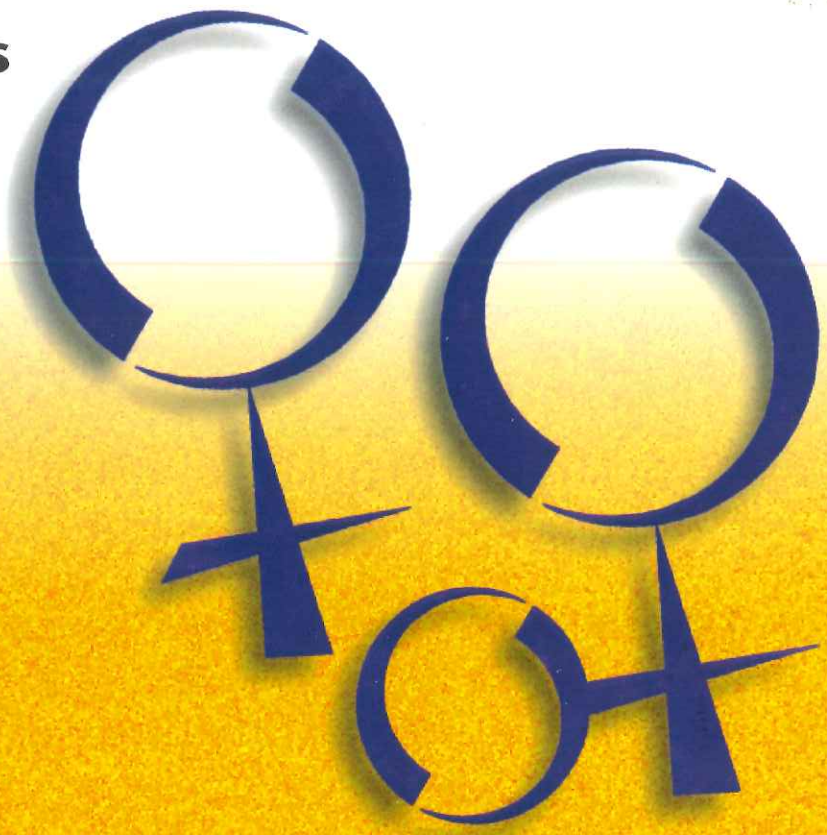
The Status of Abortion Services in Canada

Special Report to Celebrate the 10th Anniversary of the Decriminalization of Abortion



Access Granted. Too Often Denied.

CARAL
Canadian Abortion Rights Action League
Ottawa, January 28, 1998

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A Special Report to Celebrate the 10th Anniversary of the Decriminalization of Abortion

Nancy Bowes, Varda Burstyn and Andrea Knight

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Acknowledgements

There are many people to thank for the completion of this report. We are most appreciative of the accomplishments of Varda Burstyn and Andrea Knight who worked within a tight time frame to order and analyze the many sources this document draws upon. Your research and writing was invaluable in bringing us toward the finish line.

Without CARAL's provincial directors and chapter representatives this task could not have completed. You played a central role in detailing the many aspects of abortion access specific to your communities. We know this work was added to an already busy volunteer schedule. Thanks for your giving so generously of your time.

Many wonderful and courageous women work in the field of reproductive health and abortion provision — and the past weeks have affirmed this once again for each of us. To all our colleagues — working day after day to increase choice while providing the best possible services — goes our sincere thanks for the help so graciously provided to CARAL's volunteers and researchers as they gathered and checked details.

The stories of women from across Canada appear in the pages ahead, bringing the reality and struggle of abortion forward for each reader to see. We believe your stories will effect meaningful change and extend our deep gratitude for the trust you have placed in us. We hope you will see yourself reflected here in a way that will bring lasting value to your contribution.

As this report goes to print, CARAL's 10th Anniversary Committee is truly indebted to Nancy Bowes. Your work as a writer and editor on this report was exemplary. Your talent, encouragement and careful consideration brought this report to fruition. For this we extend our heartfelt appreciation.

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Executive Summary

The Canadian Abortion Rights Action League (CARAL) is releasing this report to celebrate the tenth anniversary of the historic Supreme Court decision of January 28, 1988, which acquitted Drs. Henry Morgentaler, Leslie Smoling and Robert Scott of "conspiring to procure a miscarriage." With this ruling, the Court decriminalized abortion in Canada.

Access Granted: Too Often Denied is a detailed review of the status of abortion in this country over the last ten years. This summary highlights the major findings.

Women no longer face serious illness or death, at the hands of back-street practitioners, to terminate a pregnancy. By leaving the unsafe, illegal abortions of the past behind us, we have seen rates of post-abortion complication and death drop. Access to safe and legal abortion services has improved considerably since the 1988 Supreme Court decision for women who live in Canada's metropolitan centres. (Chapter 2)

For women outside these urban centres, however, access to information, supportive physicians, and abortion services remains difficult. For rural or northern women, young and/or poor women, the last ten years have offered little improvement in practical terms. One major regional variation is abundantly evident: abortion access is more difficult in Atlantic Canada than elsewhere. (Chapter 2)

Provincial health insurance funding is extremely uneven, particularly with respect to funding for abortions in private clinics. And abortion is excluded from the reciprocal billing agreement, making it hard for women who have moved within Canada to access abortion in the first three months of residency in their new province/territory. By limiting access in these ways, the provincial governments blatantly violate federal standards and the principles of the Canada Health Act. (Chapter 2)

Freestanding clinics are now the site where one-third of all abortions in

Canada are performed (compared to less than a tenth of abortions in 1988). This report shows that women benefit from clinic access because clinic doctors and staff are more qualified and empathetic and the surroundings are more supportive. (Chapter 3)

The efforts of courageous providers have been key to the establishment of the abortion services we now have. Today, ten years after decriminalization, the pool of providers is shrinking, presenting a serious threat to abortion access in the years immediately ahead. This decline is mainly attributable to the "graying" of current abortion providers; the lack of medical education and training in abortion procedures; and escalating harassment and violence by anti-choice organizations and individuals. (Chapter 3)

The prediction of a leading anti-choice activist delivered to a CARAL board member in 1989 has been realized. He informed her that having lost in the courts, his movement would take to the streets and make the provision of abortion so dangerous that providers themselves would withdraw services. Over the last decade, in every province, anti-choice forces have waged an overt campaign of harassment and violence against providers and women seeking their help. As a result, fear of retaliation for helping women access legal abortion services has never been higher among pro-choice individuals, most notably abortion providers. (Chapter 4)

This report illustrates the ways in which women have been robbed of the full promise of the 1988 Supreme Court decision. Two main factors account for the many failures regarding quality abortion access. First, the elected representatives and highest-ranking administrators with responsibility for Canadians' health have not accorded priority to women's reproductive health. As a consequence, Canada has neither tackled the challenge of preventing unintended pregnancies, nor conscientiously attempted to provide abortion services in accordance with the "best practices" largely established by caring physicians in freestanding clinics. Second, access to abortion is being limited and further threatened by the tactics of the anti-choice movement. Their criminal acts which include threats of violence, bombings, and sniper attacks, impede women from making a free choice, and impede physicians from delivering safe, legal medical services. (Chapter 5)

Recommendations

Canada needs a national policy specifically to govern abortion rights and access. After a decade of largely unsuccessful attempts to erode the Supreme Court's decision in the Morgentaler case, it is incumbent upon federal and provincial Ministers of Health to accept, and carry out, the responsibility for ensuring women's right to this basic, acute care medical service.

Abortion services must be offered in full accordance with the Canada Health Act. Specifically,

the Ministers of Health who have not already done so should fully insure therapeutic abortion services, whether performed at hospitals or free-standing clinics;

the Ministers of Health should strike abortion from the list of procedures excluded from the reciprocal billing agreement. It is intolerable that women who move within Canada cannot access abortion services in the first three months of residency in their new province/territory. Similarly, women who must travel outside their province/territory of residence to access appropriate abortion services should be fully covered within reciprocal billing agreements;

where provision of permanent, daily service is economically infeasible, toll-free information lines and mobile clinics should be provided; and

where a region or province refuses to provide any service at all, the federal Minister of Health should use penalty funds assessed against the negligent authorities to provide travel and accommodation funds to assist those women left without access to appropriate abortion services within their jurisdiction.

The Ministers of Health should convene meetings of hospital- and clinic-based providers of abortion, so that the sharing of "best practices" can begin.

Local health authorities should strive to reduce the number of unintended

pregnancies. A positive, proactive, ongoing investment is needed in contraceptive counselling, and in the provision of safe, effective contraception. Each generation needs, and deserves, competent, non-judgmental sexual and reproductive health services. Many effective models exist, and these need to be appropriately funded without further delay.

Standards for medical education should be adjusted to ensure there will be sufficient providers of high quality abortion services for all Canadian women. While changes are being made to medical school curricula, the model developed in Toronto for training family physicians in abortion procedures needs to be established promptly across the country. This must be publicly funded for all interested obstetrician-gynecologists and family physicians.

Standards for abortion training and provision must be implemented. Professional standards must be adhered to. It should be no more acceptable for a physician to deliberately misdiagnose the gestational age of a pregnancy out of personal and moral beliefs, than to deliberately misdiagnose any other acute condition in a patient. Nor should it be professionally acceptable for any physician to refuse to give a woman information regarding abortion access. Such actions should be considered gross medical misconduct and both should be liable to professional and criminal sanctions.

The Attorneys General of Canada must move quickly to protect the rights of women to access abortion, and of physicians to provide abortion, by putting an end to the picketing of clinics and harassment of physicians, staff and clients. To this end, strictly enforced "bubble zones" must be placed around abortion facilities and doctors' offices and homes in every community where they are needed. The "bubble zones" around clinics and doctors' offices must be sufficiently large to allow women unimpeded access to hospitals and clinics, and physicians unimpeded access to their professional, and legal, work.

The Attorneys General of Canada must assign all resources at their disposal to ensure the arrest of any and all persons responsible for the shootings of three abortion providers in Canada during the last four years.

The Attorneys General, having responsibility for maintaining respect for the

law, should direct that charges be more vigorously pursued where anti-choice actions impugn the laws of the land.

Every pro-choice Canadian must assume personal responsibility for changing the climate of threats and intimidation against abortion providers and abortion seekers. In our daily discourse, in the organizations where we work, worship, and play, we must increase choice for all Canadian women.

Introduction

Canadian women dream of being able to make their own way in the world — of contributing to their families and communities in ways that fulfil the destinies they map out for themselves. Many of us anticipate the prospect of bearing and raising children as part of that destiny. The dream shatters when an unintended, unwanted pregnancy occurs. Faced with this situation, some women revise their life plans. Other women decide that abortion is the best option for their well-being and that of their families.

Canadian women's autonomy and security of person was brought many steps closer with the historic Supreme Court decision of January 28, 1988, which acquitted Drs. Henry Morgentaler, Leslie Smoling and Robert Scott of "conspiring to procure a miscarriage." The Court decriminalized abortion in Canada. In the decade since that decision, the right of women to the procedure has been democratically affirmed, legally protected, and partially institutionalized in a significant number of metropolitan hospitals and clinics across this country.

The Canadian Abortion Rights Action League (CARAL) is releasing this report to celebrate the tenth anniversary of the Supreme Court decision of 1988. It is a detailed review of the status of abortion in this country in the last ten years. CARAL's purpose is to identify and acknowledge the gains made. Our analysis of the data collected, however, leads us to challenge elected representatives and health care providers to eliminate the many pernicious barriers to access. Working together, with women's best interests at heart, this country can and must provide a uniformly high level of reproductive health care. We challenge the nation to put a stop to anti-choice harassment, attacks and shootings. It is within the power of our lawmakers and peace officers to achieve this.

The report is organized as follows:

- Chapter 1 (Abortion in the Canadian Context) assesses the place of abortion in women's lives, and provides a brief outline of the history of abortion in Canada.

- Chapter 2 (The Status of Abortion Services in Canada) is a comprehensive and up-to-date survey of the status of abortion services in Canada in the 1990s. It looks at changes in the commonly computed rates of abortions and the characteristics of the women who seek them. It also identifies how access to abortion services differs among different groups. It shows the variations in provincial funding for abortion and begins to document the effects of cutbacks in provincial health care spending and of health care system restructuring on abortion provision. Finally, it also underscores many violations of the Canada Health Act with respect to the provision of abortion across Canada.

- Chapter 3 (Quality Issues in Abortion Provision) addresses key issues in the quality of care in abortion services. It identifies lessons from the clinic experience and addresses the deficits in medical education in regard to abortion. New models are proposed for abortion services and health professions training regarding abortion.

- Chapter 4 (The Opposition: Anti-Choice Forces and their Impact) examines the effects of the anti-choice actions on abortion providers, elected representatives, government and health system administrators, and the vulnerable women who encounter anti-choice individuals while seeking abortion services.

- Chapter 5 (Conclusions and Recommendations) draws overall conclusions and compiles the recommendations offered elsewhere in this report.

Chapter 1: Abortion in the Canadian Context

This chapter gives a brief history as well as an overview of current social attitudes. It also explores women's reasons for seeking abortion and the impact of the abortion experience. Its purpose is to document abortion in Canada up to 1988.

A brief historical outline

Contraception and abortion were officially criminalized early in the nineteenth century; in practice, they were tolerated in both law and religion.

> *"Contraception and abortion were both employed early in the nineteenth century. A woman would 'put herself right' by drinking an infusion of one of the traditional abortifacients such as tansy, quinine, pennyroyal, rue, black hellebore, ergot of rye, savin or cotton root.... If these [methods] failed, women often tried anything from leaping off tables to imbibing gin, followed if necessary by dilating the cervix with slippery elm.... If it were not beyond the sixteenth week... the woman would turn to the abortionist. How would one find the help required? It was only necessary to glance at the advertisements in the personal and medical columns of the local paper.*
>
> *McLaren and McLaren, 1986*

The Canadian anti-abortion laws formulated between 1869 and 1892 remained in place until 1969. This did not mean that abortion stopped. Rather, criminalization pushed abortion underground for a hundred years. In this time, scores of women died due to illegal, unsafe abortions. Some 5,000 women are estimated to have perished due to botched abortions in the period between 1926 and 1947. This official prohibition also caused irreparable damage to women's health and altered profoundly the lives of those who bore unwanted children.

By our centennial year, we were living in a society fundamentally different from the colonial society which had outlawed contraception and abortion. The Pill was available and the state was deemed to have no place in the bedrooms of the nation. In 1969, Parliament legalized contraception and liberalized the criminal law relating to abortion.

When the thrill of this victory subsided, it became clear that the legal channels for access to abortion were extremely limited. In this new era, physicians serving on Therapeutic Abortion Committees (TAC's) were given sole authority to decide whether a pregnancy constituted a risk to the life or health of the woman. No hospital had to have a TAC, but only a TAC could authorize a legal abortion.

Women's experiences ranged from discomfort to anguish. There were long waiting periods, and many women underwent inquisition-style interrogation and humiliating 'psychiatric' assessments. This was not what women had hoped for — or expected. In 1973, Dr. Henry Morgentaler went on trial in Quebec; it was to be the first of four jury trials. The next year, CARAL held its inaugural meeting in Ottawa. Dr. Morgentaler's legal struggle galvanized the pro-choice movement.

By 1982 only 261 of 861 public hospitals in Canada had TAC's. Reliable abortion was available in only two provinces — Ontario and Quebec — and access was non-existent in Prince Edward Island. Such limited access was an insult to Canadian public opinion which strongly supported a woman's right to abortion.

The need for resolution and consistency was finally answered by the Supreme Court, when it deliberated on the 1986 charges of "conspiracy to procure a miscarriage" laid by the Government of Ontario against Drs. Morgentaler, Smoling and Scott. The defense grounded its argument in the constitutional right to have and to perform safe abortions. On January 28, 1988, the Court handed down its decision: it acquitted the physicians, struck down Section 251 of the Criminal Code, and decriminalized abortion. The ruling was worded more strongly than pro-choice activists had dared to hope, and there was much in the decisions to celebrate.

In a desperate attempt to address the anti-choice backlash that followed the 1988 decision, the Conservative government attempted to recriminalize abortion with Bill C-43. Passed by the House of Commons, Bill C-43 was blocked by a tie vote in the Senate after vigorous lobbying by women senators from all parties. A tie was not sufficient to pass the bill. As of the tenth anniversary of the Morgentaler decision, abortion remains a legal medical procedure in Canada.

Social attitudes toward abortion

Since the late 1950s, the majority of Canadians have favoured women's right to choose an abortion to terminate an unintended and unwanted pregnancy. In the last twenty years, that majority has represented roughly 70 per cent of the population: 69 to 74 per cent in the polls, depending on the wording of the question. This consistent support has permitted the development of jurisprudence that grants women the right to abortion as a matter of their constitutional right to the security, dignity and autonomy of the person.

Anti-choice Canadians, by contrast, have constituted a much smaller, if also a relatively consistent, proportion of the population. Again, depending on question formulation, their estimated numbers have registered from 16 per cent to 24 per cent of Canadians, or approximately 20% of the population. Hence, Canadians favouring women's right to abortion outnumber those who do not by more than 3:1. The majority for abortion rights is broad, solid, decisive, and consistent over time, with deep roots in many constituencies.

This stable consensus has developed in Canada at the same time as most Canadians have come to accept, and expect, the equality of women and men. Women's lives, however, are shaped as much by the economic context as by social attitudes. In current economic conditions, motherhood is a life-transforming condition. Many women are self-sustaining and/or the sole supports of their children. A significant proportion of women are partners in dual-earner parenting arrangements. Women's income is no longer "pin money." "In many cases [wives'] earnings are essential to keep their families from

falling into poverty or to prevent a substantial drop in their standard of living" (National Council of Welfare 1990). Planning and controlling whether and when to give birth is crucial to women's day-to-day survival. Thus, despite huge strides towards equality, women continue to bear much greater costs in childbearing and childrearing than men do. The right to abortion, a crucial part of fertility control, is tied to women's equality.

Full fertility control is crucial to women's ability to provide for themselves and their children; and providing adequately for children is a key consideration for those pondering motherhood. This is certainly true for women contemplating parenting for the first time — sometimes alone, often where there is little community support for the lone parenting role. The high rate of separation and divorce also forces women in traditional family arrangements to contemplate the need for economic independence. In Canada today, many women feel they have no choice but to limit their fertility in relation to their resources — financial, social, emotional, and physical. Indeed, this society disapproves of those who give birth without sufficient means to raise children independently.

"*NOVA SCOTIA: At that time of my life, I just couldn't [carry the pregnancy to term]. It was a really, really bad time, and I don't want to make it sound like a convenience or anything else. . . . I mean, here I was, I was on welfare, had one child. A child having a child, trying to raise him to the best of my ability. Working a little here, a little there, trying to get on my feet, trying to grow up, trying to take care of a household, the whole works, everything. And I really, really thought about it. I think I considered every single possibility there ever was. . . . I knew [abortion] was the right decision all along, but I had to admit it to myself.*

Pressures on women to limit their fertility have consistently translated into a single-minded determination on the part of women, spanning generations, ages, languages and economic circumstances, to find ways to terminate those pregnancies for which sufficient resources are not available.

Why Canadian women seek abortions

Contraceptive failure

Clinic workers estimate that well over half of women seeking abortions do so because of failed contraception. Dr. Marion Powell, in a 1987 study for the Ontario government, estimated that proportion to be even higher. This means that most women seeking abortions were also actively seeking to prevent conception when they became pregnant.

While there is a public perception that contraceptives are sufficiently reliable to enable effective choice in childbearing, this is not so. Some women's options are very limited, and birth control measures fail. As well, problems of access to accurate contraceptive information parallel those of access to abortion.

"*NOVA SCOTIA: I can't use a very effective form of birth control. I can't use the pill; I can't use the IUD; I can't use a diaphragm. What does that leave you with? Not much. And it's very easy for 'not much' to fail.*

"*NEWFOUNDLAND: When I first missed my period I didn't think I could be pregnant. I was doing exams at school and thought that it happened because of stress. How could I be pregnant, I was on the birth control pill. No one ever told me that if you take medication it will decrease the effectiveness of the pill. I took a home pregnancy test and found out that I was pregnant. I knew I wanted an abortion and called to make an appointment at the Morgentaler clinic. I was nervous even though I knew this was what I wanted. My boyfriend did not help me at all. I did it alone. I was too afraid to tell my family. I had my own money for the abortion. I had to borrow money to pay my tuition at university.*

Many Canadians believe that information about and the means of contraception are readily available to all women. Unfortunately, this is still not the case. Some women, notably the poor, the unwed, the physically and mentally abused, women outside metropolitan centres, immigrants and adolescents, do not have access to effective contraception.

The survey of abortion services in Chapter 2 further underscores the degree

to which health and social service cutbacks are eroding whatever services have been available across the country. For example, many Planned Parenthood branches are losing government funding and in some locales are folding. These offices are often the only source of abortion information in a region, as well as the only sources of information on other birth control and sexual health issues. If these services are lost, the problem of unintended pregnancies will grow and accessibility to abortion will narrow even further for affected women.

Economic factors

In their struggle for security and some measure of autonomy, women have made hard reproductive decisions based on difficult economic realities. Abortion statistics demonstrate the effect of economic conditions. Before 1988, the greatest increases in abortion year by year were seen among women 14–25. The years since decriminalization saw large increases in the numbers of mothers in their thirties seeking abortions. This suggests greater economic stress on adult women as a depression-like recession hit Canada, cut huge swaths through the social fabric, and foreclosed on the possibilities of additional children for many women and families. It also suggests that some women were ready to limit family size to pursue other goals when this option was more readily available.

The cost of providing children with the basics they will need to become self-sufficient in this world is an enormous responsibility. Furthermore, the prolonged period of education women now need to compete in the labour market means that many must postpone childbearing at least into their late twenties. Thus many women decide not to bring pregnancies to term during their most fertile years in order to assure themselves of a livelihood.

It is certainly a testament to the status of women in Canadian society that so many women, finding themselves pregnant, face the stark choice of motherhood and poverty or an abortion. In 1986, the child poverty rate in young families was about 1 in 3. In 1996, 44 per cent of children in these families are likely to be poor (Campaign 2000, 1996). Hence, the notion of a "choice," implying an array of equally plausible options, is a distant dream for many women.

Incest, rape, abuse, control

Because the perpetrators of abuse are rarely considerate of such things as birth control, pregnancies result from sexual crimes committed against girls and women. One in eight girls in Canada is sexually abused before she reaches the age of 17 (B.C. Task Force on Family Violence, 1992).

As the historic 1930s Bourne trial in England acknowledged, (the judge approved an abortion for a 14-year-old girl who was the victim of a gang rape), carrying such a pregnancy to term would do much more harm to the girl than would an abortion. Problems of abuse are also present in many adult relationships and provide the context for decision making with respect to pregnancy.

"SASKATCHEWAN: I am twenty-five years old, and I recently sought my second abortion. I already have two pre-school children that I am struggling to raise. Both abortions came about because my partner — who is abusive at times and wants me to have another baby — hid my birth control pills and ripped up my back-up prescriptions.

Fetal anomaly

Every decade since the 1960s has brought increasingly sophisticated techniques of pre-natal diagnosis — ultrasound, amniocentesis, alfa-fetoprotein analysis, chorionic villi sampling. The rapid proliferation of such technologies and new discoveries in genetic science and testing are accelerating the diagnosis of fetal anomaly. Such diagnoses can exert enormous pressures on women to abort a fetus with a genetic or congenital anomaly.

"NOVA SCOTIA: I sat down with myself and thought a lot about what I could do when I received the amniocentesis results. But I really thought my only option was abortion.

Because the most reliable form of pre-natal diagnosis (amniocentesis) is done at 16 weeks and takes up to 3 weeks for diagnosis, resulting abortions typically take place at 18–20 weeks. Of all abortions performed, under 4 per cent are for genetic indication.

For women who hold anti-abortion views, genetic anomaly can constitute an exception to the rule.

NOVA SCOTIA: I am really not for abortions. I don't agree with it unless there's a case like this [fetal abnormality]. . . . Our decision was made years ago when our first child died.

Shame

There are still many women who fear the shame of a pregnancy more than the fear, shame, or guilt of an abortion. The stigma of bearing a child "out of wedlock" and the family shame involved in such a situation may compel some women to seek abortions.

BRITISH COLUMBIA: If you talk to your parents they get all red and don't say a word. If you talk to your own parents they get suspicious and ask you, "Are you having sex? Why are you asking about a pregnancy test? Is it for you?"

*(14-year-old student quoted in **Realizing Choices.**)*

The stigma surrounding sex and "out-of-wedlock" pregnancy is greatly diminished from what it was a generation or two ago, particularly among urban, middle-class groups. However, it is far from gone. Where family culture is still closely related to traditional family patterns and sexual mores, pregnancy remains a mark of immoral behaviour in the lives of young, unmarried women.

The impact of abortion

Making the decision

"The literature on abortion abounds with the work of ethicists, philosophers, and theologians who repeatedly refer to the 'agonizing' process of coming to a moral decision on abortion," write the authors of *Telling Our Secrets,* a unique 1990 study that compiled both statistics and demographics for the province of Nova Scotia and conducted in-depth interviews with 25 Nova Scotia women with respect to their abortion experiences.

Fully one-quarter of the women interviewed found that the decision seemed so overwhelmingly clear and necessary that no mental anguish was present at the decision.

NOVA SCOTIA: I knew I would [have an abortion] as soon as I found out I was pregnant. I didn't even entertain the thought of carrying the baby, although I guess purely for situational reasons, not reasons that I don't like children, or I don't feel I would be a good mother, not reasons like that. Only because I was only 18, first year of university, I had a lot of plans, and the whole shame thing.

While women know what they have to do, and are clear about the decision, some women strongly wish that circumstances could be different. Sadness, however, is not anguish, and should not be interpreted as an unhealthy psychological response to a weighty decision.

NOVA SCOTIA: I was really sad that that was the way it had to be. Sad that, if things had been a little different, maybe we could have had this baby.

Waiting

For many women, the most stressful part of having an abortion is the wait between the time of making the decision, and being able to schedule the procedure itself. This time is not only difficult for women emotionally, it can also add considerable health risks related to later term procedures.

Delay in obtaining an abortion can have serious health consequences for the woman. A key variable is gestational age, defined as the length of the pregnancy calculated from the first day of the last menstrual period. A number of studies have found that the greater the gestational age when an abortion is performed, the greater the risk of complications or death.

(Powell, 1987)

Insofar as women do experience mental anguish in having an abortion, it is exacerbated by the extent to which they have to face it alone. When women are subjected to the frustrations of making many calls to obtain information, or to unnecessary waits for an abortion, or to judgmental health care providers, they bear the brunt of an unwanted pregnancy to a cruel extent.

"SASKATCHEWAN: A 21-year-old woman from Saskatoon was certain about terminating her pregnancy, but very anxious about obtaining a referral. The doctor who had provided the pregnancy test refused to talk about an abortion, or give her a referral to someone who would. Fortunately, through the help of a counsellor she was seeing, she was finally referred to Planned Parenthood. It took her two weeks to obtain this referral. She was then informed that as she was only 5 weeks pregnant, she would have to wait another two weeks to see a doctor. She then faced another two weeks of waiting for the procedure, 6 weeks of waiting in total to end the pregnancy, and this caused her great anxiety and stress. This woman had heard about medical (pharmaceutically induced) abortions. She said her extreme anxiety would have been vastly relieved had emergency contraception been available to her.

(Source: CARAL Volunteer)

This woman's experience shows that delays in obtaining abortions have to do with deficits in the system, not with women's indecision or lack of commitment to effect the best possible outcome.

After the procedure

A favourite tactic of anti-choice activists is to warn women who choose abortion that they will suffer dire psychological consequences for years following their procedures. Some researchers have concerned themselves with the emotional effects of therapeutic abortion in an effort to distinguish pathological from normal reactions. A review of the literature disputes this claim of emotional and spiritual trauma.

"Although there may be sensations of regret, sadness, or guilt, the weight of the evidence from scientific studies indicates that legal abortion of an unwanted pregnancy in the first trimester does not pose a psychological hazard for most women.

(Adler et al, 1990)

More than simply the absence of trauma, other studies have reported a positive benefit to the women — an immediate and long-lasting sense of relief that was fundamental to their well-being.

"Of all women who have first trimester abortions, up to 91 per cent report a sense of relief following the termination of pregnancy.

(Planned Parenthood Federation of America, 1987)

Similar findings were reported in *Telling Our Secrets* (Bowes, 1990). For many of the participants in that study, there was enormous relief once the abortion was behind them. They reported feeling healthy and happy, once again in control of their lives.

"NOVA SCOTIA: Relief. Initially, just a lot of relief, knowing that this worry and thinking, puzzling over what I was going to do, was over. I could get back on my feet.

"NOVA SCOTIA: Happy, just happy. I kind of felt in control of my life again, kind of like being given a second chance. . . . It was kind of like a healthy happy; it was like a big breath of fresh air.

What lingered for some of the women participating in the Nova Scotia study (they had their procedures in the years bracketing the 1988 Supreme Court decision) was not anguish over their decision, but anger at the way they had been treated by the system, the hoops they had been made to jump through to obtain their abortions and the lack of compassion, consideration or support through the procedure.

Even today, as the next chapter shows, for significant numbers of women, stress related to accessing abortion services does not begin or end with their treatment by the health care system. For them, stress involves acute economic, family and cultural issues. Very young women, or women who are poor or culturally isolated, may have to deal with making excuses for absence from school, work, or home, while arranging for an abortion. Excuses must also be found to explain the need to rest afterwards. Some women, due to circumstances beyond their control, carry on without adequate rest, increasing the risk of post-procedure complications.

"ONTARIO: Marta is a Filipina who works as a nanny in Moore Park (an affluent neighbourhood in Toronto.) She came to a Toronto clinic and had to be rushed through all the proce-

dures because she had so little time off work. When the abortion was over, she got up and made her way out the door to pick up the children she was responsible for after school.

(Source: Clinic staff)

A woman who must travel far from her local community for an abortion, and who has young children but no supportive partner, may also face the difficulties of organizing and paying for extended childcare. Even if she does have a supportive partner, she will need to choose between having the partner care for the children or support her through the abortion procedure. Either way she faces additional stress. Once again, in the matter of stress and trauma, rural, northern and poor women pay much higher costs for anti-choice conditions than southern, urban and affluent women.

With respect to women's evaluation of the emotional and spiritual cost to them of the abortion relative to the cost of having borne that pregnancy to term, studies suggest that women who chose to have abortions believed it was the best decision for themselves and their families and think in retrospect that they made the right decision.

Analysis

For women to gain reproductive control, there must be straightforward access to a full range of reproductive health services. These services, including abortion, must be delivered in accordance with "best practices" (see Chapter 3) to ensure the highest possible quality of care.

One of the "best practices" which is seldom discussed is emergency contraception. For women who have unprotected intercourse, or know immediately about contraceptive failure, emergency contraception is extremely effective within 24–48 hours of intercourse. Good education about, and availability of, emergency contraception through doctors' offices, health centres, public health units, and hospital emergency departments would attenuate the need for surgical and late term abortions. Better use of emergency contraception would eliminate the emotional and financial stress of thousands of women annually seeking abortion services.

Pharmaceuticals such as RU 486 often provide the safest, least-invasive, most economical and readily available first-line of care in dealing with unwanted pregnancies. Yet the Canadian government refuses to facilitate its entrance to Canada.

In CARAL's view, supporting motherhood also entails moving toward equalizing the responsibilities and costs of parenthood between men and women. We believe that public policy should assist parents in general, and mothers in particular. Societies that offer a full range of reproductive health services, including abortion, as well as universal day care and other supports for parents (such as the Netherlands, the Nordic countries and France) typically have lower rates of unwanted pregnancy, as well as healthier women, children and families.

"*Countries which have developed access to safe, legal abortion have typically lowered the rates of pregnancy-related complications and death as well as infanticide, and improved the health of women and their families.*

Childbirth by Choice Trust, 1990

When such woman-, child-, and family-positive supports are in place, women can freely choose when and if to parent.

Whether for reasons of contraceptive failure or due to economic factors, whether because of sexual violation or genetic indication, women decide to terminate pregnancies. Women have been, and continue to be, responsible moral agents in relation to decisions affecting their own bodies. They take into account all the complexities of their lives and the quality of the life they could offer to a child should they decide to carry a pregnancy to term.

Women's decisions, however, have been undermined — too often, and for too long — by a system that fails to accord enough priority to reproductive health.

Chapter 2: The Status of Abortion Services in Canada

Here we survey the Canadian scene — every province and territory — to bring together a comprehensive picture of abortion services across Canada. The chapter opens with a look at the statistics and what they tell us. We examine the ways in which access differs — ways that so vividly mark the Canadian landscape. Funding issues are addressed, as well as the impact that widespread restructuring health and social services is having on abortion provision. Finally we point to violations of the Canada Health Act which have resulted from the disparities and funding issues noted.

The availability of data on abortion services is uneven across the country. Statistics Canada estimates that detailed national data are available on only 69% of all abortions performed (76% of hospital abortions and 54% of clinic abortions). Only a few provinces provide good information, and only two, British Columbia and Ontario, have carefully documented the qualitative and quantitative aspects of access through task forces. These provinces have succeeded in documenting barriers to access and making recommendations for improvement.

Various sources, therefore, were used to fill gaps. CARAL Provincial Directors and local Chapter Representatives were key informants in fleshing out the current status of services in their own provinces. Other helpful sources are listed in the reference section at the end of this document.

Concern for the safety of providers and their families, and the women seeking their services, has made reporting of details difficult. In Nova Scotia, for instance, CARAL has found it necessary to conceal the names of publicly funded hospitals that provide abortion services because of the fear of anti-choice violence. For the same reasons, we do not have clear figures on the

numbers of individual physicians doing their best to provide abortion services in small communities across the country.

The resulting picture, while not as detailed as we might prefer, does allow us to report a number of significant findings and to make useful observations and comments in the following five areas:

- Incidence and Setting
- Demographics of Women Seeking Abortions
- Major Disparities
- Funding, Cutbacks and Restructuring
- Violations of the Canada Health Act

Incidence and setting

The incidence of therapeutic abortion is best understood in terms of two commonly computed rates: the rate of abortions per 100 live births and the rate per 1,000 females aged 15-44. These rates are shown in the chart on the next page and include procedures performed in our hospitals and clinics as well as those performed for Canadian women in U.S. clinics. (The following are figures reported to Statistics Canada. 1995 statistics are the most recent available at the time of writing.)

	Rate of Abortions per per 100 Live Births	Rate of Abortions per 1,000 women aged 15-44
1975	14.9	10.5
1976	16.3	11.1
1977	16.5	11.1
1978	18.8	12.0
1979	19.1	12.4
1980	19.4	12.6
1981	19.3	12.3
1982	20.2	12.5
1983	18.6	11.4
1984	18.4	11.4
1985	18.4	11.3
1986	18.6	11.2
1987	18.9	11.3
1988	**19.3**	**11.6**
1989	20.2	12.6
1990	22.9	14.6
1991	23.6	14.7
1992	25.6	15.1
1993	26.9	15.3
1994	27.6	15.5
1995	28.2	15.5

Twenty years of data provide a context for examining changes in abortion services. The rates, and their gradual changes over twenty years, suggest that abortion occurs in the context of a changing economy, legal changes and total fertility changes. A rate of 10.5 abortions per 1,000 females in 1975 and 15.5 abortions per 1,000 females in 1995 looks on the surface like an immense increase. A closer look makes the increase understandable. This twenty year period saw enormous changes in access to abortion. Certainly the increased availability of the procedure accounts for a considerable proportion of the increase in this rate. This interpretation is bolstered by the fact that the two largest year-by-year increases in the rate occurred in the two years immediately following the legalization of abortion. This suggests that the 1988 Su-

preme Court decision meant what we had hoped it would mean — the normalization and acceptance of abortion as a legitimate and safe option for women facing an unwanted pregnancy.

Similarly, the rate of abortions per 100 live births climbed steeply immediately after legalization. The continued growth is a reflection of declining numbers of live births as much as it is a reflection of increased numbers of abortions.

The 1995 statistics also confirm a trend that has been evident since the legalization of abortion in 1988. The proportion of women having clinic abortions has risen rapidly, while the proportion having hospital abortions has declined steadily. As of 1995, 33% of abortions reported in this country were performed in freestanding clinics. In 1987, the year before legalization, only 5.5% of abortions were performed in clinics.

CARAL has long recognized the advantages offered by freestanding clinics over hospital abortion services, while understanding the need for the provision of high quality abortion services within hospital settings. The experiences of women interviewed for *Telling our Secrets* (Bowes, 1990) made the differences between clinics and hospitals clear.

"*NOVA SCOTIA: You know that as soon as you're in that house [the clinic], that everyone supports you; there's never any doubt. That's the thing about a hospital, you never know. Every time you come up against somebody, you just never know how they're going to react... It [the clinic] was wonderful. Anyway, it is quite a bit different. The whole atmosphere, you know that everybody working there thinks it's an okay thing to do, and they're supporting you, and they're giving you as much information as you want. You know you can ask them for information.*

The statistics show that women are now choosing the high-quality, supportive atmosphere clinics have come to represent when they need abortion services. It is surely no coincidence that in a province such as British Columbia, where clinic abortions are fully funded, the number of abortions performed in hospitals declined by 12% in just one year (1994 to 1995). In Nova Scotia, where clinic services are only partially covered under public health insurance, the number of clinic abortions declined by 20% in the same time pe-

riod. It offends the most basic medicare principles that more affluent women can choose a higher quality service, whereas poor women must choose a poorer quality service because clinic fees are not covered by public health insurance.

Demographics: The women who seek abortions

In 1995 abortions were most common among single women in their twenties (reflected in both hospital and clinic data). This observation has held constant for over twenty years. There has, however, been significant growth over a decade in the proportion of procedures performed on women in their 30s. As we might expect, the increased age of women seeking abortions is changing the overall reproductive history of women seeking abortions. Thus, there has been a considerable increase in the proportion of abortions for women with at least one child and in the proportion who have had at least one previous abortion. The following chart contrasts the characteristics of women having hospital abortions in 1985 versus 1995.

Women having hospital abortions 1985 versus 1995

1985	1995
67% were single women	63% were single women
55% were women in their 20s	52% were women in their 20s
20% were women in their 30s	25% were women in their 30s
38% were women having at least 1 prior delivery	50% were women having at least 1 prior delivery
20% were women having at least 1 prior abortion	30% were women having at least 1 prior abortion
2.1% complication rate	1.1% complication rate

This chart, together with a knowledge of the downsizing of Canada's workplaces over the same period, suggests that abortion is increasingly the

choice of women who are limiting the size of their families in accordance with harsh economic realities. Canadian mothers by and large *need* paid employment for their families to survive. And as any Canadian mother knows, the rigours of labour-force participation are not amenable to the needs of babies and young children. Until Canadian society is truly family-friendly, we should expect to see mothers limiting their family size. Women's own legitimate goals of being both mothers and paid workplace participants are also likely part of this change. It is a choice that was neither legally nor safely available to the last generation of Canadian mothers when they had had one or two children.

Anti-choice critics are quick to point to proportions of women having more than one abortion as evidence that abortion is used as a method of birth control by ill-prepared, unfeeling women. Given that the proportion of women with one prior abortion in the 1970s was almost nil, *any* increase in the proportion of this group will appear large. Consider also that women with regular menstrual cycles have 260 opportunities to conceive in the twenty-year period of greatest fertility. It should come as no surprise, then, that some women seek abortions at 33 for the same reasons they sought them at 21 — contraceptive failure, economic factors, coercive sexual partners. Canadian women are not wanton abortion-seekers. Indeed, the proportion of abortions for women with at least one prior abortion has risen slowly over the past decade, in accordance with changes in access.

Most gratifying is the sharp decrease in the complication rate following abortion shown in this chart. This is a clear indication of the high level of confidence with which Canadian women can now choose abortion. The Nova Scotia study (Bowes, 1990) identified several post-abortion complications among its small sample. Women's own words about those complications told of their harrowing experiences. Clearly, the new legitimacy brought to the abortion procedure by the 1988 Supreme Court decision has allowed superior practices to be developed and shared.

There are many ways in which access to abortion services is more difficult for young women, especially if they are also poor, rural, or members of First Nations or immigrant groups. Like many older rural and northern women,

they often have little or no access to local abortion information and services, but the issue of privacy is even more problematic in small communities when parental consent is required. They also have fewer social resources to find the information they need, including pregnancy tests. Young women who face difficulties in explaining absences from school for doctors' appointments encounter even greater difficulties when they must explain extended absences to travel for a day or several days for abortion services. And young women also have fewer financial resources to pay for clinic abortions and travel.

The major disparities: Rural/metropolitan, north/south

Tracking regional variations in abortion services using inconsistent data is a challenge. While the hospital figures from Statistics Canada break down the number of abortions performed according to the woman's province of residence, abortion clinic figures are broken down according to the province in which the clinic is located. Although it can be assumed that the majority of clinic patients live in the province where the clinic is located, we do know that many women obtain clinic abortions in provinces other than their own. This is especially true of women in Atlantic Canada and also occurs in Saskatchewan, the Northwest Territories and Yukon.

Despite difficulties related to inconsistent data collection, at least one major regional variation is abundantly evident: abortion access is more difficult in Atlantic Canada than elsewhere.

"*NEWFOUNDLAND: I live in a rural community. There is no hospital and there are never enough doctors. I suspected I was pregnant and called my family doctor to make an appointment for a pregnancy test. I was really nervous. I asked him if I was pregnant and he said: " Congratulations, you're pregnant." I told him that I was not really excited and that I was thinking of having an abortion. I asked him for the information "just in case" and he refused to give it to me. I went to all the doctors in town and everyone gave me the same answer. I got my friend to call Planned Parenthood in St. John's and ask where you could get an abortion. By the time I found out where I could go and talked to someone at the clinic, it was too late. I was told I couldn't have an abortion because I was too far along.*

The adversity women endure due to limited access in Newfoundland is magnified in the complete absence of abortion services in Labrador, Prince Edward Island and Cape Breton. Furthermore, where the procedure itself is not provided, many women also experience great difficulty getting referrals from local physicians. Often women must look outside their region for the medical referral that will grant them access to a hospital abortion. The Halifax Chapter of CARAL has operated the AIRS Line — an abortion information and referral service — for over ten years. Women from all regions of the Atlantic Provinces have called on the AIRS Line for the names of friendly physicians and for information about the procedure in hospitals and clinics. A major part of this CARAL Chapter's struggle to provide timely access has been maintaining an up-to-date list of names of supportive physicians. Day after day, volunteers have given out those names to women who had already been turned away by their family physicians, or who knew that they could not ask their physician for help gaining access to abortion.

Prince Edward Island stands alone as the only Canadian province or territory which refuses to provide abortion services anywhere within its jurisdiction. A 1988 government resolution banned the procedure in all six Island hospitals. The estimated 200 Island women who seek abortions each year must leave the province for abortion services. The minimum procedure cost to Prince Edward Island women is $450, and that figure can rise to $750 when delays force a later stage abortion. Added to this are the associated costs of travel and, in some cases, childcare, meaning that, in total, an Island woman seeking an abortion will likely need at least $600 in up-front cash.

"*PRINCE EDWARD ISLAND: In the spring of 1997, a senior high school student called Planned Parenthood Nova Scotia (PEI does not have even a Planned Parenthood chapter.) She was the only child of supportive, but not very assertive, parents of low economic background. She told the woman who answered her call that this was the thirtieth call she had made looking for an abortion referral. The young woman thought that she was about 12 weeks pregnant and was clear that she wanted an abortion; she needed information as to how to go about obtaining one. Her parents had no car, but they would rent one to bring her to Halifax. Planned Parenthood Nova Scotia arranged with CARAL Halifax to pay for half of the Morgentaler Clinic fee, since her parents would not be able to pay for the car rental and the full clinic fee (PEI does not provide Medicare coverage.) On arrival at the Morgentaler Clinic in Halifax, the young woman discov-*

ered that she was farther along in her pregnancy than she thought, and was over the clinic's limit for gestational age. CARAL Halifax raised the money for the young woman to pay for the abortion in Montreal. Her aunt in PEI was able to pay airfare to take her niece to Montreal. The abortion was performed at 17 weeks at great personal cost to a family with very limited personal resources. A less tenacious young woman would have given up and likely given birth to an unwanted child.

(Source: Planned Parenthood Volunteer)

Two other kinds of geographic factors also affect access to abortion services. These factors, best described as rural/metropolitan and north /south variations, cut across all regions of Canada from east to west.

For women who live in Canada's metropolitan centres (Halifax, Montreal, Ottawa, Toronto, Winnipeg, Calgary and Vancouver), access to safe and legal abortion services has improved considerably since the 1988 Supreme Court decision. These cities, however, are in the south, requiring lengthy travel for women residing in Northern and/or remote regions. Working women, who might be assumed to have considerable social and economic resources to organize and pay for services in a distant city, do nevertheless face difficulties in travelling to a metropolitan area to have an abortion.

Consider then, the plight of women who live outside metropolitan areas and are young and/or poor. Often, such women have little or no access to local abortion information and services. CARAL and Planned Parenthood activists have consistently noted that in smaller, tight-knit communities confidentiality becomes increasingly difficult to assure for young women. In "one-doctor" towns, few options exist — especially in instances where parents' attitudes differ significantly from their children's in relation to sex, pregnancy and abortion. If a young woman knows, or fears, that her doctor will require parental consent, this constructs a severe barrier to access regarding contraception, pregnancy testing, and/or abortion referrals. School-aged women can also face difficulties in explaining absences from school for doctors' appointments. Such difficulties are compounded if long distance travel is required and absences become longer (one day to several — or a series of extended times away). Young women also have fewer financial resources to

pay for clinic abortions and travel. Hence we can appreciate that young, rural women have limited choices when trying to prevent and/or deal with an unwanted pregnancy. For these women, the last ten years has offered little improvement in practical terms.

In provinces such as Newfoundland, Nova Scotia, New Brunswick, Prince Edward Island and Manitoba, because the provincial governments refuse to fund clinic abortions, even where hospital abortions are not available, women who seek an abortion from a clinic must have personal resources.

"*NEW BRUNSWICK: The Supreme Court decision has had very little real impact in my region. Before 1988 women travelled six to ten hours for a costly clinic abortion in the United States. Since 1988, women travel six to ten hours for a somewhat less-costly Canadian clinic abortion.*

Source: Member of Fredericton Chapter, CARAL)

And often, where hospitals do provide abortions, women must make multiple trips, with added stress and delays, to arrange the procedure. Either way, living outside cities means arranging and financing travel (often over huge distances), paying for food and accommodation, and, for some, organizing childcare back home. Added to this are the considerable barriers to finding abortion information in rural areas. Clearly, women outside Canada's major metropolitan areas are adversely affected by poor local access to abortion services.

"*YUKON: My daughter had an abortion when she was 18. We were living in a rural area down south. She knew she wasn't ready to be a mother and her boyfriend and I were supportive of her getting an abortion, but we couldn't find a doctor near where we lived to perform the operation. She had to travel to a city away from home and she was nearly at the end of the safe time to have an abortion. It was an emotional, costly and traumatic experience.*

(Source: Multiple Roles, Multiple Voices: A Survey of Yukon Women, 1994)

In central Canada, the absence of services outside metropolitan areas is a marked feature. In Quebec, access is concentrated in Montreal, where 75% of the province's abortions are performed. Access tends to be scarce outside

Montreal. (The Quebec Minister of Health is currently working to establish full abortion services in all regions of the province.) Two-thirds of Ontario abortions take place in only five cities, all in southern Ontario. Indeed, five downtown Toronto clinics provide 1/4 of all the abortions in Ontario.

"*ONTARIO: Since there are no abortion services in Owen Sound, Ontario, a pregnant woman travels to a clinic in Toronto. Her husband is working, so she must bring her two children with her to the clinic. The clinic does not have any daycare facilities. The children's presence is stressful for the woman, for the other patients, and for the staff, but the woman is poor with no other resources to help her.*

(Source: Abortion clinic administrator)

In Saskatchewan, access is also a serious problem for women in the southern and central rural areas, who must travel up to 100 km to find services. Women in the northern part of the province must travel up to 1000 km. Some Saskatchewan women are forced to travel to Calgary or Edmonton because of delays.

For women living in the Northwest Territories and Yukon, long distance travel to available abortion services also imposes high costs and necessary absences from home. The NWT government does provide some travel grants for women who live in remote settlements to ease those costs.

In Alberta, while many rural women also face the need to travel long distances, there is a twist on the usual north/south experience. Although there are three hospitals and one clinic serving northern Alberta, only one hospital and one clinic serve women needing abortion services in southern Alberta, where there is a much larger, expanding population.

Some provinces, most notably British Columbia and Ontario (while under pro-choice NDP governments), have attempted to deal with regional inequities in access to abortion services. Following the 1994 report *Realizing Choices*, and as part of the new regionalization of health care, the British Columbia government mandated that all health boards be pro-choice, and that all general hospitals offer abortion services. In theory, this meant that 72

hospitals should have been providing the service. In actual fact, by 1995/96, only 41 hospitals were providing abortion services. Predictably, the serious gaps in service remain in the northeastern and central — the more rural — parts of the province. In Ontario, the Institute for Clinical Evaluative Sciences (ICES) report released in April, 1997 confirmed that only 76 of 158 general hospitals provide abortion services. Ontario, like the Northwest Territories, does provide Northern Health Travel Grants to Northern women who must travel to seek abortion services outside their own community.

Ontario hospitals providing abortion services, by health planning regions

- 94% of Toronto hospitals provide abortions (16/17)
- 64% of Central Eastern hospitals (14/22)
- 63% of Central Western hospitals (15/24)
- 35% of South Western hospitals (12/34)
- 30% of Northeastern hospitals (11/35)
- 31% of Eastern hospitals (8/26)

(Source: ICES, 1997)

It is impossible to provide a reliable estimate of the numbers of women who want abortion services and do not get them. However, it is absolutely clear from the research done for this report that inability to pay the costs related to abortion services keeps women away. Despite fully-funded services in public hospitals, and clinics that will not see a woman go unserved, the distance from unserviced, remote areas is an enduring barrier for women outside metropolitan areas. Add to basic travel the cost of staying overnight in a big city, of arranging childcare at home, of missing work or school, and the picture of economic inaccessibility becomes clearer. Women of means, wherever they live, can pay for the services they need. The forty-year-old mother of two, living on social assistance in Cape Breton, must choose between having another child and spending that month's food budget on abortion-related costs. That is not the kind of choice Canadians want for themselves or their daughters.

Funding, cutbacks and restructuring

The situation *vis-a-vis* provincial health insurance funding of abortion is inconsistent from jurisdiction to jurisdiction. This is particularly true with respect to funding for abortions in private clinics, the preferred or only option for many women.

Variations in provincial funding for abortion

- Newfoundland fully covers the cost of hospital abortions. In 1992, the province changed its policy in regard to clinics and began covering the physician fee portion of clinic abortions. (The physician's fee ranges from 1/5 to 1/3 of the total cost, depending on the gestational stage.) More recently, the current government has initiated changes that further assist women in accessing clinic services in St. John's.

- Prince Edward Island does not cover abortions in clinics anywhere, and no hospital abortions are performed in the province. A regulation in the province's *Health Services Payment Act* states that the government will pay for abortions only if they are performed in a hospital and are deemed "medically necessary" by a board of three to five physicians. A claim for out-of-province abortions must also show that "other options were discussed." Under these conditions, women from Prince Edward Island find it almost impossible to get access to any of the hospitals in Atlantic Canada that do offer abortion services.

- Nova Scotia fully funds abortions performed in hospital, but will only cover the physician's fee for a clinic abortion.

- New Brunswick will only cover abortions approved by two physicians and performed by a gynecologist in a hospital. Dr. Morgentaler challenged the provincial government's refusal to pay for New Brunswick women's out-of-province clinic abortions. He won this battle in 1989, but has yet to receive payment.

- Quebec globally funds abortions in hospitals and in *centres locaux de santés communitaire* and in one women's centre. Various funding formulas cover at least a portion of fees in abortion clinics.

- Under the 1990 *Independent Health Facilities Act,* the Ontario government provides global funding to abortion clinics, as well as funding abortion services in hospitals. Funding promised by the Rae government for new abortion clinics and birthing centres was axed by Mike Harris soon after he was elected premier.

- In Manitoba, abortions are covered by the province only if they are performed in hospitals, not in clinics.

- Saskatchewan now insures hospital abortions within the province and clinic abortions in Alberta. The provincial government remains opposed to the funding and establishment of freestanding abortion clinics within Saskatchewan.

- Since July, 1996 the Alberta Health Care Plan has covered abortions for all residents. The Capital Health Authority in Edmonton now allows patients to choose whether they will have their abortion in a hospital or in a clinic. This is reducing waiting lists for the procedure.

- In both the Northwest Territories and British Columbia, the health insurance plans cover abortion services in clinics and in hospitals.

- In the Yukon, hospital abortions are covered by Yukon Health Care. There are no clinics in the Yukon, but procedures done outside the territory are insurable. Women must pay up front and then apply for reimbursement.

In most provinces in Canada, women who have to travel within and/or out of province for procedures continue to have great difficulty in getting travel funding. Ontario does provide travel grants to northern women. In Saskatch-

ewan, although the province will pay for out-of-province abortions in Edmonton and Calgary, there is no government funding for travel or accommodation. Again, this represents a serious barrier for poor women.

These disparities in access across provinces, regions and groups seem to be worsening. Our review indicates that recent widespread cutbacks in health and social service budgets, coinciding with health care system reform, are having a negative impact on the availability and quality of contraception and abortion services.

Alberta is currently undergoing massive health care restructuring. There, Regional Health Authorities (RHAs) have been set up to carry out region-based planning, resulting in wide variations in services from region to region. Consequently, abortion services are now organized and funded to the level desired by regional boards and/or senior staff. Pressured both by the lack of funds from the provincial government and by competing demands from health care workers who have been hard hit by the cutbacks, RHAs are targeting women's reproductive health services. The capping of abortion services at the Kensington Clinic, Calgary, is one example of the effect of regionally-based decision-making and the lower priority placed by some RHA's on basic reproductive health services.

In Ontario, the 1996 Omnibus Bill 26, along with health care restructuring, is causing hospital closings in the name of rationalization of provincial health care services. This in turn is affecting access to abortion in many areas of Ontario. Such changes are exacerbating the inequality of access that already existed. In small communities outside Toronto, restructuring can mean the loss of a local hospital or the amalgamation of a general hospital with a Catholic hospital. The result is increasingly limited access for abortions as well as other reproductive health services.

"*ONTARIO: With increasing cuts to the health care budget, ultrasounds in pregnancies are no longer a part of routine pre-natal health care. A young 27-year-old woman visits her doctor believing she is pregnant. She is healthy and there are no manifest indications that she does not have a normal pregnancy. In her 18th week, the doctor examines the pregnant woman and feels*

that her size does not correspond to her estimated weeks of gestation. The doctor orders an ultrasound which finds a severe fetal anomaly. The woman is now 19 weeks. By the time the doctor sees the woman, she is close to 20 weeks. The woman is unable to gain admission to any of the local hospital [abortion] units for fetal indications, and she is referred to a hospital in the US. With health care cuts, fewer ultrasounds are deemed necessary. Therefore, we are going to discover things like fetal anomalies later, putting women at greater risk.

(Source: Toronto abortion clinic administrator)

The difficulty experienced by rural women in getting abortion referrals and information from local physicians undoubtedly stops many women from having abortions. The other result seen frequently by hospital and clinic staff is inappropriate delay. When women do not have timely access to pregnancy tests, counselling, abortion information and/or funding for travel to the major centres that provide those services, they are backed into seeking later term (and therefore riskier) abortions. Over twenty years of experience in helping women access safe abortions has demonstrated to CARAL volunteers that gaps and deficits in our system — not women's indecision — cause late term abortion. Once again, this is especially true for poor women who are unable to make private arrangements in order to overcome unacceptable gaps in service.

Violations of the Canada Health Act

The Canada Health Act (CHA), unanimously passed by Parliament in 1984, encompasses five fundamental principles meant to ensure that all Canadians have high-quality, comparable health care from one end of the country to the other. The five basic principles embodied in the Act are *accessibility, universality, portability, comprehensiveness* and *public administration*. As recently as the December, 1997 First Ministers conference in Ottawa, Prime Minister Chretien vowed that "if somebody breaks the law [the Canada Health Act], the federal government will be the government that enforces that law."

In the case of abortion services, however, it is evident that the federal government is not following through on Chretien's vow. All five principles of the Canada Health Act have been blatantly disregarded and fundamentally

contravened with respect to abortion services, with virtual impunity for the provincial governments that are entrusted to maintain them. For its part, the federal government has abdicated its obligation to enforce them.

This abdication is extremely disheartening to those who put faith in federal standards being applied to something as basic to women's health as abortion access. Henry Morgentaler turned to the courts to insist that funding be available for PEI women seeking assistance from his Atlantic clinics. He won in the first instance (1995) and lost on appeal. Believing the federal government would act on behalf of PEI women, he did not appeal to the Supreme Court of Canada. Dr. Morgentaler now sees this as a mistake:

> *"I was so convinced at the time that the Canadian government would force the provinces to provide the service. The ball is now in the lap of the federal government and the federal Minister of Health, who should enforce the rules of the Canada Health Act.*
>
> *(Casey, 1997–98)*

The Medicare "system" has never been fully applied in relation to abortion, and seems to be in greater peril today than ever before. Indeed, when Ottawa demanded that the provinces live up to their obligations under the Canada Health Act and pay for abortions in clinics, five provinces (Manitoba, Quebec, Prince Edward Island, Nova Scotia, and New Brunswick) refused outright.

Accessibility

Under the principle of *accessibility,* provincial governments are obliged to ensure that basic and necessary health care services are provided under "uniform terms and conditions," are "reasonably" accessible, and that there are no financial barriers to Canadians receiving the care they need. As the above review has shown, abortion services are provided under highly various terms and are not reasonably accessible to many women. As demonstrated earlier, severe financial barriers do clearly exist.

Comprehensiveness

To meet the principle of *comprehensiveness* of health care, the provinces must cover all "medically necessary" services inside or outside of hospitals. The standards and model of service delivery we outline in Chapter 3 describes the necessary services and standards for abortion provision. Currently, with regard to abortion, provincial health systems flunk the Canada Health Act test.

Universality

Under the principle of *universality*, access to a "medically required" health care service cannot be denied to any Canadian, living in any province, because of inability to pay. But the fees and related costs of obtaining a clinic or hospital abortion in a distant city are high. For thousands of Canadian women, universality in abortion services is a mirage.

Public Administration

The principle of *public administration* requires that provincial health insurance plans be administered directly by the government or by a non-profit agency fully accountable to the provincial government. Yet women in several jurisdictions do not have access to health insurance with regard to abortion services. While this state of affairs may not contravene the principle of public administration, it certainly demonstrates that some public health insurance plans are not administered justly.

Portability

The principle of *portability* ensures that Canadians are able to receive comparable care under similar conditions in different parts of the country. In order to accomplish this, and to allow Canadians to move freely throughout the country without sacrificing crucial access to health care, the provinces must ensure that benefits are portable from province to province through mechanisms of reciprocal billing. These are agreements that the provinces negotiate to decide which procedures and services one province will be able to

bill another. In other words, through reciprocal billing, the provinces articulate what they consider to be essential health care.

Abortion is excluded from provincial reciprocal billing lists, thus thwarting at the outset the principle of *portability* in relation to abortion services. And, unlike other services that have been excluded from the list, abortions cannot wait three months until a woman returns to her home province. So if a woman, moving to or living temporarily in another province, needs an abortion, she will find that most hospitals and clinics are not able to provide an abortion unless she can pay "up front." In hospitals, abortion costs can be especially restrictive. While some provinces routinely reimburse women when they apply for compensation (assuming that the woman has the resources to pay for the procedure first,) others do not.

The capping of procedures at Calgary's Kensington Clinic also challenges the portability and universality of health care *within* the province, especially for those requesting late terminations. The Clinic must restrict the numbers of Calgary area women it sees per week, and the number of second trimester procedures funded by the Calgary Regional Health Authority is limited to two per week. Ironically, women north of Red Deer (who are unable to obtain later terminations in Edmonton), can visit Calgary's Kensington Clinic and have Edmonton's Capital Health Authority pay for the procedure as required. Consequently, women from Central and Northern Alberta are obtaining better access to Calgary services than Calgary area women. As well, women from out-of-province and those without any health insurance have often obtained quicker access to the Clinic, as they are not part of the quota that has been imposed. With limits on the number of spaces allotted to Calgary area women, the Clinic often has more than enough space in their weekly schedule to meet the out-of-region demand. Unfortunately, due to reciprocal billing rules, out-of-province women must still pay a facility fee.

In 1995, the federal government set October 15 as the deadline when provinces must pay for clinic abortions both within the province and through reciprocal billing of their health insurance plans or suffer government sanctions. Although Alberta did begin to cover clinic abortions, five provinces refused. The Prince Edward Island Health Minister told Ottawa that abor-

tion policy is the provinces' business. To date, the federal government has not, to our knowledge, imposed any sanctions. According to 1996 statistics from the province's health agency, an average of six women per year, over five years, were reimbursed for abortions in hospitals while an average 148 women per year went to the Morgentaler Clinics in Halifax and Fredericton. The Quebec government also refused to accede to federal Health Minister Diane Marleau's demand that abortions in clinics be publicly funded like hospital abortions, as did New Brunswick, Nova Scotia and Manitoba. Nova Scotia Health Minister Ron Stewart said that the province was willing to pay $130,000 a year in federal penalties to maintain its policy of covering only the physician's fee in the Halifax Morgentaler abortion clinic.

Summary

It is fair to say that young single women continue to be the modal group having abortions. Ten years after the legalization of abortion, they are much more likely to go to a freestanding clinic to have the procedure, and they are much less likely to suffer complications afterward than was the case before 1988. Women in metropolitan areas are likely to find straightforward access. If they reside in any of Canada's three most populous provinces, their abortions will be fully insured. Despite this promising sketch, many women remain in the shadows: unserved by local physicians or hospitals, unfunded by their provincial health insurance plans. Women in Atlantic Canada and in Canada's rural and remote areas continue to be particularly ill-served when it comes to abortion services. In addition to these stark geographic disparities, inequality of access is noted among poor women, young women, immigrant women, and First Nations women.

Recommendations:

Canada's Ministers of Health, as the elected representatives charged with ensuring the optimum health of Canadians, must work together to achieve the highest quality reproductive health care for women. Abortion services must be offered in full accordance with the Canada Health Act.

Specifically, the Ministers of Health who have not already done so should fully insure therapeutic abortion services, whether performed at hospitals or freestanding clinics; and

where provision of permanent, daily service is economically infeasible, toll-free information lines and mobile clinics should be provided; and

where a region or province refuses to provide any service at all, the federal Minister of Health should use penalty funds assessed against the negligent authorities to provide travel and accommodation funds to assist those women left without access to appropriate abortion services within their jurisdiction.

The Minsters of Health should convene meetings of hospital- and clinic-based providers of abortion so that the sharing of "best practices" can begin.

Local health authorities should strive to reduce the number of unintended pregnancies. A positive, proactive, ongoing investment is needed in contraceptive counselling and in the provision of safe, effective contraception. Each generation needs and deserves competent, non-judgmental sexual and reproductive health services. Many effective models exist, and these need to be appropriately funded without further delay.

Chapter 3: Quality Issues in Abortion Provision

Despite tremendous gains in access over the past ten years, some women, particularly those who obtain abortions through our hospitals, continue to report trying experiences. The purpose of this chapter is to compare practices and performance records of hospitals and clinics and to identify key quality-of-care issues in abortion provision. To open a discussion of constructive alternatives, we then propose a model for delivering quality abortion services that meets the requirements of the Canada Health Act. Lastly, we address the need for professional standards in abortion provision and for changes in medical and nursing education to achieve these standards.

Evaluating hospitals and clinics

As noted in Chapter 2, abortions performed in freestanding clinics have accounted for an increasing proportion of abortions performed in Canada in the past decade (Statistics Canada, 1997). Over 1/3 of all abortions are now performed in clinics. Abortion clinics now exist in all provinces except two — Prince Edward Island and Saskatchewan. The territories are also without clinics.

Since the 1970s, there has been a significant improvement in the proportion of hospital procedures performed in the first trimester (Statistics Canada, 1997). In 1975, 81.3% of hospital abortion procedures were performed in the first trimester (12 weeks gestation or less). By 1991, that proportion had risen to 93.1%. The most recent statistics show a slight decline in the proportion of first-trimester abortions to 87.7%. Half of that decline is due to a significant increase in the proportion of abortions for which no gestational age is reported (from none in 1991 to 2.8% in 1995). The other half of the decline, however, is mirrored by a increase in the proportion of

second trimester abortions. CARAL posits that delays — caused by lack of access to information, a scarcity of supportive family physicians, non-existent or poor service in outlying regions — are the primary cause of that increase.

Statistics Canada data (1997) also show that 88% of hospital abortions were performed in the first trimester of pregnancy, compared to 83% at the clinics. In large part, this is because so many hospitals only perform abortions on pregnancies under 13 weeks, whereas most clinics are providing abortion services up to 16–17 weeks. Women, who by various circumstances have had their access to a timely abortion delayed, often must go to a clinic for second trimester procedures. Because clinics tend to offer more routine access for early second trimester abortions, they bridge a major gap in hospital abortion services.

Accessibility

Decriminalization and the elimination of cumbersome Therapeutic Abortion Committees (TACs) have coincided with generalized health care policy shifts to outpatient services. Some hospitals have taken advantage of these developments to incorporate some of the "best practices" in abortion service delivery developed in clinics across North America. Although the situation remains uneven, these improved practices have greatly enhanced both access and the quality of care offered to women. There has been a general shift toward the use of local anesthesia for the majority of procedures. In some cases, the development of outpatient clinics has resulted in abortion services being provided in more supportive surroundings. However, despite a high level of dedication and commitment among physicians and nurses working within hospital settings, vestiges of a more institutional system of service delivery remain. These include outdated equipment, bureaucratic procedures and the inappropriate use of general anesthesia.

Most hospitals still require physician referrals for a therapeutic abortion. The referring physician makes the appointment and sends a letter of referral with her to the hospital. If a woman cannot get a referral from a local physician, she must be referred to an agency (such as Planned Parenthood) since

most hospitals do not take on the responsibility of arranging a referral. Despite decriminalization, we continue to be apprised of situations where women cannot find local physicians willing to make abortion referrals. Women often must travel to another part of the province just to get a referral, adding unnecessary delay. Referrals for later term abortions are particularly difficult to obtain. For example, in one Nova Scotia hospital, abortions at 16-18 weeks gestation are subject to a Department of Gynecology policy which requires that two physicians or two psychiatrists must certify "impending harm" for a woman to have the procedure.

The enormous variation in the provision of hospital abortion services is troubling. The differences between the two hospitals in Saskatchewan that perform abortions are illustrative. Both are located in major centres, but one hospital has established a women's health centre. Women attending this hospital find a "clinic-type" atmosphere, where abortions are performed up to 16 weeks under local anesthesia, with specially-trained staff who have chosen to work in this area. The other hospital admits patients to a regular day surgery unit, where abortions are performed in the operating room under general anesthesia, by staff who have not necessarily chosen to work with patients needing abortions. It is unfortunate that nursing staff who work in general outpatient surgery units are not always given a choice about working with abortion patients.

In the Northwest Territories, a scandal erupted in March of 1992 when it was made public that women having abortions at Stanton Yellowknife Hospital were not given any anesthetic during the procedure. This disclosure resulted in the resignation of the territorial Health Minister and the launching of an inquiry. In its June 1992 report, this committee recommended thirty-two improvements for the delivery of abortion services in the Northwest Territories. The report highlighted the need for improved access and recommended the establishment of services in three additional hospitals. The committee also recommended that local anesthesia be made standard, with general anesthesia available on request, and that all abortion patients should receive better treatment, information and counselling. These are standards which are routinely met by all the free-standing abortion clinics currently operating in Canada.

There are now thirty-four freestanding clinics providing abortion services across the country. Nineteen (56%) of these are in Quebec. Eleven are government-run Centres Locaux de Sante Communitaires (CLSCs) and three are women's health centres. Added to these are five privately-operated clinics. Most abortion clinics operate on the model pioneered in Canada by Dr. Henry Morgentaler. The Quebec CLSCs were established by the Parti Quebecois government in the early days of the struggle to shift abortion services out of hospitals and to combine them with community primary care. The CSLCs were clearly ahead of their time. In terms of the delivery of publicly funded primary care, including abortion services, they represent an important and progressive step. In contrast to Quebec, when it comes to the provision of abortion services outside hospitals, the rest of the country has relied solely on the establishment of private clinics by individuals or collectives.

In general, access to abortion services in clinics is much easier because women can refer themselves. Further, most clinics do not have a minimum age of consent, permitting young women access with confidentiality. In the vast majority of cases, a woman will only have to make one visit to a clinic to have an abortion. Even second trimester services (up to 16 or 18 weeks) are routinely offered on the same outpatient basis.

The following experience illustrates how responsive free-standing clinics can be, even when cases cannot be handled within their own facility.

"*MANITOBA: A woman called the Morgentaler clinic on a Monday morning for an abortion. She had come to the city from up north and had no idea how far along she was in her pregnancy. The clinic arranged an ultrasound for her at the hospital that day, which showed that woman's pregnancy was 15 1/2 weeks gestation. She was too far along for the next procedure day at the clinic, so the clinic staff arranged for the woman to see a private doctor. The doctor did the pre-operative procedure immediately, and the next day the woman had the procedure completed in the morning and was back in her own community by evening.*

(Source: Staff, Winnipeg Morgentaler Clinic staff member)

Overall, clinics are clearly able to provide access in a way that is difficult for large institutions to achieve. By focusing on abortion as a specialty, they are able to offer highly qualified and experienced staff, as well as more supportive surroundings, and are thus better able to create positive experiences for their clients. This pattern in service provision was visible in the 1970s and 1980s, and is strongly confirmed once again by the qualitative and quantitative information we have reviewed. In determining how best to improve access to safe, effective abortion services in Canada, we must examine what constitutes quality of care in abortion services and identify the specific components that contribute to the high quality of care delivered to women by abortion clinics.

Quality of care

Almost every comparison of women's experiences in clinics and in hospitals shows that the specialized freestanding clinics consistently score higher than public hospitals in regard to the provision of abortion services. It is only fair to note, however, that large institutions do offer better protection from picketing, if only because they are not such an obvious target for anti-choice activists. While there is no doubt that quick access to abortion services is crucial to women, we have also seen that the process of gaining that access, and the quality and manner of the abortion experience itself makes an enormous difference to women's emotional and physical health. In addition to providing women with more timely access, clinics perform better than hospitals in terms of pre-operative counselling, supportive surroundings, physician and staff expertise, range of anesthesia and other pain management techniques, post-operative care and counselling, and fewer post-procedure complications. Such advantages were apparent as early as the mid-1970s when Dr. Morgentaler was asked by the Quebec government to train physicians to provide abortion services in the CLSCs. They were strongly affirmed in women's testimony about experiences in the late 1980s (Bowes, 1990). And they were key considerations when Ontario's NDP government contracted with Dr. Morgentaler to establish a training program for abortion providers in 1994.

Clearly, the standard of abortion services developed in Canadian clinics

provides women with the safest, most effective and most supportive access to a health care service required by over 100,000 women annually. The procedures used by clinics have been developed over the last twenty years, primarily by family physicians who have worked diligently and collectively to improve the quality of abortion practices. We now need to make these "best practices" into national standards and ensure their application across settings. In this way, a woman can be assured the same best standard of care whether she has an abortion in a hospital, clinic or primary care centre.

Standards for high quality abortion services

Most of the specialized abortion clinics now operating in Canada adhere to similar standards with respect to the provision of abortion services; many of them follow closely the model established by Dr. Morgentaler. Many Canadian clinics were set up by Dr. Morgentaler or by physicians whom he trained, and, as we have already noted, many of the physicians who staffed the first CLSCs in Quebec were also trained by him. All private clinics in Canada also adhere to the standards set by the Washington-based National Abortion Federation (NAF). These standards were established by the providers (including Dr. Morgentaler) who pioneered the specialized abortion clinics throughout North America in the early 1970s.

The standards set by these physicians, nurses, counsellors and administrators have dramatically improved women's access to, and experience of, abortion services. In recent years, with shifts to out-patient services, hospital abortions have begun to adopt aspects of the clinic model. The following sections highlight these standards and guidelines, which are much more routinely found in Canadian clinics than hospitals.

Access

- The first principle of quality abortion service provision is that appropriate abortion services must be readily accessible to minimize the waiting period for women. Abortion is an acute care need.
- Women must be able to self-refer, because requiring referrals wastes

precious time. And in many locations, sympathetic physicians are not available.

- Women who are unclear about the stage of their pregnancy must be assessed quickly, through interviews, physical examinations and ultrasound.
- Once women have reached a safe gestational period for abortion, the waiting period should be no more than one week.
- Whenever safely possible, abortion services should only require one visit at the abortion facility.

Services

The available services in the same facility should include:

- pregnancy testing and accurate assessment of gestational age, including both ultrasound and physical examination;
- emergency contraception and a full range of abortion services;
- contraceptive information, counselling and prescriptions where necessary; and
- IUD insertion when requested by the patient.

Counselling

All patients must have access to skilled, non-judgmental and empathetic counsellors who specialize in sexual and reproductive health, abortion and contraceptive technology.

Skilled providers

High quality services must be delivered by a team of skilled, qualified and empathetic medical staff, including a licensed physician. All team members should be specially trained in outpatient abortion procedures; able to determine gestational age accurately; experienced in emergency protocols; and experienced in different methods of pain management.

Emergencies and referrals

Where the facility is unable to perform the abortion because of physiological complications (such as tubal pregnancies), or because the gestational age is too advanced for the facility to do the procedure safely, there must be systems in place for immediate referral to another acute care facility that can handle the situation. For these reasons, and in cases of complications encountered during the abortion procedure, the facility performing the abortion must be close to a major acute care hospital to which the patient can be transferred, and facility's physicians must have full admitting privileges.

Post-operative care

Following the abortion, the abortion facility must provide full and appropriate post-operative care and instructions, with 24 hour emergency follow-up available. Post-operative check-ups need to be readily available, and for women who have travelled to get the procedure, an appropriate referral for local follow-up should be arranged.

Funding

The costs of abortion services must be fully covered through medicare, and travel grants to cover costs related to extraordinary travel must also be available.

By instituting the highest possible national standards, we can ensure that all Canadian women will receive quality care, regardless of what kind of health facility is providing the service. Access will be greatly improved through across-the-board public funding. This will place the right to choose a safe and effective abortion within the reach of all women. However, in order to establish and maintain high quality abortion services, we must also ensure that there are sufficient numbers of providers.

Abortion providers — A shrinking pool

The efforts of courageous providers have been key to the establishment of the abortion services we have. Now, ten years after decriminalization, the pool of providers is shrinking, presenting a serious threat to abortion access in the years immediately ahead. The decline in the number of service providers is attributable to three main causes: the "graying" of current abortion providers; the lack of medical education and training in abortion procedures; and escalating harassment and violence by anti-choice organizations and individuals.

The "graying" of providers

Older physicians who are performing abortions in Canada today remember the tragedy of unsafe abortion provision by "back alley" abortionists. One senior American physician, speaking at a 1990 symposium on strategies to ensure the availability of future providers in the United States, estimated that before the decriminalization of abortions, obstetrician-gynecologists used to spend 60% of their time dealing with botched abortions. These physicians were motivated by the tragedies they witnessed to begin the work of stopping the lethal toll criminalization took on women and their families. Sensitive and dedicated physicians provided safe procedures despite the personal risks involved with performing medically sound, yet illegal, procedures. Providers who offered options to women in this early era are now gradually retiring.

On the other hand, younger doctors and nurses who could step forward to fill the gaps created as older providers retire, have no personal experience of a time when abortion was illegal. More importantly, they are not being sensitized by their professional training to the issues and needs of this component of reproductive medicine.

Lack of medical education

There is an appalling absence of training in abortion procedures in Canada's medical and nursing schools. Almost none of the schools formally include

abortion as any part of undergraduate curriculum on women's reproductive health. Exceptional are McMaster University in Hamilton and the University of British Columbia. At these schools, newly formed Medical Students for Choice groups have been successful in incorporating a forum on abortion at the undergraduate level.

The Institute for Clinical Evaluative Sciences document (1997) reported that 15% of the physicians interviewed did not perform abortions because they had never received the necessary training as part of their medical education.

Most obstetric and gynecology residency (post-graduate) programs include some abortion training, but this training is offered primarily as an elective subject. Due to heavy workloads, many residents are reluctant to add "non-essential" courses. In some cases, abortion training, even at this level, may be in the form of a lecture, with no requirement to observe or perform actual procedures. Our review shows no family medicine residency programs that include abortion training. Residents in these programs who wish to gain skills in abortion provision must, at their own initiative, try to get abortion training included as an elective subject.

There is another systemic problem with the training of future abortion providers. As the National Abortion Federation (NAF)/American College of Obstetricians and Gynecologists (ACOG) symposium noted in 1990, "much of the extremely influential body of clinical and technical knowledge that has evolved with the [specialized abortion clinic] experience also evolved *outside* hospitals and the medical education and training establishment." Even if obstetrics-gynecology and family physician residents were required to have abortion training, under the current training system they would be training without the benefit of clinic experiences and practices. This would include less exposure to second-trimester abortions, since the majority of these procedures are being done in the clinics.

Despite poor access to training while in medical school, it is mainly family physicians who are performing abortions in clinics. Trained by highly-skilled physicians such as Dr. Morgentaler, these physicians perform admirably.

Unfortunately, they have little access to the in-hospital surgical training needed for post-procedure complications. The only exception to this is the two-week abortion training program in Toronto, which provides multi-site training at the Bay Centre for Birth Control, the Toronto Morgentaler Clinic and the Toronto Hospital. Because this program is funded by the Ontario government, it is only open to Ontario physicians.

The situation is not very different in nursing schools across the country. Unless senior nursing students choose an elective in women's health, they will get little or no discussion and/or training on abortion procedures. Nursing students may get some exposure to abortion procedures if they choose to specialize in out-patient or other surgical nursing. However, unless they also choose an elective in women's health, they will receive such training outside the context of women's reproductive health and the needs for supportive non-judgmental counselling for abortion patients. Positioning abortion within elective and/or specialty areas of training marginalizes this central reproductive health service.

Overall, curricula for Canadian medical and nursing schools give short shrift to abortion. Part of the problem lies in a typically Canadian division of powers. *Medical education* falls under the jurisdiction of provincial ministries of colleges and universities, while the *standards* for medical education are set by accrediting bodies who have no jurisdiction over the setting of curriculum. Professional accrediting bodies in Canada seem to have been unconcerned with this gap in the training of nurses and physicians who deliver women's reproductive health care. Whatever the reason, the gap in health professionals' training is inexcusable and must be remedied.

Harassment

The third reason for the shrinking pool of abortion providers is the serious toll on providers exacted by the harassing and violent actions of anti-choice groups and individuals. Understandably, many physicians are reluctant to expose themselves and/or their families to the constant and often vicious harassment of picketers, demonstrators, vandals and attackers. Similarly, young physicians witness the many tactics employed by anti-choice zealots

and think twice about choosing to provide abortion services. As the number of providers dwindles, the pressure on those who remain intensifies.

Improving abortion training and finding ways to increase the number of abortion providers is vital to the provision of quality abortion services across Canada. Further delay in addressing these issues will seriously jeopardize abortion access in the near future.

A model for integrating and delivering abortion services

There is a tension between the need for prompt, local access to abortion services with highly skilled and experienced providers on the one hand, and the need to protect the privacy and confidentiality of patients on the other. As discussed below, sole providers in small communities face intense anti-choice harassment of themselves and their families. Fear of harassment is also a factor for women seeking abortions. Indeed, some women are reluctant to get even pre-abortion diagnostic procedures in the small communities where they live, let alone the abortion procedure itself. But at the same time, the geographic and financial barriers of having to travel significant distances in order to get abortion services are creating insurmountable obstacles for women in many parts of Canada.

As well, it is a challenge to provide the highest quality services if procedures are being done by providers who do not perform a sufficient number of abortions to gain and retain an optimum level of skill. Ten years after the Supreme Court's decision, we still need a model of abortion service provision that balances the sometimes conflicting needs we have identified, while providing safe and accessible abortion to all Canadian women who choose it and integrating abortion services into a continuum of women's reproductive health care.

Clearly, both hospitals (largely on an outpatient basis) and clinics have a role to play in delivering abortion services. The bureaucratic, rule-bound nature of hospitals has not been conducive to responding to women's needs. Free-

standing clinics, on the other hand, can be isolated from the health care system and separated from the full continuum of women's reproductive health care needs. The CLSCs in Quebec come closest to addressing a range of criteria under a publicly-funded primary care system that is accessible to all women within a region.

Any model that addresses the demands of abortion services provision must be flexible and easily adapted to a variety of contexts. CARAL proposes a two-level model of care that could be implemented by any provincial or territorial system.

- **Level 1: Every health region should have a community-based primary care centre** providing a comprehensive range of reproductive health services. Women's privacy can be well protected in a centre that provides many related services. Each Centre should have a Reproductive Health Care component to provide contraception counselling and prescriptions, including emergency contraception where indicated; pregnancy tests and assessments including ultrasound; decision counselling; primary pre-natal care; first trimester abortions using local anesthesia; and referrals as necessary.

- **Level 2: Each province should also deliver care in coordination with a major hospital.** This would provide the same range of reproductive health services as the regional centres. In addition, it could also serve women requiring late term abortions, or women who prefer or need general anesthesia for their abortion procedures.

Analysis and Recommendations:

The two models presented in this chapter — for quality and location of abortion services — would go a long way toward preventing unintended pregnancies. Further, service delivery in accordance with these models would cut the need for late-term abortions. The vast majority of late-term abortions occur because women have not been able to obtain the contraception information, pregnancy assessment, counselling, or abortion referrals needed. The basic

services outlined in Level 1 must be available to women in their own regions, so that, like other primary care services, abortion services are truly accessible and universally available.

This review of the quality of care shows clearly that specialized abortion clinics have developed and delivered services according to standards that have dramatically improved women's experience of abortions. With a focus on timely access, supportive counselling, and local anesthesia, clinic standards stand in stark contrast to those adopted in some hospitals. It is time that clinic standards became the guidelines for all abortion service provision across Canada, in and out of hospital, and in every region.

Standards for medical education should be adjusted to ensure there will be sufficient providers of high quality abortion services for all Canadian women. While changes are being made to medical school curricula, the model developed in Toronto for training family physicians in abortion procedures needs to be established promptly across the country. This must be publicly funded for all interested obstetrician-gynecologists and family physicians.

Standards for abortion training and provision must be implemented. Professional standards must be adhered to. It should be no more acceptable for a physician to deliberately misdiagnose the gestational age of a pregnancy out of personal and moral beliefs than to deliberately misdiagnose any other acute condition in a patient. Nor should it be professionally acceptable for any physician to refuse to give a woman information regarding abortion access. Such actions should be considered gross medical misconduct and both should be liable to professional and criminal sanctions.

Chapter 4: The Opposition: Anti-Choice Forces and their Impact

On November 11, 1997, Winnipeg obstetrician Jack Fainman, 68, was shot and seriously wounded in his home. Dr. Fainman was the third Canadian abortion provider to be shot during November in the past four years. Dr. Garson Romalis of Vancouver was shot in November 1994, and Dr. Hugh Short of Ancaster, Ontario was shot in November 1995. All three physicians were targeted in the privacy of their homes.

Finally convinced of a link between these attacks, an alliance of British Columbia, Manitoba and Ontario police forces was formed to investigate the shootings. While the police and media have often referred to this alliance as a "National Task Force," it in fact carries little of the import and/or resources this title implies.

Some who describe their personal position as 'anti-abortion' agree that a woman has the right to make an autonomous choice based on her personal needs and belief. Others see abortion as permissible in certain, more extreme, circumstances — rape, incest, genetic anomaly or threat to life of the mother are those most commonly cited. Many Canadians who are anti-abortion do not act on their opinion that abortion is wrong. They respect the views of the pro-choice majority. Most importantly, they understand that within a democracy — where abortion is a legally protected choice — the law of the land should not be opposed through violence. However, those who vehemently oppose abortion have become ever more militant both in Canada and the U.S.

There is a small minority of Canadians who oppose both abortion and women's democratic right to choose it. Since the 1970s, these individuals have mobilized against abortion services. In the 90s, their actions are becoming

increasingly militant and dangerous. The net result of all their activities is that Canadian women's right to abortion is being threatened. Further, a dire situation has emerged where providers of the service must put their own personal safety (and that of their families) in jeopardy to offer women a legal medical procedure. Hence, the vicious opposition of anti-choice zealots is causing great danger, hardship and suffering.

Documents describing various terrorist acts in detail have surfaced within the anti-choice movement (e.g., publications of the Army of God.) Also notable, and very concerning, is the generalized acceptance and use of inflammatory language depicting abortion providers as unfeeling "murderers" who must be stopped from causing further "slaughter." For example, when Gordon Watson, a high profile Canadian anti-abortion organizer was interviewed after Dr. Romalis was shot, he called the attack "a nice piece of shooting" that "brought the message home to Dr. Romalis more than anything else would have."

Overall, the anti-choice movement is a well-organized, well-funded network of religious and political organizations (e.g., the Knights of Columbus and the Canadian Centre for Law and Justice.) People with anti-choice views are represented in strategic locations and positions (e.g., lawyers, doctors, nurses, and even dentists all have their own "for life" organizations) and are thus capable of exerting considerable pressure on their peers and politicians.

The anti-choice movement is comfortably housed within evangelical and fundamentalist religious organizations and right-wing political associations. It is world-wide and draws on the vast media resources of its affiliated organizations, including the Catholic Church. It is able to mount slick media campaigns and broadcast these on major television networks.

For the most part, we are witnessing anti-choice groups and individuals in Canada copying the actions of their U.S. counterparts. They harass Planned Parenthood organizations (while lobbying for their demise), picket and/or obstruct the entrances to abortion clinics, plant bombs and shoot abortion providers.

Hate literature and threats are another strategy — seen again as recently as January 1, 1998, when a letter opened at the Hamilton *Spectator* warned that the sniper's next bullet would be lethal for a Hamilton-based abortion provider. A British Columbia policeman was charged and found guilty of identifying the owners of cars parked outside an abortion clinic. He had used police department computer files to match license plate numbers to owners.

Many anti-choice individuals and groups disavow violence — describing it as the domain of a fringe element. Yet, following the most blatant acts of anti-choice terrorism, anti-choice churches and organizations seem relatively silent. Does such silence indicate that church and political institutions are providing an infrastructure for anti-choice organizing? Who is nurturing the terrorists? Who is encouraging them? Who is funding them?

Certainly right-wing political networks provide the ideological support for "direct action" with their links to "militias," neo-Nazi groups, and their strong belief in the right to bear arms. Virulent anti-Semitism is a consistent, ugly and pervasive theme included in the hate mail many pro-choice activists receive, an indication of the link between anti-choice and neo-Nazi militias.

In reviewing the overall strategies of the anti-choice movement in combination with other trends in health sector downsizing, it can be concluded that anti-choice activities, in their many facets, have placed severe limits on the ability of Canadian women to exercise their right to choose abortion. Currently, the anti-choice movement clearly represents the greatest threat to the provision of abortion services.

Anti-choice activities hit hard at two levels:

- At the governmental level, the influence of the anti-choice minority often overrides the views and positions of the pro-choice majority in government policy and health service provision. Fearing the harassment anti-choice Canadians might mount, politicians and bureaucrats are quick to sidestep abortion related issues. A prime example is the Federal Government's refusal to address the unavailability of RU486 in Canada.

- At the service delivery level, the actions of the anti-choice movement negate the right of Canadians to freedom of choice and security. Their actions span the realms of interference, fraud, intimidation, coercion and terrorism.

Clearly, the militant anti-choice movement is opposing democracy in Canada today and this is placing women's reproductive health and constitutional rights under attack. Physicians fear their lives may be taken in the course of providing legal abortion services and the Canada Health Act is being undermined by politicians and administrators in several jurisdictions who are heading, rather than challenging, virulent anti-choice threats.

Most Canadians are unaware of the extent of anti-choice activity and its influence within political parties and other institutions. This report calls for increased attention to the effects of the anti-choice movement on Canadian women and abortion providers. The following sections will highlight anti-choice actions and their outcomes on a strategy-by-strategy basis.

Local interference by anti-choicers

We have noted that the main disparities in access to abortion in Canada fall along geographical and economic lines. When professional interference creates or compounds barriers to access at the local level, the cost to women is very high. We have also noted that in Atlantic Canada and places where access is particularly restricted, negative experiences do seem more pronounced than elsewhere.

"*NOVA SCOTIA: He would not even consider talking about abortion. When I brought it up, he just wouldn't even talk about it. He said, "I'd be more than happy to look after you going through the pregnancy." I asked him if he'd refer me to another doctor who would at least talk about it, find out what all my options were; he wouldn't even do that.... At that point, I was up against a brick wall. I was trying to think of ways I could do it myself, and really, I didn't know where to turn.*

This direct form of anti-choice interference is unprofessional. Yet it occurs in

all regions. In smaller communities, where it is more likely that a sole physician or local health service counsellor will be the gatekeeper to abortion information and/or referral, it can represent a solid barrier to access. The following experience illustrates the tactics of one anti-choice physician and the anguish caused by his unethical conduct.

ONTARIO: Lucy is a native woman from a northern reserve. When she suspected she was pregnant, she consulted the local doctor who had a practice on the reserve, not knowing at the time that he was anti-choice. He asked her what her intentions were if she were pregnant, and she told him she would seek an abortion. He informed her that she was not pregnant and had skipped a cycle for some other reason. After her second missed period, she returned; once again she was told she wasn't pregnant. After the third missed period, in some desperation, she made her own way to a larger centre and sought out a women's health clinic. The clinic sent her for routine tests, found out that she was three months pregnant, and informed her she could not get an abortion in that city, but would have to travel to a nearby city in the U.S. for a procedure that cost $250 US. Clinic staff helped in a frantic search for funds; but when Lucy got there, she was told once again that she was too far along and would have to travel further and pay US $1000 for a late-term abortion. This sum was completely beyond Lucy's means. The Canadian clinic workers, on learning of what had happened, offered to help her take her local doctor to court. But Lucy demurred, fearing it would bring shame to her family on the reserve. She went back broken-hearted.

(Source: Staff, women's health clinic)

A particularly devious tactic of anti-choice organizations is to restrict women's access to abortion services through the use of phony "crisis pregnancy centres," which operate as options counselling services, although all information on abortion is blatantly anti-choice and given from the fetus's point of view. These centres are often listed in telephone directories under abortion. Pregnant women who use these services have been misinformed about critical time frames, often until the pregnancy is too advanced to permit abortion.

MANITOBA: A woman from a small town is 20 years old, married with one child. She is pregnant, but doesn't want to continue the pregnancy because she is going back to school in September. She phones directory assistance for abortion information and is given the number for an anti-abortion agency. Here she is informed that there is no gestational limit for abortion. Months later she and her family move to Winnipeg with her family, ready to start school, and she goes to

a pro-choice health organization for an abortion referral. She is 26 weeks pregnant and is forced to maintain the pregnancy. Unable to support her living child and family unless she attends school and improves her earning power, she relinquishes the child for adoption, with severe emotional consequences for all involved.

Women are routinely given pamphlets that depict abortion as a tragic event; some are shown "The Silent Scream," a tool designed to turn women away from the abortion option. Unfortunately, anti-choice counselling centres operate in every province. In Alberta, where access to abortion is highly politicized, anti-choice forces have an extensive network of centres and physicians whose purpose is to prevent women from obtaining abortions. The Women's Reproductive Health Centre, for example, is only one of a dozen different anti-choice pregnancy "counselling" services advertised in the Calgary Yellow and White Pages.

"*ALBERTA: Lynda is 28 years old and living in southeastern Alberta. She is seeking an abortion. She consults her doctor who then makes an appointment for her at the Women's Reproductive Health Centre in Calgary. Lynda risks losing her job by taking a day off for her abortion procedure. She arrives for her procedure and is immediately suspicious about where she has been sent. There is no one around, but one man talks to her about continuing her pregnancy. Soon she realizes where she has been sent and leaves the facility in tears. She then manages to obtain accurate information about abortion services, but is faced with having to make another five-hour return trip to Calgary and risk another day off work. Lynda is unsure whether her doctor deliberately sent her to this place or was misled into thinking it was the abortion clinic.*

A broad range of anti-choice health professionals within the public health care system, from nurses to laboratory technicians, can interfere with women who have unintended pregnancies. A former Director of a Toronto Clinic reports that clients regularly received calls from anti-choice activists after receiving their pregnancy test results in their doctors' offices. She could only surmise that someone in the office and/or laboratory was passing along confidential test results and contact information so that anti-choice activists could make dissuading calls.

The need for confidentiality for both clients and providers is particularly acute in small communities. Indeed, the stigma of abortion created by the

anti-choice movement is so off-putting for some rural women that they avoid services available to them in their local community. For example, women from small communities could be referred for an ultrasound at a local hospital. However, they resist using the local service for fear others will discover they were pregnant. As a result, they will defer the ultrasound until they arrive for the abortion. Problems ensue if they are either too early or too late for the planned procedure.

There is a terrible irony to the impact of anti-choice forces on so many individual women. Their delaying tactics contribute to the problem of second-trimester abortions — the very procedures which anti-choice proponents rail against most. Delays place women at greater risk, as later term abortions are associated with increased operative and post-operative complications.

Despite the highly questionable conduct of crisis pregnancy centres, some local governments continue to support anti-choice services, as do several United Ways. The City of Edmonton, for instance, continues to fund Birthright, an anti-choice service. Repeated complaints from agencies and individuals about misleading advertising have been lodged with Yellow Pages, the Alberta College of Physicians and Surgeons, Alberta Consumer Affairs, and Industry Canada. No one accepts jurisdiction or responsibility, and the fraud continues at the expense of Canadian women who fall prey to their anti-choice mandate. In Manitoba, the United Way gives financial support to a "pregnancy counselling service" which refuses to make abortion referrals.

Local strategies to narrow health system access through hospital take-overs

Anti-choice individuals and organizations initiated their efforts to limit abortion access shortly after the criminal law was liberalized in 1969. This reform moved the responsibility for abortion access into the hands of Therapeutic Abortion Committees (TACs) in hospitals. Whether or not a hospital would form a TAC was voluntary. Anti-choice forces began lobbying and seeking membership on local hospital boards. In this way, the anti-choice movement

could compel individual hospitals to deny abortion services. This strategy created tremendous acrimony for many of the stakeholders in health service delivery organizations and for their communities.

The 1988 Supreme Court decision had the effect of striking down Therapeutic Abortion Committees. With these no longer required, the anti-choice movement concentrated its efforts in the electing its members to Regional Health Authorities and Community Health Boards.

In some cases, the anti-choice policy of a hospital is due to a religious affiliation, especially when the Catholic Church or the Pentecostal Assembly is involved. For example, St. Martha's, the regional hospital for Antigonish County, Nova Scotia, with an obstetrics/gynecology mandate, offers neither abortion services nor routine tubal ligation, due to the Catholic Church's position on these issues.

This is particularly dangerous in the context of health care restructuring which tends to mandate fewer hospitals, or only one, in a region with provision of specific services. When such hospitals are mandated as the only reproductive health care provider, restructuring eliminates abortion access. According to Kathleen Hawes, a member of Catholics for a Free Choice, hospital mergers in Ontario allow the Vatican to have an increased say in women's reproductive health — not only with respect to abortion services, but also emergency contraception and sterilization (*Pro-Choice News*, Summer 1996).

Harassment of abortion providers and their clients

With the increasing liberalization of attitudes toward abortion in the 1980s, then its decriminalization in 1988, the anti-choice movement was losing ground. Enraged by the opening of new freestanding clinics and the ability of individual doctors to provide abortion services outside the control of Therapeutic Abortion Committees, the anti-choice movement adopted a policy of direct harassment of abortion providers and their clients.

Immediately following the 1988 Supreme Court decision, Frank Foley, Executive Director of the National Office of Campaign Life said: "We will pull out all the stops. There will be clamour, more picketing." Indeed, the prediction of a leading anti-choice activist delivered to a CARAL board member in 1989 was to be realized. He informed her that having lost in the courts, his movement would take to the streets and make the provision of abortion so dangerous that providers themselves would withdraw services.

Over the last decade, in every province, anti-choice forces have waged an overt campaign of harassment and violence against providers and women seeking their help. At first, they picketed peacefully outside clinics. Soon, their strategies escalated to the harassment of both staff and patients at hospitals, clinics and doctors' offices.

This harassment has included: "sidewalk ministries" (designed to bully women into changing their minds); the dumping of manure and other waste substances at the doors of abortion facilities; and "Operation Rescue" campaigns, in which clinics are literally blockaded by dozens of anti-choice activists who refuse to move. Clinics in Toronto have been subjected to many "Operation Rescue" campaigns, as well as daily picketing and harassment.

By 1992, interference and harassment had escalated into urban terrorism. On May 18, 1992, Dr. Henry Morgentaler's Toronto clinic was destroyed by an explosion at 3:23 a.m. While no one was charged in the attack, anti-choice activists were the key suspects. The Reverend Ken Campbell of Choose Life Canada issued a press release only hours following the explosion, in which it was referred to as "an Act of God" (Dunphy, 1996).

In early 1990, terrorism was also at the forefront of anti-choice activities on the West Coast. When Everywoman's Health Centre in Vancouver opened, harassment by anti-choice protesters was immediate. The clinic was broken into and medical equipment vandalized. Both the Vancouver Everywoman's Clinic and the Toronto Morgentaler Clinic were able to obtain private injunctions that required anti-choice protesters to stay outside a "bubble zone," specifically defined by the courts. But sporadic harassment by the most zealous picketers continued and clinics began to rely on private security services for protection.

Anti-choice activists do target individual abortion providers when their identities are discovered. Not content to harass only doctors, anti-choice strategies target doctors' families as well.

"*BRITISH COLUMBIA: My children were admitted to the local Catholic school. Although I am not Catholic, this is certainly the best [and only] private school in the area. About a month before the beginning of the school year I was informed by the Principal that the local priest had ruled that my children were not welcome in the school because their father does abortions.*

BC Task Force Consultation 1992, Realizing Choices

"*ONTARIO: At one picketing, CARAL members observed a mother talking to her son (he looked about 10 years of age). The boy then went up to the porch of the doctor's house, put his finger down his throat and made himself vomit on the doctor's porch. The anti-choice picketers gave a cheer and then welcomed the boy back to their picket line.*

(Source: CARAL Board Member)

In December, 1992, the *Report on Access to Abortion Services in Ontario* recommended that services be increased and harassment be stopped by giving facilities and providers access to public injunctions and police protection. Following this, CARAL members attended several anti-choice picketing events in Ontario to take photographs and notes. This information was then given to the Ontario Government as evidence of ongoing harassment to assist in the granting of the injunction.

In January 1995, a death threat was made against four physicians who performed abortions at a Halifax hospital.

TEXT OF ANONYMOUS HATE LETTER

Jan. 24, 1995
Halifax, Nova Scotia

"The Shooting of doctors, workers and patients in USA clinic are made out to be horrible acts of violence. What of your horrible acts against unborn innocent babies? Are they too to go unanswered? No, No, No!! please take this message seriously...I have imported the finest hand guns and one silencer. Also included is a marksman's rifle and scope. After January 30, 95, I solemly (sic) promise to take action against any and all persons involved in the operation of abortion mills, clinics and or government run and publicly funded hospital abortion clinics. Take heed, Dr. X of Dartmouth. He knows just who I mean. I have a list of names and addresses of persons that have and still work in these disgusting jobs. Take warning!! I am not insane but I am against the taking of innocent lives. I do not consider consenting adult abortionists's (sic) to be innocent.

Please, I beg of you stop aborting innocent babies. Copies of this message will be in the hands of the RCMP, City Police and the Halifax North Abortion Mill."

This threat caused two physicians to resign from the Termination of Pregnancy Unit. As a result of the immediate physician shortage, hospital abortions were temporarily restricted to women whose pregnancies were in the first trimester.

On April 19, 1993, NDP Attorney General Marion Boyd applied for a public injunction, asking the court to restrict anti-abortion harassment and intimidation of patients, health-care providers and their families at specific locations in London, North Bay, Brantford, Toronto and Kingston.

Another 16 months elapsed before a temporary injunction was granted. It aimed to protect women entering clinics as well as specific physicians at their offices and homes. This injunction is still in effect. In response, anti-choice harassment seems to have intensified in Sault Ste. Marie, Peterborough, Windsor and the Kitchener-Waterloo area, as well as North Bay (Premier Harris's constituency). Many abortion providers in these areas have withdrawn services in response to this harassment.

In September 1995, the B.C. government demonstrated its intent to protect abortion providers and their clients by passing the Access to Abortion Services Act. This legislation created "bubble zones" around abortion clinics, physicians' offices and around the homes of abortion providers. Under this legislation, it is illegal to watch repeatedly, to approach or follow anyone who provides abortion services with the intent of dissuading them from providing such services. Videotaping and/or physical interference with women seeking services is also covered under this Act. Violators face a maximum fine of $5,000 and 6 months in jail.

A November 11, 1996, acid attack at a Winnipeg abortion clinic disrupted service but caused no injuries.

This review of anti-choice tactics underscores the extremes to which zealots will go in their crusade to stop abortion. The consequences for women and abortion providers are devastating. As well as punishing, frightening and sometimes traumatizing women seeking abortions, these tactics are also designed to have a profound effect on current and potential abortion providers. And fear amongst providers of abortion services is heightening and spreading with the escalation of sniper attacks and threats.

The chilling effect that this degree of embattlement achieves cannot be ignored. Providers have withdrawn abortion services. Students and recent graduates of the health professions are making career decisions with constant reminders that the price to pay for providing abortions may be too high. Ontario's Centre for Clinical Evaluative Studies' (ICES) report looked at the reasons for physicians' unwillingness to provide abortion services. Their report found that after "personal beliefs" (42% of those surveyed), anti-choice harassment was the next major factor (reason given by 30%). Lack of training was the reason given by 15% of those not providing abortion services. In other words, at least 45% of physicians surveyed have been directly and negatively affected by the politicization of abortion.

Thus, a small anti-choice minority is having a very significant influence on the medical and political institutions of this country. Abortion, a procedure that is safe, legal and central to women's reproductive freedom, is not being

offered and taught in accordance with the need for this service. The potentially positive outcome of the Supreme Court decision is stymied while abortion providers live in fear for their lives.

Provincial governments' attempts to inhibit access

The record of provincial governments in restricting the right to abortion and the delivery of services is troubling indeed. Anti-choice decisions are seen as administrative measures linked to health system "priorities" and "standards."

"*ALBERTA: Andrea is 17 years old, lives near the Saskatchewan border, and recently discovered she was pregnant. She wished to terminate her pregnancy but had to travel to Calgary to obtain an abortion. She lives with her parents but did not tell them she was pregnant. Her periods are irregular and she did not know when her last period was. As the trip to Calgary takes several hours, both the clinic and hospital required she obtain an ultrasound in her own community to confirm the gestational age of her pregnancy. Andrea's doctor was unable to obtain an ultrasound in her local community for several weeks, because the ultrasound labs put abortion low on the priority list. The poor access to service was explained as the result of cutbacks in health care funding. No matter how much her doctor pled on her behalf, the radiology lab would not get her in sooner. The Clinic in Calgary finally waived the requirement for an ultrasound and Andrea took the chance that her procedure would be done that day without it.*

A number of provincial governments have employed every weapon in their arsenal to limit access at freestanding clinics. In the last ten years, numerous elected representatives and governments have acted, or been used, as agents for an anti-choice agenda. The consequences of their actions include millions of public dollars to pay for protracted court processes. These actions have had detrimental effects on Canadian women's right to timely access to abortion and have been taken despite the availability of case law and medical evidence that suggested alternative, often opposite, approaches would be in society's best interest.

In 1989, after Dr. Morgentaler announced he would open a clinic in Halifax,

the Nova Scotia government quickly outlawed clinic abortions. This act, officially named the Medical Services Act, was dubbed the "Keep Henry Morgentaler out of Nova Scotia" law. It was clearly orchestrated to prevent abortion clinics from being set up in the province.

Dr. Morgentaler was acquitted in 1990 in the Provincial Court. The Province of Nova Scotia appealed. The Provincial Court's decision was sustained in the Appeal Court. Once again, the Province appealed. Finally, the Supreme Court of Canada struck down the law in 1993, ruling that the province was trying to legislate in the area of criminal law, which falls within federal jurisdiction.

Having been soundly beaten in the courts, the Nova Scotia government entered the clinic debate again when it announced in 1995 that it would prefer to suffer financial penalties at the hand of the federal government rather than fund either of two procedures at freestanding clinics. The procedures specified were the removal of disfiguring port wine stains at dermatology clinics and abortion services. A few months later, the government quietly dropped its opposition to port wine stains being removed in private clinics.

CARAL, the Nova Scotia Advisory Council on the Status of Women, Planned Parenthood Nova Scotia, and the Halifax Morgentaler Clinic asked to meet with the a senior bureaucrat in the Department of Health to challenge the province's refusal to extend the same coverage to abortion clinics. The pro-choice groups were clearly told by a senior official that the provincial Department of Health had no interest in funding abortion services provided in settings other than a public hospital — regardless of whether the clinic is privately managed or operated through a community-based, not-for-profit, volunteer board.

> ***"The senior civil servant in the Nova Scotia Department of Health emphasized that decisions regarding access to abortion services are treated as political decisions by the Nova Scotia Liberal government; they are not treated as health issues.***
>
> ***Meeting with three CARAL members, 1996***

Premier Frank McKenna, in collaboration with the New Brunswick Attorney-

General's office, attempted to ban clinic abortions in his province in the mid-1990s. (McKenna did this despite similar Nova Scotia anti-clinic legislation having been struck down.) In 1994, the New Brunswick Court of Queen's Bench ruled that the government's anti-clinic regulations under the Medical Act were enacted primarily to stop Dr. Morgentaler and to suppress abortion, not to ensure the quality of health care or to maintain professional standards.

The New Brunswick College of Physicians and Surgeons, which had lent support to the New Brunswick government in its attempt to restrict clinic abortions by withdrawing Dr. Morgentaler's license, had to restore it. The New Brunswick government appealed the decision. On January 23, 1995, the New Brunswick Court of Appeal again ruled in Dr. Morgentaler's favour. The province was denied leave to appeal by the Supreme Court.

Successive governments in Prince Edward Island have been blatantly anti-choice in their positions. Despite warnings from Health Canada, the government continues to forbid abortions on the Island and makes reimbursement for abortion off the island almost impossible. PEI officials have stated that they would rather pay the substantial cash penalties for violating federal/provincial requirements than reverse government policy regarding abortion access.

Even when medical associations become pro-active on the issue of abortion, provincial governments can remain hostile. In March, 1991, the Saskatchewan College of Physicians and Surgeons passed a by-law to allow abortions in freestanding clinics. In an unprecedented move, the Saskatchewan government refused to approve the College's by-law.

In October of that year, in conjunction with the provincial election, Saskatchewan premier Grant Devine challenged the funding of hospital abortions through a plebiscite. Voters were asked if they favoured medicare funding for abortion, and the majority who answered said "no." When Devine's government was defeated, Romanow's NDP government sought legal advice as to whether his government would have to de-insure abortion. In May, 1992, after consulting with legal experts, Saskatchewan's Health Minister, Louise Simard announced, "it is not legally possible for our government to de-insure abortions."

It is disheartening that Romanow's NDP government has steadfastly opposed the establishment of any abortion clinics in Saskatchewan, despite poor access in that province. Ironically, this government funds abortions obtained by Saskatchewan women in private clinics in Alberta and Manitoba.

Partly motivated by the desire to prevent Henry Morgentaler from opening a clinic in Saskatchewan, the Regina General Hospital opened its Women's Health Centre in July, 1992. This is the first facility to offer abortions in the city of Regina — a positive outcome of anti-Morgentaler sentiment within Saskatchewan's provincial government.

In Manitoba, abortions are only covered by the province if they are performed in hospitals and only if they are approved by two physicians and performed by a gynecologist. Dr. Morgentaler challenged Manitoba's refusal to pay for abortions performed in the only abortion clinic in the province. On March 2, 1993, he won his case. On July 27, 1993, the Manitoba government passed legislation to counteract the Court's decision by excluding payment for non-hospital abortions. Dr. Morgentaler is currently challenging this new legislation.

Newfoundland was publicly embarrassed when it was revealed that its social services department was paying to send social assistance recipients for out-of-province hospital abortions at a cost of up to $4,000 per woman instead of covering their abortions at a cost of approximately $500 at the St. John's Morgentaler Clinic. Recent changes are addressing this waste of limited health care resources.

Anti-choice attempts to limit access through legal challenges

The successes of the anti-choice camp in narrowing access to abortion, through political pressure and other interventions, are particularly striking given how little support there has been in Canadian law for the premise that underlies anti-choice challenges (i.e., assigning personhood to the fetus.) The consistent refusal of the Supreme Court of Canada to accept the logic of the

anti-choice position is a reassuring signal that the anti-choice position is logically problematic. In a broad range of contexts, the highest court of the land has repeatedly rejected the notion that a fetus could have sovereignty over the body of a woman.

The Supreme Court of Canada has placed great importance on the inseparable connection between a woman and her fetus, thus emphasizing the need to ensure women's welfare as a means of enhancing pregnancy outcomes. This is evident in the recent Supreme Court decision (Winnipeg Child and Family Services vs. G.(D.F.)). The Supreme Court ruled that the appellant could not incarcerate a pregnant woman in an attempt to protect her fetus from her glue-sniffing addiction.

However, the Supreme Court's position does not signify that abortion rights have been carved in stone. To the contrary, what is striking is how often women's reproductive rights are being challenged and how far these challenges get in the provincial courts. For example, in the summer of 1989, a Quebec man sought, and was granted, an injunction to keep his partner, Chantal Daigle, from having an abortion. The decision was overturned on appeal and quickly became a national rallying point for activists on both sides of the issue. After weeks of delay caused by repeated appeals, the Supreme Court of Canada quickly ruled that a father has no right to veto the decision a woman makes about the fetus she is carrying.

More recently, in August 1996, a New Brunswick man asked the Quebec court to block his partner's access to an abortion. The man, whose partner was vacationing in Quebec, asked the Quebec Superior Court for an injunction to stop his common-law wife from terminating her pregnancy. The judge quickly rejected the request, pointing out that the law does not recognize a fetal or paternal right to stop an abortion because of the 1989 Chantal Daigle case.

So far, the courts have held firm in upholding a woman's right to choose abortion as part of her right to personal security, dignity and liberty. At the same time, the Supreme Court has indicated that, under some circumstances, "society" (i.e. the state) could have an interest in the fate of the fetus in the later term of pregnancy.

While we can expect anti-choice proponents to continue to use the courts to attempt to establish "fetal rights," the greatest danger lies not in the judicial sphere but in that of politics. It is only appropriate that law be made by democratically-elected elected law-makers. But as this review amply demonstrates, pro-choice activists have good cause to fear the potential misuse of legislative powers.

Summary and recommendations

The full potential of the 1988 Supreme Court decision is not being felt in women's daily lives since 1998. Access to abortion is limited and further threatened by the strategies of the anti-choice movement. Unlike ten years ago, when the primary site of the struggle over a woman's right to choose abortion was the courtroom, that struggle has now diffused to multiple sites — clinics, doctors' offices and homes, phony crisis pregnancy centres, medical schools, community health boards, Provincial Cabinets, and the sidewalks.

The anti-choice movement is choking public discourse on abortion. Their virulence has made abortion an issue to be circumvented by bureaucrats and elected representatives and avoided at all costs, particularly in an election year. They have also made it a topic to be avoided in daily conversations in classrooms and health care settings. For individual women, it remains a dark secret. Thus women have been robbed of the full promise of the 1988 Supreme Court decision: that abortion would not only be legalized, but also normalized.

Canada needs a national policy specifically to govern abortion rights and access. After a decade of largely unsuccessful attempts to erode the Supreme Court's decision in the Morgentaler case, it is incumbent upon federal and provincial Ministers of Health to accept and carry out the responsibility for ensuring women's right to this basic, acute care medical service.

The Ministers of Health should strike abortion from the list of procedures excluded from the reciprocal billing agreement. It is intolerable that women

who move within Canada cannot access abortion services in the first three months of residency in their new province/territory. Similarly, women who must travel outside their province/territory of residence to access appropriate abortion services should be fully covered within reciprocal billing agreements.

The Attorneys General of Canada must move quickly to protect the rights of women to access abortion, and of physicians to provide abortion, by putting an end to the picketing of clinics and harassment of physicians, staff and clients. To this end, strictly enforced "bubble zones" must be placed around abortion facilities and doctors' offices and homes in every community where they are needed. The "bubble zones" around clinics and doctors' offices must be sufficiently large to allow women unimpeded access to hospitals and clinics, and physicians unimpeded access to their professional, and legal, work.

The Attorneys General of Canada must assign all resources at their disposal to ensure the arrest of any and all persons responsible for the shootings of three abortion providers in Canada during the last four years.

The Attorneys General, having responsibility for maintaining respect for the law, should direct that charges be more vigorously pursued where anti-choice actions impugn the laws of the land.

Every pro-choice Canadian must assume personal responsibility for changing the climate of threats and intimidation against abortion providers and abortion seekers. In our daily discourse, in the organizations where we work, worship, and play, we must increase choice for all Canadian women.

Chapter 5: Conclusions and Recommendations

On January 28, 1988, pro-choice supporters across the country celebrated the decision of the Supreme Court of Canada. The highest court in the land had decriminalized abortion. That decision eliminated Therapeutic Abortion Committees (TACs), and we trusted that timely access to fully-insured abortion services would follow.

Ten years later, many Canadians do have timely access to fully-insured abortion services, and in some provinces both clinics and hospitals are available to serve women. By and large, access is best for urban women, women of means, and women living in Quebec, Ontario or British Columbia. While access to abortion services is much improved, it is disheartening to realize how precarious that access is for many women and how illusory it has been for women in rural and northern areas and for young and poor women. This report illustrates the ways in which women have been robbed of the full promise of the 1988 Supreme Court decision.

Two main factors account for the many failures regarding quality abortion access. First, the elected representatives and highest-ranking administrators with responsibility for Canadians' health have not accorded priority to women's reproductive health. As a consequence, Canada has neither tackled the challenge of preventing unintended pregnancies, nor conscientiously attempted to provide abortion services in accordance with the "best practices" largely established by caring physicians in freestanding clinics. Second, access to abortion is being limited and further threatened by the tactics of the anti-choice movement. Their criminal acts, which include threats of violence, bombings, and sniper attacks, impede women from making a free choice and impede physicians from delivering safe, legal medical services.

Canadians deserve much better sexual and reproductive health care and

abortion access than currently exists. Canada needs to pursue immediately the following recommendations. Safe, medically-insured abortion services must be available to all Canadian women.

Recommendations

Canada needs a national policy specifically to govern abortion rights and access. After a decade of largely unsuccessful attempts to erode the Supreme Court's decision in the Morgentaler case, it is incumbent upon federal and provincial Ministers of Health to accept, and carry out, the responsibility for ensuring women's right to this basic, acute care medical service.

Abortion services must be offered in full accordance with the Canada Health Act. Specifically,

the Ministers of Health who have not already done so should fully insure therapeutic abortion services, whether performed at hospitals or free-standing clinics;

the Ministers of Health should strike abortion from the list of procedures excluded from the reciprocal billing agreement. It is intolerable that women who move within Canada cannot access abortion services in the first three months of residency in their new province/territory. Similarly, women who must travel outside their province/territory of residence to access appropriate abortion services should be fully covered within reciprocal billing agreements;

where provision of permanent, daily service is economically infeasible, toll-free information lines and mobile clinics should be provided; and

where a region or province refuses to provide any service at all, the federal Minister of Health should use penalty funds assessed against the negligent authorities to provide travel and accommodation funds to assist those women left without access to appropriate abortion services within their jurisdiction.

The Ministers of Health should convene meetings of hospital- and clinic-based providers of abortion, so that the sharing of "best practices" can begin.

Local health authorities should strive to reduce the number of unintended pregnancies. A positive, proactive, ongoing investment is needed in contraceptive counselling and in the provision of safe, effective contraception. Each generation needs, and deserves, competent, non-judgmental sexual and reproductive health services. Many effective models exist, and these need to be appropriately funded without further delay.

Standards for medical education should be adjusted to ensure there will be sufficient providers of high quality abortion services for all Canadian women. While changes are being made to medical school curricula, the model developed in Toronto for training family physicians in abortion procedures needs to be established promptly across the country. This must be publicly funded for all interested obstetrician-gynecologists and family physicians.

Standards for abortion training and provision must be implemented. Professional standards must be adhered to. It should be no more acceptable for a physician to deliberately misdiagnose the gestational age of a pregnancy out of personal and moral beliefs, than to deliberately misdiagnose any other acute condition in a patient. Nor should it be professionally acceptable for any physician to refuse to give a woman information regarding abortion access. Such actions should be considered gross medical misconduct and both should be liable to professional and criminal sanctions.

The Attorneys General of Canada must move quickly to protect the rights of women to access abortion, and of physicians to provide abortion, by putting an end to the picketing of clinics and harassment of physicians, staff and clients. To this end, strictly enforced "bubble zones" must be placed around abortion facilities and doctors' offices and homes in every community where they are needed. The "bubble zones" around clinics and doctors' offices must be sufficiently large to allow women unimpeded access to hospitals and clinics, and physicians unimpeded access to their professional, and legal, work.

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