! [laughter] It might be cheaper than the flour, but it’s not what you needed (Interview with Jessi Taylor, September 21, 2015)

As Jessi points out, although expanding services to Moncton may have been more cost effective for Horizon Health, it did little to solve the problem of regional access in the province. Since RJNB first formed in 2014, the collective – in collaboration with members of ARCC and FYF – has urged state and medical authorities to expand services in each of New Brunswick’s seven geographical regions. Yet rather than invest in regional expansion, Horizon Health brought more services to a region where the procedure was already available. And while cost savings was among the core reasons for limiting care to Moncton, excluded from this calculation was the fact that women located outside of Moncton and Bathurst would continue to incur disproportionate financial barriers to access. Thus, while the Moncton expansion was the most cost-efficient move for Horizon Health and the provincial government, it has effectively offloaded the costs of care onto patients who must travel from outside Moncton to access the procedure.

As nearly all my research participants suggested, the decision to expand services to the Moncton Hospital alone was not rooted in the needs and experiences of patients in the province, but rather in the interest of pursuing the most cost-effective option possible and staving off the threat of anti-abortion protestors. As I have shown in earlier chapters, anti-abortion protestors indeed create significant challenges for patients who seek abortions, as well as the physicians who provide them. However, as several of my participants have expressed, Horizon Health’s decision to avoid rather than confront anti-abortion pressure

in the Saint John area did little to address the problem of anti-abortion ideology, adding instead to the culture of shame and stigma around abortion. Despite their frustration, however, most of my research participants admitted that, at the very least, the Moncton expansion would have positive implications for the number of patients able to access services within the city. To be sure, the addition of a new medical site providing abortion care is a positive step toward expanding service provision in the province—despite doing little to address the problems of regional access. Still, as my participants have consistently argued, the expansion of services within the province’s public funding model alone does not address the fact that New Brunswick continues to uphold anti-abortion policies that deny funding for clinic abortions. Nor, my participants reminded me, does it help to shift the climate of shame and stigma surrounding women’s sexuality and reproduction in the province. There is more work to be done.

“We’ve Given You Access:” Exploring the Optics of Change in New Brunswick

A core obstacle that activists have encountered in their ongoing work to repeal Regulation 84-20 and improve hospital abortion care in New Brunswick is the provincial government’s unwillingness to continue improving access to surgical abortions. In conversations with my research participants, they expressed frustration at the government’s tendency to cite both the amendment to Regulation 84-20 and the Moncton expansion as evidence of their having eliminated all access barriers in the province. While meeting with Health Minister Victor Boudreau, for instance, members of RJNB

were struck by his claim that the government had “already solved the problem of access” in New Brunswick. Shona expands on this below:

[Boudreau] turns around and was like, “Well, we’ve given you more access. We have another hospital.” Yeah, in the same flippin’ city that we had it before! And like, in an urban area! They’ve provided *no* more access to rural communities *at all*. But from their point of view they’re like, “Well, you have access in Moncton, you have access in Fredericton, you have access in Bathurst!” (Interview with Shona Newton, 2015).

As introduced near the end of Chapter 5, this theme – which Hannah Gray refers to as a “semblance of access” – came up often in my interviews. Several of my research participants have framed this as a game of optics: while the provincial government publicly appears to have “solved” New Brunswick’s access problems, it continues to uphold several key barriers to abortion in the province. In my interview with Joyce Arthur, for instance, she described how the government’s policy change, together with Horizon Health’s Moncton expansion, helped position the government as amenable to pro-choice interests, while also enabling them to walk back on further changes to the province’s regulatory framework:

And it’s kind of too bad, because I think that the Liberal government in New Brunswick kind of feels like, “Well, we’ve fixed things! We’ve done what we can! Let’s put this back on the shelf and forget about it,” you know? Because they were so reluctant to do anything, they had to be really forced into it, you know? Dragged kicking and screaming. So, they’re not going to do anything more. At least not for a while, and not without more pressure, or not until something harmful happens (Interview with Joyce Arthur 2015).

As Joyce suggests, without the unrelenting work of activists and their supporters, it is unlikely that the provincial government would have removed any barriers to abortion access in the province. It took decades, Joyce reminded me, for the provincial government to make these changes. Faced with a material crisis in service provision, the Gallant Liberals broke from successive provincial governments’ overtly anti-abortion

policies and practices. However, as Joyce also suggests, the fact that the government amended Regulation 84-20 and expanded services in Moncton means that, today, the Gallant Liberals are under far less public pressure to address the remaining access barriers in the province. Below, Max Arsenault of Clinic 554 makes connections between the government's optics of change and the semblance of access that the province currently faces:

But they were able to take the narrative over from that of, "We need change, we need change!" To, "We changed! We took off the two-doctor thing [...] it's a little bit less restrictive, a *little* bit less restrictive, two steps forward one step back, okay, next!" And then everyone stopped listening. Or everyone stopped, I don't know, talking about it (Interview with Max Arsenault 2015).

In the above excerpt, Max discusses how the amendment to Regulation 84-20 helped to shift the popular discourse from the activist-mediated "we need change!" to the state-mediated "we've given you change." Many of my participants shared this perspective, noting that the provincial government's changes to Regulation 84-20 also had the added effect of silencing and stymying activists' demands for clinic funding and rural access. Indeed, securing "access to abortion" means something quite different – that is, the standpoint is quite particular – to activists than it does to the provincial and regional institutions responsible for regulating publicly funded care.

As these excerpts demonstrate, there is a clear disjuncture separating the provincial government's theoretical commitment to expanding abortion access on the one hand, and its practical implementation of that commitment on the other. As a few of my participants have suggested, part of this has to do with the conceptual framework of

“access” itself, and the ease with which this discourse became co-opted by the provincial government. Maggie Fitzgerald-Murphy expands on this below:

The government says all the time, ‘There is access. This procedure is offered in this province.’ Okay,” Maggie told me, “I guess there *is* access, right? But the thing is, a lefty group of feminists’ version of access is very different from Victor Boudreau’s version of access (Interview with Maggie Fitzgerald-Murphy 2015).

As Maggie and others have suggested, one of the core challenges that activists have faced post-amendment has been the provincial government’s insistence that there is sufficient access to abortion in New Brunswick. This has led several of my participants to question whether the concept of access has been generative for the struggle over abortion in the province. While the discourse of access has been useful for highlighting the relationship between abortion and structural inequalities, it has also provided an opening for the government to say, “We’ve given you access.” Two significant findings emerge from this: first, that the situated knowledge of activists offers particular insights into the social organization of abortion care – insights that are often overlooked within administrative regimes – and second, that the government’s claim of having solved New Brunswick’s access problem hinges on a reified and hollowed-out conception of “access;” one that collapses the social and material relations that continue to restrict people’s ability to obtain care. This line of fault between the provincial government’s understanding of access on the one hand, and activists’ definition on the other, also points toward the tensions in activists’ use of the reproductive justice framework. Concerns over their own co-optation of the term “reproductive justice,” as I have discussed, led many activists to distance themselves from explicitly taking this framework on in their work. And while focusing on access can indeed help bring into view many of the social relations that the

reproductive justice framework aims to interrogate, it can also work to occlude the ongoing, dynamic, and social character of establishing access for *everyone*, regardless of their social location. As a result, the provincial government has been able to effectively declare that they have granted New Brunswick women access to abortion, without attending to the important questions of who has access, who does not have access, and what that access looks like in the context of people's everyday lives. As I have argued elsewhere in the dissertation, the provincial government's co-optation of "access" further demonstrates the need for activists to be more explicit in their demands, and to continue holding the government accountable not only for "access," but for the broader project of reproductive justice.

While the amendment to Regulation 84-20 and the investment in TMH's family planning clinic have certainly worked to remove some barriers to abortion in the province, these practices alone have not "solved" the access problem. Further, as many activists have suggested, they have also produced new challenges for the pro-choice movement. While members of RJNB and their allies continue to push for the repeal of anti-abortion provisions within the province's *Medical Services Payment Act*, they are also forced to grapple with the reality of a public funding model that denies insurance coverage for services provided in clinic settings. As part of this work, activists have recently shifted their focus toward the access barriers produced within New Brunswick's hospital-only system for abortion care. By shifting focus in this way, activists are caught between two simultaneous demands: to advocate for the transformation of New Brunswick's regulatory framework for abortion care, and to fight for the transformation of patient experiences within the province's providing hospitals. In the remainder of this

chapter, I present an analysis of several remaining barriers that activists and their allies have identified within the province's public funding model. In this same discussion, I address how activists, as situated knowers, are well positioned to offer strategies for rethinking the organization and distribution of abortion care across the province.

Barriers to Hospital Care: Activists' Perspectives

In the aftermath of The Moncton Hospital expansion, activists double-downed on their emphasis between the quality of care provided in clinics and that provided in hospital settings. In a media release from January 2015, members of RJNB wrote that clinic services are “preferred by patients because they are better able to provide timely service, confidentiality, follow up care, and counselling and are significantly less expensive than abortions provided in hospitals” (RJNB 2015).¹⁰² Nearly all my participants expressed caution here; while hospitals are important sites for abortion provision, they argued, they should not be the only sites offering publicly funded care. Instead, by bringing visibility to the access barriers occurring within hospital settings, activists sought to highlight the importance of including clinic abortions within the province's public funding model. Publicly funded abortion clinics, they argued, not only have the potential to expand access to care, but would also help to mediate and offset the

¹⁰² In this same release, members of RJNB identified problems with the regional distribution of abortion services in the province and the travel that many patients must undertake to access services. Here they also argued that New Brunswick's abortion regulations contravene the *Canada Health Act* by restricting “reasonable access to services without financial and other barriers,” infringe upon women's Charter rights and contravene the Supreme Court decisions (1988, 1993) which “supported Dr. Henry Morgentaler's challenges to restrictive [abortion] laws and regulations.” The release also noted the importance of funding abortion services in “medically and regionally appropriate community-based settings,” citing the refusal to do so as contrary to “evidence-based best health care practices” (RJNB 2015: no page).

barriers imposed by the province's hospital system. In this section, I explore how activists have expanded the scope of their struggle to shed light on the many access barriers that exist within hospital settings. Following this discussion, I consider how the provincial governments' optics have created concrete challenges for activism. In responding to the provincial government's reorganization of abortion services, activists shifted the scope of their struggle to expose, and ultimately transform, the barriers present within the province's hospital system. Implicit within this struggle are the ways that New Brunswick's *Medical Services Payment Act* interacts with and often compounds these barriers. However, as I demonstrate, this shift in struggle has had the inadvertent effect of distracting from the movement's broader goal of transforming the province's regulatory framework for publicly funded abortion care.

Implementing Regulation 84-20: Caught between policy and practice

As several of my research participants described, part of their work following the amendment to Regulation 84-20 has included addressing whether – and to what extent – the government's changes in policy have been implemented within the hospital system. Of particular concern to activists is whether patients are continuing to seek a physician's referral prior to obtaining the procedure. Nearly a year after my initial interviews with activists, I followed up with a representative from Horizon Health Network to gain administrative insight into the organization of abortion services at The Moncton Hospital (TMH). During this conversation, I was told that patients seeking care at TMH could do so on a self-referral basis, but that patients were also accepted through physician referrals (personal communication, 2016). Similarly, Horizon Health's website states that patients may access care at TMH's Family Planning Clinic “with or without a referral from a

physician.” During my interview with Jessi Taylor of RJNB, she drew attention to the links between access to information and access to care—specifically, that the lack of information regarding how to access sexual and reproductive healthcare presents challenges for those seeking care, in particular those who experience multiple relations of inequality. At one point, Jessi remarked that, although patients no longer require a referral to access the procedure, the relative silence surrounding the procedure means that people “might not know” that they are now able to self-refer (Interview with Jessi Taylor, 2015).¹⁰³ Hannah Gray shared similar concerns. During our interview, she described how the province’s failure to provide accurate and widespread information on how to access an abortion means that many patients have and will continue to seek referrals prior to their procedure. Although physician referrals are no longer textually mediated by Regulation 84-20, Hannah described how, for many patients in the province, “the actual lived experience is the same” (Interview with Hannah Gray, 2015).

A recent qualitative study conducted by Angel Foster et al. (2017) has confirmed that people are, in fact, continuing to seek referrals for hospital abortions in New Brunswick. In their study, Foster et al. (2017) conducted thirty-three telephone interviews with women who had obtained abortions between 2009 and 2014, as well as those who had obtained abortions after the amendment to Regulation 84-20 on January 1, 2015. Through this study, they found that all of those who obtained a hospital abortion after the amendment (n=4) sought a physician referral prior to their abortion. Echoing Jessi’s and Hannah’s concerns over misinformation, Foster’s research team found that none of these

¹⁰³ As a former sexual health educator in the province, Jessi Taylor is well-attuned to address people’s experiences with sexual and reproductive healthcare, as well as the shame and stigma surrounding reproduction and sexuality in the province.

patients were aware of the policy change when scheduling their appointments (Foster et al., 2017: 480). This helps to reveal a disjuncture between policy and practice in the context of New Brunswick's public funding model: while there are no longer policies in place mandating physician referrals for hospital abortions, many patients continue to seek referrals due to a lack of knowledge about how to access an abortion in the province. This demonstrates the need for greater access to information surrounding sexual and reproductive healthcare in New Brunswick. This second finding was reflected in each of my interviews with members of the Fredericton Youth Feminists, who described how, for high school students in the province, knowledge surrounding sexuality as well as sexual and reproductive health largely depends on who you know, where you live, and who happens to be teaching your sexual education classes. For instance, Abbie Moser described how some teachers go more in-depth into the curriculum, while others aim to “get this over with in one class!” or end up “skimming through the pictures” of STDs due to their personal discomfort (Interview with Abbie Moser 2015). Later in our interview, Abbie described how class politics tend to be implicated in the ability for people to access information regarding their sexual and reproductive health:

There aren't a lot of places to go, even in Fredericton, for that kind of information, so it's even [worse] in rural New Brunswick. And like... I mean, we're not a very wealthy province, so that doesn't help. Like, not everyone is able to have a computer or a cell phone or internet, so they can't just type in “abortion access in New Brunswick.” They can't get the information so easily (ibid).

Thus, while access to abortion remains weak under the province's public funding model, it is also weakened by the culture of shame, stigma, and relative silence surrounding sexuality and reproduction in the province. Moreover, the uneven distribution of sexual and reproductive health education across the province effectively prevents people – and

youth in particular – from having the resources they need to make informed decisions regarding their sexual and reproductive lives.

The “two-appointment” rule

Regardless of the need for a physician’s referral, women in New Brunswick are typically required to book two appointments when seeking a hospital abortion: the first for an ultrasound and consultation, and the second for the procedure itself. Throughout my research, many activists have identified the “two-appointment rule” as a major barrier for accessing a publicly funded abortion in the province. Allison Webster expands on this below:

Another sort of stumbling block when it comes to access is that those hospitals require two appointments. So, patients can’t just call and make an appointment—they call, make an appointment – as long as they’re not fifteen minutes late, I mean allegedly¹⁰⁴ – and then get their ultrasound done. And *then* have to wait a week or so to come back and get their actual procedure done. So, for patients that don’t live in Moncton, you have to take a day off work, twice; drive to Moncton and back, twice; pay for gas, twice; pay for childcare, twice. So, it’s actually a really big barrier (Interview with Allison Webster 2015).

As Allison identifies, the two-appointment rule has significant impacts on patients’ abortion experiences, including increased wait time, travel time, and associated travel costs. As Foster et al (2017) found in their research, the coupling of this rule with the fact that many patients remain unaware of New Brunswick’s policy change means that patients often end up booking a total of three appointments for their procedure: one with

¹⁰⁴ Both Allison and Hannah Gray mentioned that certain hospital staff would refuse patients’ care if they showed up fifteen minutes late to their appointment. While I was unable to locate documented evidence of this practice, its alleged occurrence points towards activists’ concerns surrounding the tendency for hospital staff to act as self-appointed gatekeepers by restricting patients’ ability to access the procedure.

the referring physician, and two with the hospital providing the service (480). Their research also provides much-needed context into patients' abortion experiences. For instance, one of their participants, Sadie, incurred "significant financial costs" as a result of travelling to two separate appointments in a city located three hours away from her place of residence, as well as the accommodation costs for the night prior to her procedure (ibid).

The fact that the hospitals' two-appointment rule imposes barriers to patients' ability to access care is an issue that was discussed at several meetings of RJNB's political action committee. It has also been raised by activists in meetings and correspondence with representatives from the Department of Health and the regional health authorities, and was featured as a key barrier in RJNB's communications strategy following the provincial government's plan to expand access within the province's hospital system. As Max Arsenault identified, in addition to creating barriers to access, requiring multiple appointments for a single procedure also adds to the financial cost of that procedure: "Because if a patient comes to see a physician or healthcare person twice, then you can charge the government twice" (Interview with Max Arsenault 2015). During this conversation, Max framed the two-appointment rule as a mechanism by which the regional health authorities are able to "make money off of poor people" who cannot afford to pay out-of-pocket for services at the clinic (ibid). While Max was the only participant who made explicit connections regarding the profitability of the two-appointment rule, others similarly expressed concern regarding the cost of expanding abortion care within the hospital system. Again, this concern commonly arose as a means of criticizing the government for upholding the province's hospital-only system. Clinic

abortions, they would argue, are more cost effective than their hospital counterparts.

While this theme is taken up further in the final section of this chapter, it is worth mentioning here, as it demonstrates activists' tendency to focus on the shortcomings of the province's hospital-only model in an effort to shift public opinion in favor of clinic abortion care.

When I asked a Horizon Health representative to speak to the hospitals' two-appointment requirement during our interview, I was told that there are "a number of reasons" why this protocol is in place. For instance, they said, not everybody who books their appointment wishes to follow through with the actual procedure. Booking a separate appointment in advance of the procedure, I was told, gives people the opportunity to learn more about the service, reflect on their pregnancy options, and decide whether they wish to proceed with their next appointment (personal communication, 2016). Many of my research participants took issue with this response. Abortion clinics, they told me, are able to circumvent such delays to the procedure by providing the patient with counselling services on the same day their abortion is scheduled. At Clinic554, as at the former Morgentaler Clinic, counsellors work to ensure that patients are confident in their decision, that they have considered all their pregnancy options, and that their choice to terminate a pregnancy is not the result of influence or external coercion (Interview with Alison Webster 2015; Interview with Simone Leibovitch 2015; Interview with Valerie Edelman 2015; Interview with Max Arsenault 2015).

Furthermore, Horizon Health's justification for the two-appointment rule – that patients require additional time to reflect on their decision post-ultrasound – assumes that patients are not capable of making appropriate and informed decisions prior to booking

their appointment. These sorts of assumptions work to detract from women's reproductive autonomy and self-determination, calling into question their decision-making capacity as well as their agency. While it is essential that patients have access to the resources necessary to *make* such decisions – including counselling services and information regarding pregnancy options – such access must be granted without enforcing a waiting period between one's ultrasound and their abortion, as in the case of Clinic 554 and the former Morgentaler Clinic.

When I asked about the challenges patients may experience in attending multiple appointments, the representative assured me that TMH does, in fact, have provisions for same-day appointments, should patients require such accommodations. “Both options are available,” I was told, in circumstances where patients are unable to attend two separate appointments (personal communication, 2016). Here, too, the lack of information regarding patients' options – specifically the ability for patients to forgo the two-appointment requirement as necessary – further demonstrates the relationship between access to information and access to care.

Multi-week wait times & hospital gestational limits

Time was a common theme that arose throughout my research—specifically, that the time a patient must wait prior to receiving their abortion should remain as minimal as possible. However, as many of my research participants told me, those who seek abortion care within the hospital system often face multi-week wait times for their appointments. As Allison mentioned during our interview, although the amount of time that patients

must wait for a hospital procedure varies, it was extended by the hospitals' two-appointment requirement:

I've heard that there's still a 4-week wait to get *into* the hospital. And I think, and same with the clinic, we sort of see peaks and valleys with services. There are certain times of year that we're a lot busier, times that we're slower. I think the hospital is also like that. But just as recent as a few weeks ago someone told me that they called the hospital, and somebody told them it would be four weeks to get their *first* appointment! (Interview with Allison Webster)

While patient demand ebbs and flows in either location, the fact that Clinic 554 requires only one appointment for the procedure effectively guarantees a shorter waiting period than a patient might face at the hospital. During these conversations, too, participants tended to frame clinic services as preferable to those provided in hospitals. In each of these conversations, participants suggested that clinic staff consistently work hard to ensure that patients – in particular those at a later gestational period – experience the most minimal wait time possible. As Simone told me during our interview, “I know when women want to have an abortion, they want to have it *yesterday*” (interview with Simone Leibovitch, 2015). Reflecting on her work as clinic manager, Simone described how, at the Morgentaler Clinic, staff would work to ensure patients received care as soon as possible. “Like, if you can get them in tomorrow, you get them in *tomorrow!*” she told me (ibid).

Participants making comparisons between clinic and hospital wait times also tended to highlight concerns for patient safety and well-being. Valerie, for instance, described how prolonging an unwanted pregnancy can be both physically and emotionally burdensome for patients:

People don't want to wait. Like, they don't want to wait. I'll be on the phone booking the appointment, and they really don't want to wait. And if they

have to wait for whatever reasons [...] it's just—they're quite distraught about it, you know? And they're very, very thankful and relieved when they can get it done timely, like within a week. Very, very grateful. They feel like they can get on with their lives (Interview with Valerie Edelman, 2015).

During this conversation, Valerie suggested that people experiencing an unwanted pregnancy tend to feel something akin to illness—complete with medical, physical and emotional symptoms. They “don’t want to be pregnant,” she told me, and they “don’t want to wait” for their pregnancy to be terminated (ibid). A similar concern for patients’ experiences and well-being arose during many of my conversations with activists, but was particularly present in interviews with staff and service providers at Clinic 554 and the former Morgentaler Clinic. Drawing on their first-hand experiences of working with patients, these participants – specifically Alison, Simone, Valerie, Max, Marilyn and Jaden – tended to foreground the relationship between abortion access and patient self-determination, as well as the importance of providing care that is compassionate and patient-centered. As Marilyn stated during our interview, “as health professionals and as a health system, we ought to try to be working *with* you to [determine] what is it you really want to do, and what kind of resources do you need. And how can we, as a society and a community, help put those in place?” (interview with Marilyn Merritt-Gray, 2015).

Central to these discussions – of access to timely abortion services specifically, and the importance of compassionate and patient-centered care more generally – was a critique of New Brunswick’s hospital system, whose long wait times impose material and emotional barriers to abortion access in the province. As Max of Clinic 554 told me

during our interview, because abortion is a time sensitive procedure, the longer a patient must wait for care, the more “complex” the procedure becomes:

Well, there’s a reality to an abortion becoming more complex as a pregnancy increases in gestational age. And patients are on the internet, and they’re aware of complications and rates of complications, and their preference is to have the least complicated procedure, of course. That’s what we strive to provide, you know? And at the hospital, there’s always like, a multi-week waitlist. *Multi-week!* And that makes a difference in a person’s life (Interview with Max Arsenault 2015).

While this excerpt demonstrates Max’s perspective on the medical issues arising from hospitals wait times, he also situates the problem as an emotional and social one, expressing concern not only for patient safety, but also for their preferences, experiences and general well-being. Ultimately, he told me, extensive wait times – and the ways in which they are experienced by patients – make a “difference in a person’s life” (ibid).

As nearly all my research participants told me, hospital wait times, combined with the need to attend multiple appointments, risk putting patients beyond the hospitals’ fourteen-week gestational limit, and thus outside of the province’s public funding model.¹⁰⁵ As a result, many patients end up seeking care at Clinic 554 – where they may

¹⁰⁵ Hospital gestational limits were also identified as a key barrier to accessing a publicly funded abortion in the province. Because there are no federal laws governing abortion, gestational limits are set by hospitals and clinics at the local or regional level, and tend to correspond to the comfort and training level of the physician providing the service. This too has contributed to Canada’s patchwork landscape of abortion access: in Nunavut and Yukon, patients seeking abortion care can access the procedure up to 12 weeks gestation; in the Northwest Territories and Saskatchewan abortion is available up to 14 weeks; in Nova Scotia, Newfoundland and Labrador services are available up to 15 weeks; in Manitoba abortion is available up to 16 weeks; Alberta and British Columbia perform procedures up to 20 weeks; and while Quebec performs the procedure up to 23 weeks, Ontario is the only province that performs second trimester abortions, up to 24 weeks of gestation (National Abortion Federation of Canada n.d.). In New Brunswick, all three hospitals providing abortion care impose a 14-week gestational limit—two weeks earlier than that of Clinic 554 and the former Morgentaler Clinic. While my research participants’ perspectives on this were varied, the common thread among them was that physicians should not be forced to provide services that they are uncomfortable providing safely and effectively. Instead, as Allison stated during one meeting, what is important is that activists continue to call

pay out-of-pocket for the procedure up to sixteen weeks gestation – or travelling to Quebec or Ontario, where abortions are provided up to twenty-three and twenty-four weeks, respectively. Judy and Jaden reflect on this below:

And I've heard that, you know, the waiting time can be up to six weeks. Well, you know, if you're already ten or twelve weeks, what are you gonna do? You're gonna go to the clinic, if you can. And that's what's gonna happen (Interview with Judy Burwell 2015).

Like, we've got people who have had hospital abortions, telling us that you know, they had to wait ten weeks! Because like, you don't find out, generally, until you're probably at least four weeks. And by the time you wait ten weeks—uh oh! You're past due for the fourteen-week cut-off (interview with Jaden Fitzherbert 2015).

Although their estimations of hospital wait times varied, participants consistently expressed concern over the effect that hospital wait times have upon patients' abortion experiences. As both Jaden and Judy illustrate, such wait times not only extend the duration of an unwanted pregnancy, they also risk pushing patients to seek abortion care outside of the province's public funding model. As Judy describes above, this often results in patients seeking care at the clinic. During my interview with Valerie, she described how patients often seek care at Clinic 554 once they've surpassed the hospitals' gestation limit:

Sometimes [the hospital is] not an option, depending on how far someone is along. Because the hospital only goes up to 14 weeks. So, if someone is over fourteen weeks, and they have no money, and they have other

attention to the ways in which these practices “burden patients” by restricting their ability to receive timely and publicly funded abortion care (personal communication, 2017).

responsibilities, I just say, “Bring what you can” (Interview with Valerie Edelman).

Following in the footsteps of the Fredericton Morgentaler Clinic, Valerie told me, Clinic 554 also helps to offset costs for patients who are unable to afford the fee for a clinic abortion. While this practice certainly illustrates Clinic 554’s commitment to providing patient-centered abortion care, it also demonstrates how the province’s regulatory framework works to offload the costs of care onto the patients themselves—or, should they be unable to pay, onto Clinic 554. As Max told me during our interview, this practice “forces patients to suffer” (Interview with Max Arsenault 2015). “Because,” he said, “the province will only fund a patient to have an abortion in a hospital facility, so if a patient has to go to [...] a clinic and have an abortion [...] the government doesn’t pay them back,” (ibid). To borrow again from Namaste (2006), patients that fall beyond the hospital’s gestational limits often find themselves caught in an administrative abyss, in which the requirements of the hospital system, combined with New Brunswick’s public funding model, leave patients with few options other than Clinic 554.

During my research, I found that activists tended to amplify their concerns over wait times and hospital gestational limits following both the amendment to Regulation 84-20 and the expansion of hospital abortion services in Moncton. Through this work, activists and their allies have sought to bring visibility back to the inadequacy of the province’s public funding model for abortion care while also calling for improvements to the quality of services offered within the hospital system. Furthermore, by contesting these particular barriers – wait times, gestational limits and the two-appointment requirement – activists were also responding to the provincial government’s failure to follow through on its commitment to ensure “timeliness of access,” (GNB 2014). As

described earlier, it was this announcement, combined with both the opening of Clinic 554 and the expansion of services within the Moncton Hospital, that gave way to an optics of transformative change in the New Brunswick context.¹⁰⁶ However, despite material changes in the distribution and regulation of abortion services, the struggles in which activists find themselves remain conditioned by the province's regulatory framework. It is this relationship between access and provincial regulation – made visible in 2014 by the closure of the Morgentaler Clinic and the wave of political resistance that followed – that has, to borrow from Lianne McTavish, “fade[d] into the background once again,” revealing the cyclical quality of abortion politics in New Brunswick, in which attention rises and falls as restricted access moves in and out of the public imaginary (2015: 130).

Conclusion

When confronted with a rapidly shifting social and political climate, activists and movement participants are often compelled to make difficult decisions about what to focus our energy and resources on. The clinic's closure ushered in one of those rapidly shifting climates. As many of my participants described it, the spring and summer of 2014 threw the province into a period of crisis. The loss of the clinic left a sizeable gap in the province's capacity for abortion service provision, forcing the provincial government to reassess its organization of care. It was an enormous loss to the Fredericton community, marking the end of a more than twenty-year long battle with the provincial

¹⁰⁶ The “timeliness of access” commitment was made in the same news release wherein Premier Brian Gallant announced the amendment to Regulation 84-20 in November 2014.

government. Since before abortion was decriminalized, successive provincial governments in New Brunswick, both Liberal and Conservative, have committed to restricting women's access to the procedure in violation of the *Canada Health Act* and the *Charter of Rights and Freedoms*. From 1985 to 1994, Dr. Morgentaler and the feminist pro-choice community fought for the right to provide clinic abortion services in New Brunswick, where Premier Frank McKenna promised to give Morgentaler the "fight of his life." When the Morgentaler Clinic was established in 1994, the battle over the province's public funding policies began, including the court case that the province dragged out until Morgentaler's death in 2014.

With this history in tow, the clinic's closure catapulted a new wave of feminist pro-choice activism in the province. Because that activism began in response to the clinic's closure, activists tended to position the clinic at the center of their analysis, as a key site for service provision as well as a rallying point for demanding regulatory transformation. And while the movement for abortion access has been enormously successful in the province, it has also been faced with significant challenges. Taken together, the establishment of Clinic 554 and the provincial government's work to amend Regulation 84-20 and expand services in Moncton have created a semblance of access in the province. Though significant barriers remain, the momentum that activists worked so hard to generate in 2014 has been weakened by the optics of a provincial government that finally "put an end" to New Brunswick's decades-old anti-abortion policies. In response to the government's decision to expand abortion only within its existing public funding model, activists felt compelled to shift the scope of their struggle to include advocating for better quality services in hospitals. Though an important site for intervention, this

shift has required activists to redistribute their energy and resources to lobby for change within the province's public funding model, while also calling for the transformation of that model. Today, two years following the Moncton Hospital expansion, activists in the province continue to struggle for the removal of hospital barriers and the repeal of Regulation 84-20.

Chapter 7: Concluding Thoughts & Looking Forward

Revisiting Abortion Access in New Brunswick

When the Fredericton Morgentaler Clinic closed its doors in 2014, New Brunswick's access problems made national headlines, as people across Canada turned their attention toward the province's decades-old regulatory framework for abortion care. Over the course of several months, activists called upon the provincial government to repeal Regulation 84-20 and fund clinic abortions for those who seek them. Activists organized direct actions, mobilized knowledge through social media, drafted press releases and briefing documents, distributed flyers and factsheets, lobbied the provincial government, and formed alliances with groups across the province. Activists pushed for improved regional access to services, worked to abolish the culture of shame and stigma around abortion, and brought visibility to the relationship between reproductive rights, abortion access and structural inequalities. Together, members of Reproductive Justice New Brunswick (RJNB) and the Fredericton Youth Feminists (FYF) launched the #SaveTheClinic campaign, fundraising enough money to facilitate the opening of Clinic 554, a family practice that offers clinic abortion in downtown Fredericton, in the same site as the Morgentaler Clinic before it.

Due to the groundswell of feminist pro-choice activism in the province, as well as the public support it garnered, the newly-elected Gallant Liberals announced they would move to eliminate barriers to abortion access in the province. This commitment included amending Regulation 84-20's two-doctor and specialist requirements, as well as working with Horizon Health Network to establish the Family Planning Clinic at The Moncton

Hospital to increase service provision in the city. Though this marked an important win for abortion activists, the provincial government simultaneously upheld its public funding restrictions for clinic abortions, leaving many New Brunswick women without access to safe, timely, and affordable care. Today, several access barriers remain. Abortions provided at Clinic 554 are still ineligible for public funding. Patients seeking abortion care in hospitals often experience procedural delays due to long wait-times and early gestational limits. Many women must travel long distances to access the procedure in one of three cities where it is offered, often incurring significant expenses in the process. Such access barriers are compounded for people who experience multiple oppressions due to their social location and identity, as well as those living in rural areas of the province.

When I began my research, I did so with the intention of learning from the people who were most directly involved in the movement to expand abortion access in New Brunswick. Central to this project is the claim that movement spaces are dynamic sites in the production of theory and knowledge, and thus offer a useful starting point for research that aims to challenge the status quo. Activists have always been at the forefront of historical initiatives to change the world, as well as the social relations that shape it. As such, they are well-situated to teach us something about the way the world works, how it is put together, and how we might collectively change it.

Summary of Findings and Analytic Takeaways

As I have demonstrated in my dissertation, there are five key insights that we can take from feminist activists' work on abortion access in New Brunswick. These include:

1) the tensions between the federal mandate for abortion access and the provincial regulation of abortion care; 2) the institutionalization of abortion stigma and reproductive control as mediated by New Brunswick's *Medical Services Payment Act*; 3) the central role that clinics and crises have historically played within Canadian feminist pro-choice organizing; 4) the significance that activists placed upon the discourse of access, as well as the tensions that they experienced in adopting a reproductive justice framework; and 5) that by co-opting activists' access discourse, the government successfully created an optics of change in the province, despite upholding the very funding restrictions that led to the Morgentaler Clinic's closure in 2014.

First, although *R v. Morgentaler* (1988) decriminalized abortion in Canada, it simultaneously shifted regulatory authority to provincial and territorial health departments. This transfer of authority in the context of regulatory transformation opened a line of fault between the federal mandate for universal healthcare on the one hand, and provincial policies and practices governing the provision of care on the other. In Chapter 3, I explored how this transformation took place by tracing the evolving role of the state, the medical community and social movements in shaping abortion policy across Canada's history. As I have shown, this line of fault between federal and provincial governments has resulted in the current uneven landscape of abortion care in Canada, wherein one's ability to access the procedure largely depends upon their province or territory of residence, as well as their location in the social relations of inequality. Due both to the regulatory transformation of abortion in 1988, and the division of powers under Canadian federalism, several provinces — including New Brunswick, Nova Scotia and Prince Edward Island — have moved to restrict abortion access by limiting the

conditions under which the procedure may be deemed eligible for provincial health insurance.

Next, the activists I interviewed have helped bring a new wave of visibility to the fact that, nearly thirty years after the Supreme Court decision in *R v Morgentaler*, New Brunswick remains the only province in Canada that continues to uphold regulatory barriers to clinic abortions. As I have shown in Chapters 3 and 4, both Regulation 84-20, Schedule 2 (para a.1) and Chapter M-7, Section 2.01(b) of the province's *Medical Services Payment Act* are artefacts left over from a rapidly changing sociopolitical climate in Canada, both in the years leading up to and immediately following the decriminalization of abortion in 1988. For decades, activists and their allies have called upon the provincial government to repeal these policies and ensure public funding for abortions provided in clinics. These demands accelerated when the Fredericton Morgentaler Clinic announced it would be closing due to the financial barriers imposed by the province's public funding model. In Chapters 4 and 5, I provided insights into the impact these policies have on people's ability to access care in the province, as well as their implication for service delivery at the Morgentaler Clinic and Clinic 554. As I have made clear, both policies work to institutionalize reproductive control, as well as abortion stigma, by placing arbitrary limits upon women's ability to obtain safe, timely, and affordable abortion care in the province.

The third insight that we can take from activists' work on abortion access in New Brunswick concerns the relationship between clinics, crisis and pro-choice feminist activism in Canada. The renewed attention to Regulation 84-20, brought about by the closure of the Fredericton Morgentaler Clinic, demonstrates the integral role that abortion

clinics have and continue to play in the context of Canadian abortion politics. As I have shown in Chapter 3, feminist activists in the 1970s and 1980s positioned clinics as central to the struggle for abortion rights, as well as to the broader project for reproductive freedom. In Chapter 5, I explored the groundswell of activism that erupted in New Brunswick in 2014, discussing how members of Reproductive Justice New Brunswick, Fredericton Youth Feminists and Abortion Rights Coalition of Canada divided their efforts between keeping clinic abortions in the province and transforming the regulatory framework governing the service. This trajectory demonstrates a consistency in the history of pro-choice organizing in Canada, wherein feminist activists tend to construct abortion clinics as spaces providing a much-needed health service during a period of crisis, as well as spaces that are symbolic of, and rallying points for, political organizing and resistance against the status quo.

The notion of crisis has also played a central role in the history of pro-choice feminist organizing in Canada. While activists in the 1970s and 1980s sought to transform a crisis in the social organization of abortion through the repeal of the abortion law and the establishment of clinics, the activists with whom I have researched were catapulted into action following the closure of the Morgentaler Clinic. As Allison Webster told me during our interview, this was “crisis mode.” Nearly all of my participants described how this crisis — intensified and made visible by the clinic’s closure — was the result of a broader, structural problem in the province’s regulatory framework for abortion care, as mediated by the *Medical Services Payment Act*. When the clinic closed, not only did it bring visibility and awareness to New Brunswick’s

access problems, it also provided an impetus for grassroots mobilization unlike anything the province had ever experienced.

During this period of mobilization in New Brunswick, activists largely framed their struggle through what I have referred to as a discourse of access. As I have shown in Chapters 4 and 5, my research participants tended to conceptualize “access” as the ability for people to obtain safe, timely, affordable, and non-judgmental abortion care in a context that makes sense for them, their family and their community. This conceptualization, which mirrors socialist feminists’ organizing in the 1970s and 1980s, has largely been informed by the reproductive justice framework, which makes visible the ways in which systems of oppression shape the possibility for people to obtain the reproductive healthcare they want and need. In New Brunswick, activists argued, access to abortion is largely a matter of “luck and privilege,” conditioned by one’s ability to travel to one of three urban centers, and to pay out-of-pocket should the procedure be obtained at a clinic. Activists frequently called for an intersectional approach to abortion care by advocating for those at the margins, who face disproportionate barriers to accessing a safe, timely and affordable abortion.

Yet although the reproductive justice framework was influential to nearly all my research participants’ analyses, it was also a site of tension and negotiation among activists. While the discourse of access helped open the relationship between intersectional oppressions and the ability to obtain an abortion, the single-issue approach to organizing meant there was little room to tackle broader problems that are central to reproductive justice work. As I discussed in Chapter 5, the struggle over whether and how to work toward a broader reproductive justice project was in part a symptom of the

crisis in which activists found themselves. Thrust into crisis mode with the loss of the clinic, activists immediately centered their work on solving the problem with which they were confronted: access to fully funded, clinic abortion care.

Finally, despite the advances brought forward by feminist pro-choice activists in New Brunswick, the province's regulatory framework for abortion care remains intact, leaving New Brunswick with what many of my participants have referred to as a semblance of access, and an optics of change in the social organization of abortion care. As I explored in Chapters 5 and 6, by amending Regulation 84-20 and working to expand hospital abortion services, the provincial government was able to articulate a platform that appeared amenable to the demands of pro-choice activists, while simultaneously upholding the very funding restrictions that led to the clinic's closure and the ensuing movement for access. In my conversations with activists, they felt overwhelmingly as if the government had co-opted their language around access to further their political agenda, while failing to deliver on activists' demands. As I have shown, part of this had to do with the tensions in activists' use of the reproductive justice framework, and their tendency to mobilize around "access" as a proxy for reproductive justice work on abortion—that is, work that makes explicit the relationship between structural inequalities and the ability to obtain safe, timely, and affordable abortion care in the province. While my participants largely took an intersectional approach to theorizing access, locating their demands within a discourse of access also provided an opening for the provincial government to restructure service provision without considering the question of who does and does not have access to care. In effect, the government's optics of change and the resulting semblance of access have weakened the capacity for activists to garner the

public support necessary to repeal Regulation 84-20 and ensure safe, timely, and affordable abortion care for everyone, regardless of their social location. This tension points not only to the importance of taking activist accounts seriously when developing abortion and related sexual and reproductive health (SRH) policy, but also the need to be explicit in our demands for access by placing the reproductive justice framework at the center of our organizing.

Policy Recommendations

As my dissertation has made clear, feminist activists have historically played a key role in expanding access to abortion in Canada. Throughout my research with activists, they consistently expressed their strong desire for the provincial government to engage them in meaningful dialogue when developing plans for expanding access to abortion in New Brunswick. As I have argued, due to their location in the social relations of struggle, feminist pro-choice activists bring unique insights into the barriers that women face when accessing abortion care. As my research has demonstrated, when developing abortion policy, it is important to consider how one's ability to obtain a safe, timely, and affordable procedure is inextricably linked to where an individual is located within intersecting relations of oppression. Should policymakers wish to develop inclusive and comprehensive abortion policies that reflect the diverse needs of patients who seek abortions, then it would be useful for them to bring key stakeholders and experts — including but not limited to activists, advocates, service providers, patients and other community leaders — to the table when making important decisions regarding reproductive and sexual healthcare. In general, policymakers would do well to bring key stakeholders and experts. In New Brunswick, such decisions should begin with the full

repeal of Regulation 84-20, Schedule 2 (para a.1) and Chapter M-7, Section 2.01(b) of the *Medical Services Payment Act*. As so many of my research participants have described it, these restrictions were enacted with the stroke of a pen and can thus be abolished with the stroke of a pen. In addition to repealing these provisions, policymakers in New Brunswick should work with key stakeholders to develop accessible, comprehensive, accurate, non-judgmental, culturally relevant, and bilingual information and education regarding SRH in the province.

Should the provincial government continue to deny public funding for clinic abortions, the Federal Minister of Health must hold the province accountable. As I have demonstrated in my dissertation, the government's refusal to fund clinic abortions is in direct violation of the *Canada Health Act*. Because abortion is considered a "medically required" service, the procedure must be funded regardless of whether it is provided in a hospital or clinic. While in the past, Federal Health Ministers Diane Marleau (1995) and Ujjual Dosanjh (2005) have attempted to hold New Brunswick accountable to the provisions set out in the *Canada Health Act*, the current Federal Health Minister, Ginette Petitpas Taylor, has yet to comment on the matter. Considering that Prime Minister Justin Trudeau, a self-proclaimed feminist, has frequently expressed his unwavering support for "a woman's right to choose," it would be amiss for his government to remain complicit in

a regulatory framework that denies access to abortion for women across New Brunswick.¹⁰⁷

Suggestions for Future Research

Given the complex network of institutions responsible for organizing abortion care in New Brunswick, future IE research is necessary to investigate the social relations of ruling that continue to uphold the province's anti-abortion policies, as well as those that are responsible for overseeing and managing service delivery within hospital settings. For instance, how does the everyday work of government employees, hospital staff, and employees within the province's two regional health authorities coordinate the experience of patients seeking abortion care? How do those employed within these institutions conceptualize their work to implement, oversee, regulate, distribute, and/or expand care? While PAE research is helpful in mapping the social relations of struggle, and for offering insights into the work that activists do to transform relations of ruling, more IE-based research may provide a window into the experiences and perspectives of people located within ruling regimes, thus helping to illuminate which institutional actors

¹⁰⁷ Examples of Premier Trudeau's explicitly pro-choice stance include but are not limited to his government's policy that all MPs are expected to vote pro-choice on all abortion-related legislation (Payton 2014); the pledge to fund \$20 million in global sexual health and family planning initiatives (Blanchfield 2017); and the requirement that faith-based organizations applying for funding through Canada's Summer Jobs programme must attest that their core mandate respects "the right to access safe and legal abortions" (Smith 2018).

have the most influence over the development of abortion and related SRH policy in the province.

While conducting research for this project, several activists described feeling somewhat disconnected from the communities they were advocating for in their work to expand abortion access. Though many activists gained insights into the challenges facing patients through their work with the Fredericton Morgentaler Clinic and Clinic 554, others spoke of the need for more direct lines of communication between activists and those seeking abortion care. A mixed method project that brings visibility to people's experiences accessing abortion in New Brunswick would be helpful for identifying the barriers that people continue to face, as well as exploring how those barriers might be experienced differently depending upon one's social location. Combining quantitative and qualitative methods would be particularly useful in New Brunswick due to the climate of shame, stigma, and secrecy that continues to surround abortion in the province, as it would provide people with an opportunity to communicate their abortion story with little risk of exposure. Such a project would build upon the important work of Foster, LaRoche, El-Haddad, DeGroot & El-Mowafi's (2017), whose qualitative research documents the abortion experiences of thirty-three women who sought care in New Brunswick between 2009 and 2014.

As other scholars, researchers, healthcare workers, activists and advocates have expressed before me, Health Canada's 2015 approval of the mifepristone and its subsequent launch in 2017 has the potential to transform the landscape of abortion care in Canada, particularly for those living in rural, coastal and Northern communities. According to Health Canada's guidelines, mifepristone may be prescribed up to nine

weeks gestation to terminate an unwanted pregnancy. In April 2017, New Brunswick Health Minister Victor Boudreau announced that, in an effort to “remove financial barriers to a woman’s right to choose,” the province would provide mifepristone free of charge to any patient with a valid medicare card, making New Brunswick the first province to offer “universal access” to the drug (CBC News 2017). While activists on the ground welcomed the province’s announcement, many also expressed concern over the ongoing semblance of access and optics of change in the province. On social media, several of my research participants criticized the government’s move to declare universal coverage for mifepristone while simultaneously denying public funding for clinic abortions. As a collective, RJNB continues to advocate for expanded access to both surgical and medical abortion, including the repeal of Regulation 84-20, the improvement of services within hospital settings, and the development of resources and accountability mechanisms to ensure that physicians and pharmacists are well-equipped to prescribe and dispense mifepristone within their communities. Future research into patient, pharmacist and physician experiences with mifepristone will undoubtedly help to anticipate and navigate barriers to medical abortions in the province. Researchers may also look to groups such as Planned Parenthood Ottawa, which is working with medical practitioners in the city to help them overcome barriers to prescribing and dispensing the drug, including but not limited to training staff and learning new billing methods for the procedure (McCooley 2017).

Finally, more research is needed into the future of reproductive justice organizing in Canada generally, and in New Brunswick specifically. Future research in this area should examine what reproductive justice organizing might look like in the Canadian

context, in particular in light of recent studies documenting the history of coerced sterilization among Aboriginal women in Canada (Stote 2012, 2015, 2016, 2017), and the ongoing advocacy, activist and educational work of grassroots groups such as the Native Youth Sexual Health Network, which has been foundational to reproductive justice organizing among Indigenous communities in Canada.

Epilogue: Looking Forward

When I began drafting this final chapter of the dissertation at the start of 2017, RJNB was in the middle of launching a new campaign to repeal Regulation 84-20 and demand public funding for clinic abortions. In less than 24 hours, the “Axe 84-20” campaign made headlines in Atlantic Canada’s news media, calling attention to activists’ continued frustration with the state of abortion access in New Brunswick. The intention of this campaign was to be loud and unrelenting, and to call out the provincial government for failing to follow through with its commitment to remove all barriers to abortion in the province, a promise that was first made by Premier Brian Gallant during his 2014 election campaign.

From January to May 2017, I watched as RJNB’s Axe 84-20 campaign struggled to gain traction in New Brunswick and across Canada. Perhaps this lack of uptake was because we are no longer operating in response to a publicly recognized crisis. Indeed, the social organization of abortion in New Brunswick has shifted in recent years: the opening of Clinic 554 and the addition to The Moncton Hospital have created the conditions for a greater number of services to be provided than immediately following the closure of the Morgentaler Clinic in 2014. Still, abortion services at Clinic 554 are not

funded by provincial healthcare. Patients seeking care in hospitals are still reporting wait times, procedural hoops, problems with stigma, and hospital staff functioning as informal gatekeepers. Services remain poorly dispersed in rural and Northern areas of the province. The culture of shame, stigma, silence, and misinformation surrounding sexual and reproductive health continues to pervade much of New Brunswick. As activists, advocates, researchers, and scholars, we must continue to peel back the layers of this semblance of access, and continue to fight for a vision of access that is active, ongoing, and situated within a broader framework of reproductive justice. Our work continues.

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Appendix A

A.1. Sample Email Invitation

To Whom It May Concern,

My name is Sarah Rodimon, and I am a PhD Candidate in the Department of Sociology and Anthropology at Carleton University in Ottawa, Ontario.

Research objectives:

You are invited to participate in a study titled “*We Have the Law / We Need the Access:*” *Activist Perspectives on the Social Organization of Abortion Access in New Brunswick*. The objectives of this study are two-fold: 1) to address the social organization of abortion care in New Brunswick post-1988; and 2) to explore how activists and service providers are challenging the way that reproductive healthcare is regulated and distributed across the province.

Specifically, this project sets out to understand how conservative and anti-abortion forces within the state and the medical community have contributed to the (in)accessibility of abortion services in New Brunswick post-decriminalization. My intention is to begin this investigation from the perspectives of pro-choice activists and service providers, in order to gain insight into their strategies that both hold institutions accountable for their actions, and that work to transform how abortion is regulated, distributed and stigmatized in New Brunswick and across Canada.

Interview Details:

This study involves one in-depth, 60 to 90-minute (minimum) interview, with the possibility of one 30-minute (maximum) follow-up interview. Each interview will take place in a location that is mutually agreed upon, convenient and safe. Providing your consent, interviews will be audio-recorded for the purposes of transcription. Immediately following transcription, all audio files will be destroyed.

Though this project does involve potential emotional and professional risks, it is my intention to protect your identity to the best of my ability by ensuring that all of your responses remain anonymous and confidential.

As a voluntary interview participant, you have the right to refuse any questions, to request that certain responses not be included in the final project, and to end your participation in the study at any time, for any reason, up until December 1, 2015. If you

do choose to withdraw from this study, all information that you have provided will be immediately destroyed, and will not be used in the final project.

Research data will be accessible only by the researcher. All electronic data, including audio-recordings and transcriptions, will be stored in encrypted and password-protected files on my personal computer. All hard copies of data, including handwritten notes, USB keys and consent forms, will be kept under lock and key at my private place of residence.

Ethics details:

The ethics protocol for this project was reviewed and cleared by the Carleton University Research Ethics Board (CUREB). Ethics clearance expires on May 31, 2016. Should you have any questions or concerns related to your involvement in this research project, please feel free to contact the CUREB Chair, Professor Louise Heslop, at ethics@carleton.ca or at 613-520-2517.

If you are interested in participating in this research project, or have any questions related to the research, please feel free to contact me at SarahRodimon@cmail.carleton.ca.

I look forward to hearing from you!

Sincerely,

Sarah Rodimon

PhD Candidate
Department of Sociology & Anthropology
Institute of Political Economy
Carleton University
Ottawa, ON

Researcher contact information:

Sarah Rodimon
Department of Sociology & Anthropology
Institute of Political Economy
Carleton University
SarahRodimon@cmail.carleton.ca

Supervisor contact information:

Dr. Alexis Shotwell
Department of Sociology & Anthro.
Carleton University
Alexis.Shotwell@carleton.ca

A.2. Sample Consent Form

Project Title: “We have the law / we need the access!”: Activism and the Social Organization of Abortion in New Brunswick

Date of ethics clearance: April 24, 2015

Ethics clearance for collection of data expires: May 31, 2016

TO BE COMPLETED IN DUPLICATE

I, _____, voluntarily choose to participate in a study on abortion access and pro-choice activism in New Brunswick. The objectives of this study are two-fold: 1) to address the social organization of abortion care in New Brunswick post-1988; and 2) to explore how activists and service providers are challenging and resisting the inaccessibility of abortion care throughout the province.

The researcher for this study, Sarah Rodimon, is a PhD Candidate in the Department of Sociology and Anthropology and the Institute of Political Economy at Carleton University. Sarah is pursuing this study under the supervision of Dr. Alexis Shotwell.

This study involves one in-depth, 60 to 90-minute interview, with the possibility of one 30-minute follow-up interview. Each interview will take place in a location that is mutually agreed upon, convenient and safe. Providing your consent, interviews will be audio-recorded for the purposes of transcription. Immediately following transcription, all audio files will be destroyed.

As this project will ask about your volunteer work and/or employment, there are some professional risks to you if your statements are critical to the organization for which you volunteer and/or work. Although this risk is expected to be minimal, I (the researcher) will take the necessary precautions to ensure that your identity is protected, by keeping all responses both anonymous and confidential. All participants will have the opportunity to be given a pseudonym to be used in the final dissertation, as well as subsequent write-ups and presentation of findings.

Furthermore, as this project will ask about potentially triggering topics, including though not limited to personal experiences with pro-choice activism and reproductive health and care, there are some potential emotional risks involved should you choose to participate.

Should you experience any emotional discomfort, anxiety or distress during the interview, you will be provided with counseling and support services available nearby.

As a voluntary participant in this study, you have the right to refuse any questions, to request that certain responses not be included in the final project, and to end your participation in the study at any time, for any reason, up until December 1, 2015. In order to request partial or full withdrawal from this study, please contact the researcher using the information provided at the end of this form. Please note that the researcher will not question or refuse any requests for partial or full withdrawal from this study. If you do choose to withdraw from this study, all information that you have provided will be immediately destroyed, and will not be used in the final project.

Research data will be accessible only by the researcher. All electronic data, including audio-recordings and transcriptions, will be stored in encrypted and password-protected files on my personal computer. All hard copies of data, including handwritten notes, USB keys and consent forms, will be kept under lock and key at my private place of residence.

Upon completion of this study, the researcher will keep all research data for five years for potential use in other projects and publications on this same topic. After five years, all research data will be immediately and securely destroyed.

Research for this project will be carried out using political activist ethnographic (PAE) methods. As such, research participants are invited to collaborate with the researcher during all stages of the research project. This collaboration includes: the possibility of follow-up discussions and/or interviews to ensure data saturation; the opportunity to review the researcher's dissertation prior to submission; the opportunity to be provided with a hard copy of the finished research project; and the possibility to collaborate with the researcher on future projects (academic, activist and otherwise) related to this study.

The ethics protocol for this project was reviewed and cleared by the Carleton University Research Ethics Board (CUREB). Ethics clearance expires on May 31, 2016. Should you have any questions or concerns related to your involvement in this research project, please feel free to contact:

REB contact information:

Professor Louise Heslop, Chair
Professor Andy Adler, Vice-Chair
Research Ethics Board
Carleton University
511 Tory
1125 Colonel By Drive
Ottawa, ON K1S 5B6
Tel: 613-520-2517
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Researcher contact information:

Sarah Rodimon
Department of Sociology & Anthropology
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Tel: 613-292-5974
SarahRodimon@cmail.carleton.ca

Supervisor contact information:

Dr. Alexis Shotwell
Department of Sociology & Anthro.
Carleton University
Tel: 613-520-3028
Alexis.Shotwell@carleton.ca

Participant consents to be audio-recorded: ____Yes ____No

Participant requests a pseudonym be used in dissertation and subsequent publications,
presentations and conference proceedings: ____Yes ____No

Signature of participant

Date

Signature of researcher

Date

Appendix B

Figure 1. Mapping exercises to trace social relations of struggle over abortion access in New Brunswick