

Barriers to Access to Abortion Services in Ontario

Major Research Paper

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Abstract

Although abortion is a legal, insured medical service in the province of Ontario, the procedure remains unequally accessible for women based on socio-economic status and geographic location. The procedure's availability in Ontario is limited by provider shortages and anti-abortion stigma. Women in the province of Ontario do not have equal access to a medically necessary service as a result of these barriers to access.

This Major Research Paper explores the barriers that exist in Ontario that prevent women from accessing abortion services in the province. The paper explores the barriers to access to abortion services in three areas of focus. These areas are the stratification of the experience of barriers based on socio-economic status, barriers related to service wait times and a shortage of service providers, and the barrier to access created by anti-abortion campaign and stigma. This paper provides practical recommendations for policy measures that can contribute to breaking down current barriers to access to abortion in each of these three areas.

This Major Research Paper will use a "reproductive justice" approach, in acknowledgement that the ability of a woman to fulfil her right to determine her own choices regarding matters of reproduction is linked to factors over which she has no control, including, but not limited to, socio-economic status. A reproductive justice approach recognizes that each woman is composed of many intersecting identities, and that reproductive inequality is closely related to some of these identities. Policy recommendations aimed at improving women's abilities to exercise their right to reproductive choice must take the multi-factored nature of the right into account in order to be achieve their stated goal.

Introduction

Induced abortion is a common procedure experienced by up to a third of Canadian women during their reproductive years (Norman 2012, p.185). In spite of the decriminalization of abortion by the Supreme Court of Canada's Morgentaler Decision in 1988, there are still barriers to universal access to abortion in Canada. These barriers remain throughout the state, and vary considerably by geographic and socio-economic setting. As Eggerston (2001: 847) puts it, "the availability of abortions in Canada now depends on a woman's location and the size of her pocketbook".

For instance, there are no abortion facilities in Prince Edward Island while abortion is insured in New Brunswick only if approved in writing by two medical doctors and performed in hospital. The province of Ontario insures abortion procedures provided in both hospitals and clinic settings. Despite being insured and legal, there are a number of barriers to accessing abortion in Ontario. Abortion access is not experienced equally by Ontario women - in too many cases, socioeconomic status or geographic location determines the degree to which abortion is available to an Ontario woman. Abortion access in the province is limited by a shortage of providers and associated wait times, and is limited by anti-abortion stigma and campaigns.

Ensuring that they have equitable access to abortion services as required is essential to ensuring high quality health care for all Canadian women. The full realization of women's rights requires full enjoyment of reproductive health, of which access to abortion is one of several major components. As Loretta Ross and Jessica Shaw both advocate, a reproductive justice lens highlights the inequality that exists regarding who can control their reproductive destiny, and advocates for an end to structural power

differences that prevent the empowerment of women (Ross 2006; Shaw 2013), The 'reproductive justice' approach is relatively new - it was coined by women of colour at the Illinois Pro-Choice Alliance in Chicago (Shaw 2013, p.154). A reproductive justice approach is a useful way of approaching women's rights while recognizing the intersecting identities of each woman: race, class, sexual orientation, ability, national origin, relationship status, age, and so on, each have an impact on a woman's ability to exercise her reproductive rights. As Jessica Shaw notes, reproductive justice recognizes the need for full-spectrum reproductive health care activism (Shaw 2013, p.155).

Because abortion services in Ontario are legal and insured, barriers to access to the service are often over-looked or diminished in analyses that are focused on the starker realities of the Maritime Provinces. However, implementation of the legal right to access to abortion is reliant on factors that go beyond legal status and funding. This paper explores three types of barriers related to (1) socioeconomic status and geography, (2) provider shortage and (3) anti-abortion stigma. The paper argues that the implementation of access to abortion in Ontario remains incomplete because it is limited by the interaction of these barriers and develops a series of policy recommendations to improve access to abortion for women in Ontario.

This paper takes as given that abortion procedures are medically necessary, and thus, as with any other medical procedure, should be provided as needed (as deemed by the patient). Section 1 explores current rates of abortion in Ontario, and engages with what data is available on abortion rates to demonstrate that access remains uneven. Section 2 assesses the three types of barriers in turn. The first type of barriers addresses how uneven access due to geography or financial cost is compounded by socioeconomic status. The

second type of barriers concentrates on the impact of a provider shortage on access to abortion in the province. The third type of barriers, in recognition of the sensitive nature of abortion as a procedure that remains contested by some, draws on anti-abortion stigma and its consequences for access to abortion. Section 3 presents practical policy recommendations aimed at removing barriers to access to abortion. These recommendations call for improved access to contraception, accreditation of abortion services, improved access to medical abortion, a medical practitioner awareness campaign, improved medical practitioner training and funding, an adjustment to OHIP billing fees, and improved data collection. These recommendations, taken together, would address the main barriers to access to abortion in the province of Ontario.

Section 1: Legal status, analytical approach, and statistical reality of abortion access in the province

Legal status in Canada:

Canada is one of the few countries in the world in which having an abortion is not a criminal act. Abortion was first criminalized in 1869 in Canada, building on pre-Confederation statutes (Sethna, Palmer et al 2013). In 1969, omnibus reforms of the Criminal Code (R.S.C. 1970, C-34, s.251) provided for the limited legalization of abortion by stipulating that a woman could receive a hospital-based abortion if she obtained permission from a Therapeutic Abortion Committee of three physicians, which could approve a hospital-based abortion if continuation of the pregnancy would or would likely endanger woman's life or health. This reform was based on the assumption that medical expertise was required and sufficient for determining when abortion was warranted. However, TACs were optional, delays for permission were common, and abortion remained inaccessible for most women in Canada (Palley 2006 p. 569). In the 1980s Montreal-based physician Dr. Henry Morgentaler, who had been performing abortions in Montreal since 1968 (for which he spent 10 months in a Montreal prison before being acquitted), opened up abortion clinics in various provinces without TAC permission. Morgentaler faced criminal prosecutions in Quebec and Ontario, where juries refused to convict him of performing unlawful abortions (Palley 2006, p.572). The Supreme Court's decision in 1988 to overturn an Ontario court ruling against Dr Morgentaler struck down section 251 of the Criminal Code, ruling that legal, accessible abortion is a Charter right guaranteed to women to protect their bodily security, liberty, and conscience (R. v. Morgentaler, 1988 CanLII 90

(SCC), [1988] 1 SCR). Abortion services in Canada were thus decriminalized in 1988. Although additional legislation to regulate and limit access to the procedure was passed by the House of Commons in 1990, the bill was met with a tie-vote in Senate in 1991, and thus defeated. Canada remains one of the few nations in the world with no federal legislation limiting Canadian women's access to abortion services. Ontario and Quebec were the only provinces in the confederation to not subsequently withdraw public health insurance funding for abortion following the Morgentaler decision of 1988 (Erdman 2006, p 1094).

Reproductive Justice under contestation:

The individual human right to reproductive choice and autonomy, including the right to decide freely and responsibly on the number and spacing of children, has been widely recognized in international law, including by the International Conference on Population and Development Programme of Action, and in the 1979 UN Convention on the Elimination of All Forms of Discrimination Against Women. The right to reproductive choice takes into account the potential that both incentives and disincentives have to conflict with autonomy in reproductive decision-making (Freedman & Isaacs 1993, p.25). Barriers to abortion may act as disincentives to seek the procedure, and in that sense act in conflict, or as limitation to each woman's right to autonomous reproductive decision-making.

The concept of "reproductive choice" has come under attack in recent years, challenged for its narrowness of focus and potential for eugenic imperatives targeted at women of colour, minorities, Aboriginal women, disabled women. Some have called for reproductive "justice" rather than choice, in order to move away from choice-narrative reductionism. This line of argument calls for a shift of focus away from only abortion to

include a woman's choice to become pregnant, give birth, raise children in optimal circumstances and so on. It is however in the context of *renewed opposition to abortion in Canada* (see Section 2) that continued scholarly investigation into barriers to access to abortion such as Canadian women's travel to abortion services is merited (Sethna 2013 p1). A reproductive justice framework focuses attention on the social, political, and economic inequalities among different communities that contribute to infringements of reproductive justice. A reproductive justice approach recognizes that health outcomes are socially determined, and vary not only by population but within population, according to socioeconomic, cultural (and other) factors. In order for health equity to be achieved, socially determined inequities in access to care and in health outcome must be taken into account

Abortion is a critical component of reproductive healthcare. The procedure is a valuable component of public health programs, since many women would otherwise risk their lives to obtain unsafe, illegal abortions. The Society of Obstetricians and Gynaecologists of Canada affirms that "abortions are a necessary component of comprehensive family planning services", while the Canadian Medical Association states that induced abortion should be uniformly available to all women, with no delay in provision of abortion services (CMA 1988). Canadian women assume that they can obtain an abortion on demand, and see it as one of several fertility options open to them (CARAL 2003, p.5).

Why focus on Ontario/ provincial level?:

In a study of the impact of federalism on the implementation of reproductive and sexual rights, Linda White found that, despite favorable Supreme Court rulings recognizing the essential validity of access to abortion and contraception, cooperation by another level of government is necessary in order to implement that access (White 2013, p.1). Judicial rulings alone do not necessarily trigger wholesale change in policy practices. Equality in practice depends therefore not only on changes to formal rules and societal norm change, but also on government action to accept and implement practices and conduct deemed “legal” by the courts. Federalism complicates matters of implementation of rights, by involving two levels of governments, one to acknowledge the legality of action and the other to ensure access to services (White 2013, p.22). The result of the Supreme Court’s rights ruling in 1988 was to transfer implementation responsibility away from the federal government towards the provincial and territorial governments of Canada.

Most therapeutic abortions are the result of unintended pregnancy:

Most women seeking induced abortions do so because of an unintended pregnancy. A smaller number of women have abortions due to fetal abnormalities or maternal health concerns. Most abortions due to fetal abnormality take place after 12 weeks. It is unclear what proportion of abortions is undergone for this reason in Canada, although the majority of abortions occur before 12 weeks (POWER 2012, p.75).

The rate of unintended pregnancy in Canada is unknown, but in the United States, more than 95% of aborted pregnancies are unintended (Sabourin 2012, p.536). In a review of the prevalence, access and safety of abortion in Canada, authors found that unintended pregnancy can result from lack of contraception, contraceptive failure, or sexual assault

and may be unwanted because of no supportive partner, financial difficulties, genetic condition, serious fetal malformation, and maternal health concerns (Sabourin 2012, p.539).

Lack of access to abortion has a negative public health impact:

It has been shown that a lack of access to abortion has a negative impact on the health of women who bring unwanted pregnancy to term. According to a 2003 Guttmacher Institute study, women who carry an unwanted pregnancy to term are more likely to smoke, receive delayed prenatal care and have low-birth-weight infants than those carrying a mistimed pregnancy. Mistimed pregnancies have better health outcomes, however seriously mistimed (by more than 24 months) ending in live births, are associated with less breastfeeding, a shorter gestation, higher risk of low birth weight than pregnancies mistimed by 24 months or less (Santelli 2003, p.95).

Abortion is a “medically necessary” procedure:

The federal *Canada Health Act*, 1984, sets out nine requirements that provincial governments must meet through their public health care insurance plan in order to qualify for full federal cash contribution under the Canada Health Transfer (CHT). These requirements include five criteria (“national principles”) that apply to insured health services: public administration, comprehensiveness, universality, portability, and accessibility (Madore 2005, p.6). Under the criterion of comprehensiveness (in section 9 of the *Act*), the health care insurance plan of a province must insure all services that are “medically necessary”. The *Act* stipulates that “medically necessary is that which is

physician performed.” The federal government and Canadian courts have not defined “medically necessary” beyond this provision of the *Act*. Provinces and territories decide what is medically necessary under the *Act* by creating a list of insured services, which are automatically deemed medically necessary (ARCC Jan 2011, 1). Once procedures make it onto the provincial list, they are deemed medically necessary *ex post facto* (Kaposy & Flood 2006). The province of Ontario insures abortion procedures performed in regular hospitals; therefore abortion has been deemed a medically necessary hospital service (Joyce 2002). The ARCC points out that delisting the procedure would require the cooperation of the provincial college of physicians and surgeons (ARCC 2013). (All provincial and territorial colleges of physicians and surgeons in Canada have declared abortion a medically necessary procedure (Palley 2006, p.567).

There is a certain amount of circularity to the above argument that abortion in Ontario is medically necessary because it has been included on a list of insured (and therefore “medically necessary”) procedures. However, the fact remains that abortion in Ontario *is* an insured procedure, whether performed in hospital or in clinic, publicly or privately. The sheer act of raising questions about the necessity of abortion procedures differentiates and stigmatizes abortion, framing it as a procedure inherently different from other medical services.

This paper will take the approach that the next step in de-stigmatizing this critical component of women’s health care is to normalize the procedure by emphasizing analysis on barriers to access, rather than questions of necessity. Abortion is legal and insured in Ontario. The question becomes: What can be done to insure that abortion is accessible for

all Ontario women, regardless of geography, socio-economic status or environmental factors? What are the barriers limiting access to abortion in Ontario?

Ontario Statistics

The Project for an Ontario Women's Health Evidence-Based Report (POWER) 2012 study chapter on women's reproductive and gynecological health in Ontario presents the most complete picture of abortion rates in Ontario available. The Canadian Institute for Health Information (CIHI) currently has responsibility for reporting national abortion statistics, however CIHI data may not present as accurate a picture as the POWER study data, due to unreported privately performed (but nevertheless legal) abortions. Statistics Canada provides national estimates of abortions performed until 2006, but warns that it may underestimate rates by as much as 5% for Ontario, due to reporting only from hospitals and funded clinics. Likewise, CIHI estimates that it may represent only 90% of all abortions performed on Canadian citizens.

The POWER study used OHIP billing data in order to capture abortions billed to the provincial insurance plan, including those performed privately, in addition to those performed by hospitals and clinics funded directly by the Ontario Ministry of Health and Long Term Care. The data also include abortions provided out of province, although these were estimated to be less than one percent of all abortions. The study also does not include medical abortions (POWER 2012, p.81).

Key Statistics about Abortion Access in Ontario (2007)

Table 1:

Factor	Induced abortion rate per 100 women	Source
Neighbourhood income	Lowest income: 2.1	POWER 2012, p.78
	Highest income: 1.0	
Age*	20-24 years: 3.4	POWER 2012, p.78
	40-49 years: 0.2	
Urban/ rural	Urban areas: 1.6	POWER 2012, p.79
	Rural: 0.9	
Age-standardized by LHIN	Erie St. Clair: 2.5	POWER 2012, p.84
(Local Health Integration Network)	North East: 1.0	
	North West: 1.1	

It becomes clear from Table 1 that abortion rates vary significantly for Ontario women by neighbourhood income, age, urban/ rural location and LHIN. The POWER study notes that, as expected, age was the most important predictor of abortion rates. The data tells a compelling story about the impact of location on a woman's access to abortion. The age-standardized rate by LHIN is particularly telling: the age-standardized rate should have eliminated variations due to fertility or contraception failure (which might vary along geographic lines, rural areas for example might have higher rates of contraception failure, higher fertility rates associated with a younger population), however despite age-standardization, the rate in Erie St. Clair LHIN is still 2.5 times that of North East LHIN. This

may be indicative of fewer barriers to access to abortion in the urban region of Erie St Clair LHIN, which is on the Windsor-Montreal corridor, at most a 2.5 hour drive from Toronto where the majority of abortion clinics in the province are located.

A note on POWER study data:

The POWER study includes a ratio of abortions to live births to measure the number of induced abortions in women 15-49 per 100 live births, and notes that in countries with legalized, induced abortion, this ratio is used to estimate the proportion of pregnancies that were unintended, stating that abortions are “a compelling indicator of the incidence of unintended pregnancies” (POWER 2012, p.77). Overall in Ontario, this ratio was 37 induced abortions per 100 live births. It is worth noting, however, that this ratio does not take into account pregnancies that were unplanned, unwanted, but nevertheless brought to term for reasons that might include, but are not limited to, lack of access to abortion services. The 2008 Preconception Health Survey of 200 pregnant women and 151 women with a child under the age of 7 years living in Ontario, Canada, revealed that 30% of pregnancies were unplanned and 67% of women were happy with their last pregnancy (BSRC 2009, p.9). The US rate of unintended pregnancies in 2008 was estimated to be 49% (Loutfy et al 2011). The POWER study’s use of the ratio of abortions to live births as a proxy for unintended pregnancies is premised on the assumption that all women who might choose an abortion in Ontario have barrier-free access to that decision.

The nature of abortion is such that reporting the procedure remains sensitive: it is likely that under-reporting occurs, particularly for early-term abortions, and that as a result, abortion data does not provide complete or perfect information. The POWER study

data also does not include medical abortions, which the report estimates to be negligible. However, several Ontario clinics advertise online that they do provide medical abortions for early pregnancies. Therefore this data may underestimate the rate of medical abortions performed in Ontario. There are also no data included or collected on Ontario women who seek abortions in the United States for abortions beyond 20 weeks of gestation. This data therefore probably still underestimates the rate of abortions sought and received by Ontario women.

Section 2: Barriers to Access to Abortion

This paper's investigation of the barriers to access to abortion in Ontario revealed barriers that can be structured into three main observations about barriers to access to abortion in Ontario. Firstly, barriers are experienced differently by different population sub-groups. Secondly, barriers are often linked to providers. Thirdly, some barriers in Ontario are related to the anti-abortion movement, anti-abortion stigma and the dirty politics of anti-choice ('pro-life') advocates. Of course, each set is closely related to the other: provider shortages are at least partly a result of anti-abortion stigma, different socio-economic groups are more or less vulnerable to the impact of stigma, and so on. However, a systematic analysis of barriers along these three threads will help tease out specific recommendations in later section.

Barrier 1: Stratification of experience of barriers

Barriers to abortion in Ontario are experienced differently by different groups in the province. "The inequity of exclusion resides at the intersection of wealth, sex, and gender" (Erdman 2006, 1096). The Guttmacher Institute points out that often socio-economically disadvantaged groups who have higher rates of barriers to abortion also experience higher rates of risky behaviours, which in turn dovetail into higher rate of unintended pregnancy (Santelli 2003). As in many jurisdictions, this is the case in Canada. The factors associated with poor access to abortion service are often related to, or are the same as, the factors associated with failure to practice contraception (Sabourin 2012, p.539). Nationally, in geographical terms, women from northern, rural and (or) Maritime regions face the

greatest hardship when accessing services. In identity terms, marginalized women, Aboriginal women and socio-economically dis-advantaged women are the hardest hit by barriers to access to abortion (Sethna 2013, p.6). Unsurprisingly, as in most areas of health care equity, many of the barriers faced by women to accessing abortion are the result of deeper social problems, the most salient of which is, arguably, poverty (Downie 2007, p.160).

Poverty and single motherhood

The Ontario 2012 POWER report echoes these facts, observing, “for women who have access to induced abortions, studies suggest that demographic factors, such as the woman’s age, socioeconomic status, and ethnicity are important determinants of whether she will have the procedure.”(POWER 2012 p.76). The institutional policies to be discussed below that affect access thus have a disconcerting way of acting in tandem with the individual (and/or socio-cultural) disadvantages of some women; as Kaposy puts it, “social location can affect autonomy status” (Kaposy 2010, p.21). Kaposy points out that many women seek out abortion to avoid single motherhood: 49% of women seeking abortions canvassed in an American study cited this reason; in Canada, at 47.1%, female lone parents have, by far, the highest rate of poverty of any family ‘type’ (Kaposy 2010, p.22).

Further highlighting this reality, a study of Canadian women presenting for abortion in an Ontario hospital found that a history of physical or sexual abuse was significantly associated with repeat induced abortions (Sabourin 2012, p.536). The close relationship between poverty and violence has been widely studied; violence against women has been shown to be more frequent and severe in lower socio-economic groups (Jewkes 2002). It is clear that poverty compounds the effects of violence, and violence the effects of poverty.

It seems likely that the various barriers to abortion access addressed below will have a greater effect on the behaviour and choices available to some women than others. The efforts to limit a woman's choices will also be more successful the less knowledge, resources, support and self-confidence she has (Kaposy 2010, p.21).

The burden of administrative fees

The cost of abortion procedures is a considerable barrier to access for some women. The Ontario Health Insurance Plan covers the cost of abortions provided in hospitals and at free-standing clinics (with a valid Ontario health card). University Health Insurance (UHIP), Interim Federal Health (IFH), Canadian Military Insurance (DND) also fully cover abortion costs. However, some clinics do have administrative fees that are not covered, and can range anywhere from \$60 to \$120 to \$300. A valid health card from another Canadian province may make re-imburement possible for an out-of-province woman seeking a procedure. Without a valid health card from a Canadian province, costs range from \$300 to \$900. Some clinics, such as Planned Parenthood Toronto, have funds for those without insurance, although information and access to these funds varies (Planned Parenthood Toronto 2012, online). Some clinics operate on a for-profit basis, which disadvantages women who are less able to pay.

Concentration of abortion services in the main cities

Although each of Ontario's LHINs contains at least 1 hospital that performs abortions, abortion services in Ontario are mainly restricted to urban centres (POWER 2012). (Consider also that the Northwest LHIN in Ontario is comprised of 47% of the geographic area of the province). There is a single hospital north of the Trans-Canada

Highway that provides abortion services (Cross 2009, p.5). All but one clinic in the province are located in Ottawa or in the Greater Toronto Area (Reid 2013, online). One study of Canadian women's journeys to an abortion clinic in Toronto reports that 25% of all abortions performed in Ontario are performed in Toronto-based clinics, and 66% of all abortions take place in Southern Ontario (Sethna 2012, p.644). This reality is reflected in the rates of abortions performed in Ontario. According to the POWER study, women living in urban areas were more likely to have induced abortions compared to women living in rural areas (1.6 abortions were performed per 100 women living in urban areas, compared with 0.9 per 100 living in rural) (POWER 2012, p.79). A strong majority (73.5%) of women who provided information to a pilot study at the Morgentaler Clinic in Toronto had travelled an hour or more to reach that clinic (Sethna 2012, p.644).

As a result of the rural-urban geographic disparity in provision of abortion services, access to the procedure varies widely based on geographic location and financial resources with respect to travel costs and fees (ECHO 2011, p.3). Since abortion services are significantly easier to receive in larger urban centres, some women will have to travel outside of their communities in order to have access to the procedure. A 2003 CARAL survey documents that such travel is time-consuming, expensive, and can conflict with work, as well as require special child-care arrangements. When women are forced to go outside of their community for services, any necessary follow-up is also made difficult (CARAL 2003, p.3). The need to travel and to justify one's absence while seeking the abortion elsewhere may also jeopardize the confidentiality of a woman, although it is probably worth acknowledging that some women from rural places may want to travel to urban centres for anonymity (Kaposy 2010, p.20). Certainly women who are already

parents, particularly those who are primary caregivers, have additional costs and challenges associated with accessing abortion. Poverty compounds the issue of geography-related costs: women are more likely than men to have minimum wage jobs, and are less likely to be able to afford the travel or take the time required for travel (Downie 2007, p.153). Women may be able to afford to pay to go to a clinic, but not for a companion. There are Northern Health travel grants available with referral for Northern women who must travel south (Sethna 2012, p.643).

Portability

All provinces in the confederation participate in reciprocal hospital billing agreements, and all provinces and territories except for Quebec participate in reciprocal physician services billing agreements. The Inter-provincial Health Insurance Agreement Coordinating Committee (IHIACC) is responsible for determination of what is included, excluded from the Interprovincial Reciprocal Billing Agreement. According to the Canada Health Act Annual Report 2010-2011, abortion is on a list of services that are excluded from the Interprovincial Reciprocal Billing, and for which prior approval from the Medical Services Commission is required (Canada Health Act Annual Report 2010-2011). As a result of this exclusion of abortion from the interprovincial billing agreement, Ontario women who might require an abortion while in another province that does not insure the service would be required to pay for the procedure out of pocket, thus facing a major barrier to accessing the service. Women from other provinces who would require an abortion while in Ontario would face a similar barrier.

Barrier 2: Wait Times & Provider Shortage

Lack of hospitals that provide abortion services

Related to the geographical distribution of hospitals and clinics that provide abortion services is the shortage in the number of facilities that provide services. Canadian women who choose hospital abortion (for financial or medical reasons, or due to personal preference, or because of the lack of a clinic nearby) must often wait for services (Downie 2007, p.150). According to the POWER study 2012 report, only 31% of hospitals (not including hospitals with religious affiliations or specialties such as children's hospitals) in Ontario provide abortion services. This represents a decrease in the number of hospitals that provide abortions in Ontario since 2003 (Cross 2009, p.5), with no indication that this trend will be reversed or improved in the next decade.

Palley (2006: 575) writes that the hospital merger movement involving Catholic hospitals is a major factor limiting the availability of abortion services, noting for example that in 1996, Peterborough Civic Hospital was forced to agree that its Women's Health Care Centre would become an independent facility because of the anti-abortion position of its new Catholic affiliated partner, St Joseph's Health Centre. The case was similar for Toronto's Wellesley Hospital, which closed its abortion services when taken over by St Michael's Catholic hospital.

A lack of hospitals that provide abortion services is a considerable impediment to access to abortions in Ontario. Given that abortion procedures are procedurally complication-free to the point that the service can be provided in free-standing clinics with minimal surgical infrastructure, it stands to reason that 100% of hospitals should be able to

provide abortions. However, many hospitals refuse to provide the service due to ideological decisions made by their boards (Kaposy 2010, p.20).

The low quantity of hospitals that provide abortion procedures contributes to long wait times for receiving abortion procedures. A 2003 CARAL survey documented wait times that spanned from 24 hours to as long as six weeks (CARAL 2003, p.3). The 2003 CARAL report notes that even hospitals that do provide abortions can still obstruct access: the survey found that a range of gestational limits from 10-23 weeks for when an abortion could be performed, even within a hospital, and noted inconsistencies (CARAL 2003).

Waiting lists for abortions can push a woman past the facility's gestational limits, requiring her to invest resources in traveling to another location. Sethna's study of travel for abortion services (2012: 644) points out that the inconvenience most cited by respondents was that no appointments were available at hospitals. In addition, Sethna's study (2012: 646) indicates that some women are forced to travel to clinics for abortions because wait times or extra fees denied them access to abortion services in their home communities. Delays in accessing abortion are associated with increased risks to the woman, which are well-documented in the literature (Bartlett et al., 2004). Even waiting a few weeks increases the medical risk of the procedure. The late Dr. Henry Morgentaler has said that "Every week of delay increases the medical risks to women by 20 percent" (ARCC 2011).

In their 1988 decision, Justices Beetz and Estey recognized the risks associated with delays: "The risk of post-operative complications increases with each passing week of delay. There is a heightened physical and psychological risk associated with later stage pregnancy techniques for abortion. Finally, psychological trauma increases with delay. The

delays mean therefore that the state has intervened in such a manner as to create an additional risk to health, and consequently this intervention constitutes a violation of the woman's security of the person" (Morgentaler note 2 at para 121. Downie 2007, 161).

Provider Shortage:

In addition to waiting times due to hospitals that do not provide abortion services, there exists in Canada a shortage of trained medical professionals able and willing to provide women with safe, legal abortions and abortion-related care (ARCC 2005, page 1 position paper #1). The literature agrees that the lack of abortion providers is one of the most significant barriers to abortion access in Canada (Downie 2007, 173; Kaposy 2010 p.20).

This shortage of abortion providers is related to past dangers associated with the task, particularly intimidation and violence directed against abortion health providers in both hospitals and clinics (Palley 2006, p.582). In 2001, Dr. Ted Busheikin, part owner of Calgary's Kensington Clinic stated: "Doctors are scared. If they're young and have a family, they're frightened for their own safety and their children" (Eggerston 2001, p.847). Ontario was the scene of a shooting targeting a physician in his own home (Hugh Short of Ancaster, Ontario).

The potential for violence and harassment makes privacy a major issue for abortion providers. Threats to 'unmask' abortion providers by anti-choice activists, distribution of pamphlets to neighbors to warn them that they are living near an abortion provider; privacy issues seem to be particularly deterrent to physicians considering providing abortion services in small Canadian communities (Downie 2007, p.147).

Some doctors are unwilling to become providers because of financial considerations. Abortion provision is not a lucrative area of practice, and lacks non-pecuniary 'rewards', whereas other areas of practice offer prestige, greater quality of life (Downie 2007, p.148). This is compounded by the perception that providers face poor working conditions due to overwork and stress due to harassment, and the potential of violence. The shortage of doctors may also be due to the fact that many doctors are willing to provide abortions only up to a certain point in the pregnancy, ranging from 10-23 weeks (Downie 2007, p.148). Gestational limits on service provision are determined individually, according to staff and hospital preference. The number of providers willing to provide later-term abortions is much lower than those willing to perform abortions in the first trimester (Downie 2007, p.148). Only about 20% of OB/Gyns will provide abortions in their career, and most GPs in Canada either do not perform abortions, or perform only a handful a year for their regular patients (ARCC 2005, position paper #5).

Abortion providers have to a certain extent been demonized by the anti-choice movement in Canada, through pickets, obstruction of entrances, and other forms of harassment at women's centres (Palley 2006, p.580). The Toronto Morgentaler Clinic experienced an arson attack in the first year of its existence, and was firebombed in 1992 (Sethna 2012, p.642). These concerns are also experienced by patients: 15.3% of the respondents in Sethna's 2012 survey cited concerns about their safety due to anti-abortion protesters (Sethna 2012, p.644).

The shortage of abortion providers is partially attributable to a lack of comprehensive training in abortion care at medical school. Training in abortion techniques in Canadian medical schools is 'neither extensive nor mandatory' during obstetrics and

gynaecology residencies (Kaposy 2010, p.21). Canadian medical schools on average spend less than one hour over a four year curriculum discussing abortion techniques (find Canadian Medical Students for Choice study, cited in Downie and Kaposy). Abortion is now an elective course at the residency level. The Medical Students for Choice Canadian website states that there is only one family medicine residency offering an established local elective in abortion training (in Dartmouth, Nova Scotia), and two OB/Gyn residencies (UBC and University of Manitoba) (Medical Students for Choice: <http://www.msfc.org/medical-students/applying-for-residency/obgyn-residency-guidelines/>). 18% of the hospitals that provide abortion services indicate that their physicians and staff do not receive any further abortion training upon graduating from medical school (Downie 2007, p.148). Doctors who do learn abortion techniques are often limited by their training to certain types of procedures, which can lead to self or externally imposed gestational limits on their practice (Downie 2007, p.147). Although the Morgentaler clinics and others have offered up their spaces as training centres for doctors interested in learning the procedure, they have seldom been taken up on their offers. According to Eggerston, Morgentaler trained about 25 doctors in his Toronto clinic (Eggerston 2001, p.847).

This shortage of medical practitioners able and willing to provide abortions is compounded by the ageing of the population of abortion providers in Canada. This 'graying' phenomenon is a source of concern among Canada's current abortion providers, as the new number of abortion providers being trained is not considered adequate to counter the larger attrition of older doctors. One explanation for this phenomenon is that most physicians who are currently being trained have never experienced a time when abortions could not be obtained legally (Downie 2007, 149; Kaposy 2010, 20; CARAL 2003, p.5;

Eggerston 2001, p.847). Further, a majority of abortion services in Canada is provided in teaching hospitals, where seniority is the dominant factor in determining which practitioners get operating room time. Some providers can't obtain sufficient operating room time to meet demand for their services (Downie 2007, p.150).

Rural providers face particular circumstances that exacerbate the above barriers. A recent study of British Columbia abortion providers found that rural participants faced barriers disproportionately greater than urban providers, who faced fewer or no barriers to provision, and noted the professional isolation and need for discretion within a rural community, as well as a lack of replacement providers, including barriers to training opportunities (Dressler 2013). Most likely this phenomenon is reproduced in Ontario.

Medication/Medical Abortion is not uniformly accessible in Ontario (ECHO 2011, p.1):

Medical abortion is an alternative to surgical abortion that involves the use of abortifacient pharmaceuticals to induce abortion. Only 1 to 2% of abortions in Canada are pharmaceutically induced, and the Ontario POWER 2012 study estimated that less than 1% of abortions were medically induced in the province (Erdman 2008; POWER 2012). Acceptable protocols vary for medical abortion, usually involving the administering of 2 medications in sequence to effect the abortion over time. Mifepristone is thought to be the safest and most effective pharmaceutical for medical abortion (Erdman 2008, p. 1). Canada is an outlier amongst its peers by not yet having approved mifepristone for use – the United States and the European Union have both approved mifepristone for abortion, as have Russia and China (White 2013, p.14). There is sufficient data available from European

states and the United States to approve the safety and efficacy of the drug in a Canadian context (Downie 2007).

National trials in Canada on the termination of pregnancy by chemical inducement using RU-486 (in a combination of mifepristone and misoprostal) were suspended by the Liberal federal government in 2001, and no manufacturer has yet applied to market mifepristone in Canada. It is likely that fear of anti-abortion protest contributed to the decision to end trials, and to manufacturer reluctance. The cost of an application for marketing approval may also be prohibitive, ranging from \$52,000-\$117,000 (Downie 2007, p.152).

Medical abortion would increase the range of options available to women who seek abortions in Canada. Medical abortion can be initiated as soon as pregnancy is confirmed, diminishing access issues related to timing and travel (many abortion providers require that a woman wait until she is 5-6 weeks pregnant). Given the absence of facilities for surgical abortions in Canada, the decision by the federal government not to approve mifepristone is restrictive of choice (White 2013, p.14).

Medical abortion (through the prescription of mifepristone for off-label use) may occur more often in Ontario than is estimated by the POWER study. Several Ontario abortion clinics advertise online that medical abortion is an option for early terminations (usually before 5 weeks pregnancy).

Barrier 3: Anti-abortion campaign & stigma

The anti-abortion movement in Canada is a well-organized, well-funded network that includes religious and political organizations (Knights of Columbus, Canadian Centre

for Law and Justice), REAL (Real, Equal, Active, For Life) Women, United for the Family, Birthright and the Coalition for Life (Palley 2006, p.580). These “for-life” organizations apply pressure to limit or deny abortion services by health delivery system, as well as pressure on political representatives. Anti-abortion lobby groups such as Campaign Life argue that abortions are too available to women in Canada (Eggerston 2001, p.847), frame abortion as a lifestyle choice, equating it to “cosmetic surgery” which is not covered under Canadian health insurance (Eggerston 2001, p.849).

Anti-abortion beliefs limit access to abortion by contributing to misinformation. CARAL reports inconsistency regarding the usefulness of information given to women seeking an abortion at hospitals (CARAL 2003, p.4). CARAL documents the case of an Ontario hospital that did provide abortions, but the switchboard operator would not disclose this information but instead referred the caller to Birthright, an anti-choice organization. 15 of the hospitals CARAL contacted referred the caller to an anti-choice agency, 16 hung up without offering a referral (CARAL 2003, p.4).

Even the very use of the word “choice” by anti-abortionists marginalizes medical necessity of abortion. “Choice” rhetoric is purely political: every medical procedure is essentially a choice in the sense that each patient has the right to choose or turn down a procedure (ARCC 2011, p.3)

Anti-abortion physicians and conscientious objection:

The Canadian Medical Association (CMA) policy on Induced Abortion allows conscientious objection by a physician, who need not recommend, perform or assist at an

abortion. The policy allows physicians to refuse to initiate referral for another physician. The National Abortion Federation argues that this CMA policy impedes women's access to abortion services (http://www.med.uottawa.ca/sim/data/Abortion_Law_e.htm). A 2008 study of British Columbia women at abortion clinics argues that physicians who fail to refer patients for abortion or to provide information about obtaining an abortion can cause distress, impeding access for a significant minority of women requesting an abortion (Weibe 2008). There are also anecdotal reports of women whose anti-choice doctors have actively tried to block their attempts to obtain a referral elsewhere, by lying about the legality of abortion, delaying tests until pregnancy is too advanced for the procedure, or by pretending that they have sent a referral when they have not (Downie and Nassar 207).

The College of Physicians & Surgeons of Ontario issued a similar policy in September 2008 on the scope of physician obligations under the Human Rights Code (<http://cpso.on.ca/policies-publications/policy/physicians-and-the-ontario-human-rights-code>). On the other hand, the Society of Gynaecologists and Obstetricians of Canada directs physicians to make an appropriate referral in the case where a woman requests a termination and that physician is unwilling or unable to provide the service (Sabourin 2012, p.534). The Catholic Health Ethics Guide forbids abortion, and is applied in many hospitals and clinics in Canada. The Guide distinguishes between direct and indirect abortion. Direct abortion is: "a procedure whose deliberate purpose is to terminate the life of an embryo or a fetus", whereas indirect: "procedure necessary to save the life of the mother in which the death of the fetus is an inevitable result, eg treatment of an ectopic pregnancy" (http://www.med.uottawa.ca/sim/data/Abortion_Law_e.htm)

CARAL documents that slightly over half of Planned Parenthood affiliates completing written questionnaire noted that anti-choice physicians were serious barriers to access. CARAL cites Planned Parenthood evidence of anti-choice physicians lying to women about abortion services, claiming not enough time to perform the procedure, or that an 8-week limit might apply (CARAL 2003, p.4).

So-called Crisis Pregnancy Support Centres:

According to the Canadian Association of Pregnancy Support Centres (CAPSS) website, there are 32 Crisis Pregnancy Support Centres operating in Ontario, including in rural Ontario. CAPSS has been affiliated with centres that have been shown to give misleading advice to women seeking abortion, overstating or simply mis-stating the risks of the procedure (<http://bc.ctvnews.ca/surrey-charity-gives-dubious-abortion-advice-investigation-1.754309>). The ARCC has published a brochure about how CPCs mislead women (<http://www.arcc-cdac.ca/action/CPC-brochure.pdf>). It is not unreasonable to assume that, particularly in the rural areas in which some of these centres are located, these centres do play a significant role in the presentation of options to women with unwanted pregnancies. These centres act as barriers to access to the procedure by providing mis-information, by failing to provide the full picture of what is possible to women with unwanted or unexpected pregnancies.

Legislative attempts to re-criminalize abortion:

A policy analysis counts 26 private member bills, at least 8 private member motions, 1 government-sponsored bill that have been introduced since 1989 with the purpose of limiting or restricting access to abortions, although there have been no bills that directly address abortion (Sabourin et al 2012, p.533). These legislative attempts reinforce the

negative stigma on abortion, do not incite new abortion clinics to open in the province and provide services. They do not provide any positive incentive for landlords to rent out space for abortion services. They also send a strong signal to the anti-abortion movement that there is political support for their actions.

Section 3: Policy Recommendations

All three of the barriers to access to abortion outlined above must be addressed in order to improve access in the province of Ontario. These barriers do not exist in isolation from each other, and neither do the policy measures that can be taken to address them. A policy measure aimed at improving the medical practitioner shortage, for example, will have a deep impact on anti-abortion stigma. The ultimate goal of policy recommendations is to remove barriers to access to abortion, in order that women be able to exercise their right to reproductive choice throughout the province, no matter their background, socio-economic status or location. One of the principle ways in which these barriers can be removed is by removing the stigma associated with the abortion procedure. Policy measures aimed specifically at improving access to the procedure will remove some of its stigma by addressing the procedure with a long-term goal of normalizing without minimizing it.

In addition, access to contraception is a closely related issue to access to abortion, because contraception is the primary method of preventing unintended pregnancies (for which abortion is often used). Therefore, this recommendation section will address improving access to contraception, and will then move on to six major policy measures that can be taken to improve access to abortion in the province of Ontario. These six measures include 1) Accreditation of abortion services 2) Medication abortion 3) Medical practitioner awareness campaign 4) Medical practitioner training and funding 5) Adjustment of OHIP billing fees and 6) Improved data collection.

Improving Access to Contraception:

Comment [IE1]: here you have to add a introduction paragraph that presents the core of the recommendations and spell out the argument: tackle the 3 types of barriers as they have interaction effect on each other. and add: improving access to contraception in the recommendations as the first one

Canadian women use contraception inconsistently: a 2009 cross-sectional study of over 3000 Canadian women found that 15% of respondents “never” used contraception, and 20% of respondents were inconsistent users (“sometimes” or “usually”). The study concluded that interventions focused on the “never” and inconsistent users could have a significant impact on public health concerns such as rates of unintended pregnancies and abortion (Black 2009, p. 638). Wendy Norman’s 2012 study takes Canadian abortion rates as a proxy for unintended pregnancy (thereby possibly underestimating the rate of unintended pregnancies brought to term, while also underestimating the impact of barriers on access to abortion). These concerns aside, Norman’s conclusion that there remains a significant unmet need for effective contraception in Canada is valuable (Norman 2012, p.190). It is clear from these and other studies that where fertility is constant, increased use of contraception reduces the number of induced abortions (POWER 2012, p.74). There is no doubt that access to contraception and access to abortion are closely linked areas of reproductive justice and reproductive policy.

Factors that limit access to, or use of, contraception are likely to be similar to the factors that limit access to abortion, such as stigma, lack of education, contributing to a shortage of trained providers, shortage of available medication at pharmacies and so on. The Common Drug Review, a federal board that advises the provinces on which pharmaceuticals to list on their formulary, has recommended against the contraceptive patch and vaginal contraceptive ring on provincial drug formularies, therefore the cost accrues directly to Canadian women, limiting choice to those who can afford it (Black 2009, p.634). Additionally, high cost reduces demand, low demand reduces availability, with negative consequence on availability of such medications.

For Aboriginal women (who have some of the highest nation-wide abortion rates as a population), the Non-Insured Health Benefits program considers vaginal contraceptive rings to be limited-use medication, and the contraceptive patch to be an exception drug. This is thought to delay or prevent access to these methods, putting Aboriginal women further at risk of unintended pregnancy (Black 2009, p.635).

Policies targeting improved access to contraception may have positive effects on need for abortion; however they will never reduce the rate of unintended pregnancy to zero, for reasons that include an above zero failure rate of contraception, violence against women, including rape, stigma, and lack of knowledge. Policy recommendations in this paper will therefore focus on changes that will directly improve access to abortion services in Ontario, bearing in mind, however, that policy recommendations aimed at improving access to contraception should be seen as complimentary, rather than supplementary, to recommendations to improve access to abortion, and vice versa.

The lowest abortion rates in the world (in Switzerland and Germany) have been achieved in environments with comprehensive sex education, a sustained commitment and dedicated resources to family planning and reproductive health services (Arthur and Cawthorne 2013).

Improving Access to Abortion:

The analysis in Section 2 of barriers to access to abortion in Ontario paints a worrisome picture of a fragmented 'system' of abortion services available to women in Ontario, experienced differently by different socio-economic groups, and impacted negatively by

anti-abortion stigma and campaigns. There are a number of avenues along which to improve this picture.

1. Accreditation of Abortion Services:

a. Lobby the Canadian Council on Health Services (CCHS) Accreditation to include abortion services in its list of health services subject to their accreditation process.

b. Provide a mechanism for disciplinary action to be taken against those who fail to provide such information

Considerations: The CCHS Accreditation would standardize the provision of care, would contribute to a perception of abortion clinics as safe and mainstream. This standard would include standardized practitioner knowledge and hours of experience, and ensure that women throughout the province receive equal care (including follow-up).

A risk of any move towards regulating abortion service provision is that regulations could be altered at a later date to include restrictions to the nature of service provided, such as limits to the gestation period after which abortions may no longer be provided, or limits determining who is able to decide to seek an abortion.

A further risk of any move to regulation lies in pushback from medical practitioners, who are often reluctant to agree to any move towards regulating their autonomous decision-making. CCHS Accreditation is a good compromise in this regard, because it is already well-known by the Canadian medical practitioner community.

2. Medication abortion

- a. Lobby federal government to resume clinical trials in Canada of mifepristone (RU-486) for abortion purposes
- b. Approve use of mifepristone (RU-486) and misoprostol as on-label use in Ontario
- c. Approve use of methotrexate and misoprostol as on-label use in Ontario

Considerations: Limacher et al point out that mifepristone and misoprostol together have been used in Europe as abortifacients since 1988, in the United States since 2000, and that the use of misoprostol and mifepristone for early abortions is also considered safe by the literature (Limacher et al 2000, p. 142). In a recent study, 52% of family physicians would consider providing medication abortions should mifepristone become available (Raymond et al. 2002:538).

The approval and introduction of mifepristone and the indication of mifepristone and methotrexate in combination with misoprostol for abortion purposes would reduce total costs of abortions to the Ontario health system, because the cost of medical abortions is significantly lower than that of surgical abortions.

There is a risk of failure associated with medication abortion that must be considered, in which case surgical abortion must be performed, contributing to increased costs both to patient and system. However this risk has been reported to be rare, and medication abortion is significantly less intrusive than surgical abortion (Limacher et al 2000). There is also a fairly substantial, and powerful, anti-abortion movement dedicated to ensuring that no abortifacients should be made available in Ontario or Canada. The resumption of clinical trials will be framed by this anti-abortion movement as a dangerous step, likely to threaten the lives of women by making abortion services 'too easy' to receive. The federal government has not given any signals of willingness to resume clinical trials,

however might be willing to engage in the process in a context of low media attention. There will also be substantial political lobbying aimed at ensuring that no movement be made to approve new label indications.

However, anti-abortion campaigning and political lobbying should not take precedence over the widely accepted data that shows medical abortion to be a safe, non-invasive alternative to surgical abortion, widely practiced in the US, Europe and elsewhere.

3. Medical Practitioner Awareness Campaign

a. Work with Society of Obstetrics and Gynaecology Canada (SOGC) to produce and publish two sets of guidelines:

- 1) Guideline on the off-label prescription of methotrexate and misoprostol for medical abortions
- 2) Guideline to normalize pre-12 weeks abortion procedure in regular family physician practices

Considerations: Canadian laws don't prohibit "off-label" use of pharmaceuticals approved for other indications (Sabourin 2012, p.535). These guidelines could be developed and released in a relatively short time frame, thereby reducing current barriers to accessing medical abortions for women in the interim period before mifepristone (RU-486) is legally approved, and before the prescription of mifepristone and misoprostol and methotrexate and misoprostol for abortions is indicated on labels.

Family physicians are able to provide early-term abortions in their regular practices with no extra provisions required. Early term abortions performed by general practitioners is absolutely not illegal, nor is it dangerous to patient health. Guidelines aimed at

normalizing the procedure performed in the family doctor environment would contribute to a reduction in demand for late-term, more complex and potentially more medically complicated abortion procedures, thereby reducing costs to the health care system. They would also contribute to reducing stigma surrounding abortion procedures as highly complex, highly dangerous, abnormal procedures.

There is a risk of anti-abortion lobbying aimed to prevent such guidelines. However, given that SOGC already publishes guidelines in which medical abortion is considered a safe alternative to surgical abortion, it seems unlikely that SOGC would take anti-abortion lobbying into account.

Appendix 1 illustrates that both clinics and hospitals are vital providers of abortion services. However it is important to note that family practitioners are the most cost-effective source of abortion service delivery for early-term abortions. An effective, efficient and accessible system in which abortion is accessible to all requires that all three sources of abortion delivery are supported.

4. Medical Practitioner training & funding:

a. Make accreditation for Ontario medical schools conditional upon provision of meaningful opportunity to all students who wish to take the opportunity to receive training and experience in abortion techniques.

Considerations: This policy move would receive significant anti-abortion reaction and lobbying, which might be perceived to outweigh the benefits of the measure. Compulsory training in abortion techniques might also clash with the objection clause in Canadian Medical Association (CMA) guidelines for medical practitioners, which currently allow

physicians to opt out of providing procedures they feel are in contravention of their personal values.

This measure would, however, go a long way to combating the 'graying' phenomenon of abortion providers who are retiring and no longer providing crucial abortion services. The policy would also fight anti-abortion stigma, which would further contribute to reducing barriers to accessing the service for Ontario women.

b. Provide further scholarships for medical students who spend time training in abortion clinics

Considerations: The Dr. Henry Morgentaler Future Choice Award offers five \$1000 scholarships to medical students in years 2,3,4 who spend time training in abortion clinics, to help offset the cost of an MD degree. In 2004, Planned Parenthood Federation of Canada introduced a series of scholarships to support medical students seeking clinical training in abortions and abortion-care

These scholarships would also combat the 'graying' phenomenon of abortion providers retiring and no longer providing the abortion service, and would possibly attract less negative attention from anti-abortion campaigners. They would also allow those who choose to opt out of providing the procedure for personal value reasons to continue to do so.

5. Adjust OHIP billing fees

a. Adjust OHIP fee codes for both surgical and medical abortions to allow follow-up by email and phone to meet the needs of hard-to-reach women, and increase follow-up rates.

Considerations: This would contribute positively to ensuring that women who experience complications would receive necessary follow-up care, and would also make the service more accessible to women who might be able to only afford a single trip to a southern clinic or provider (rather than the second trip or additional length of stay required for in-person follow-up).

b. Adjust OHIP fee codes to allow medical practitioners to bill for medical abortions performed through off-label prescription. Facilitate inter-provincial billing by adding abortion services to the Interprovincial Reciprocal Billing List, in order to ensure that all Canadian women in Ontario, regardless of home province, are able to receive abortions as necessary.

Consideration: The Inter-provincial Health Insurance Agreement Coordinating Committee (IHIACC) is responsible for determination of what is included, excluded from the list. Interprovincial billing for the provision of abortion services in Ontario for women from all provinces will ensure that women from any Canadian province or territory who requests an abortion procedure in the province of Ontario will be able to receive one without financial barrier.

The risk involved in facilitating inter-provincial billing for all Canadian women in Ontario is that women will travel to Ontario specifically from provinces that do not currently fund the procedure in order to receive it for free, thereby increasing the cost of service provision to the province.

6. Improve Data Collection:

a. Establish a data system to support system monitoring

Consideration: There is inconsistent, inadequate reporting of prevalence and complication rates in Canada. Improved reporting is necessary for quality assurance, and to ensure safety. This data system would collect information about the age, contraception use, socio-economic status, pregnancy history, marital history, ethnicity of patients, as well as geographic location of the service, nature of service delivery (family physician, clinic, hospital), and any complications associated with the procedure.

b. Make reporting to the above data system by family physicians, clinics and hospitals mandatory, but publish data only in the aggregate

Consideration: Clinics do not currently have to report any data more than simply rates of abortions performed. There is a real risk that family physicians, clinics and hospitals will be targeted by anti-abortion campaigns. Any detailed data must therefore be protected, in order to ensure the anonymity and privacy of patients and service providers. This data system may also receive pushback from health care providers and the pro-choice movement for this reason.

c. Fund and conduct more research to determine how far women must travel for abortion services in Canada

Consideration: Sethna's 2012 pilot study and anecdotal evidence indicate that more data should be collected (Sethna 2012).

More comprehensive data on abortions in Ontario will assist in better monitoring the rate of abortions provided in the province, and will contribute to a better understanding of the way that socio-economic inequalities compound barriers to access to abortion. The more information available about the type and significance of barriers to access to the procedure, the more effective interventions aimed at reducing barriers will be.

Conclusion:

The barriers to access to abortion in Ontario are not easily addressed. They are by nature insidious, multi-factored, and will require an equally multi-pronged approach to be torn down. There is no simple solution in this area of health care, which remains heavily contested and to a certain extent at least, politically taboo. Anti-abortion stigma is too often framed as value-based, yet of legitimate consideration, and continues to have a deep impact on personal as well as institutional and political decision-making. Despite popular belief, abortion is not readily accessible, nor is it financially viable, for all women in Ontario. As in so many aspects of access to health care, barriers to access to abortion are compounded by wider socio-economic barriers to opportunity. An ever-worsening concern, as in Canada at large, is that rural women face steeper barriers to access than urban women.

Barriers to access to abortion that result in the stratification of access based on geography or socioeconomic status; barriers related to the shortage in abortion providers and lengthy wait times and barriers related to anti-abortion stigma must each be addressed in their own right. In an effort to build much needed cohesion, these barriers must also be addressed as part of a wider provincial reproductive – women’s - health strategy.

The picture is not entirely grim. Unlike other Canadian provinces such as New Brunswick or Prince Edward Island, Ontario Health Insurance will reimburse practitioners for provision of abortion services. However there is still work to be done. Medical abortion should be made available by raising medical practitioner awareness regarding off-label prescription of methotrexate and misoprostol. Medical practitioners should be encouraged to learn how to provide surgical abortions as part of OBGYN residencies, and incentivized

to do so through scholarships. LHINs should be encouraged to decrease wait times for abortion services in their region. The Canadian Council on Health Service Accreditation should be lobbied to include abortion services on their list of accreditable services. OHIP billing fees should be adjusted to better allow for billing for medical abortion, and to allow for inter-provincial portability. Finally, further research is needed to gather more data on women's experiences, particularly in the northern and rural areas of the province, but more generally too.

Policy changes aimed at widening the availability of abortion services in Ontario will contribute positively to fighting harmful anti-abortion stigma, just as efforts to combat stigma will reduce the impact of barriers that continue to exist, and will facilitate the involvement of more young medical practitioners in the provision of this essential service.

Appendix 1:

Table 1: Clinics and Hospitals are both essential for provision of abortion services, in addition to primary care provision (in family practices).

	Clinics	Hospitals
Number of induced abortions reported in Canada in 2012 (CIHI 2012)	In Clinic: 15,249 (CIHI 2012) *rate of induced abortions in clinic is higher than in hospital, this reflects a gradual increase in abortions sought in clinics since 2005 (Norman 2012, p.187)	In Hospital: 12,137 (CIHI 2012)
<i><u>With proper follow-up and availability of timely surgical abortion when necessary, primary care providers can offer medical abortions at low cost and low risk to the patient.</u></i>		
Benefits	Clinics usually offer important services not available in hospital: counselling, supportive pro-choice care, 24-hour on-call service, birth control support, reproductive health screening, more cost-effective after care Do not require doctor's referral Generally takes fewer	Integral as training centres for new abortion providers Immediate access to emergency care in case of complications Some women simply prefer to have their abortion in a hospital, because of broader range of sedation options, techniques available or because of perception

	appointments than in a hospital	that hospitals have higher level of expertise
Drawbacks		<p>Longer waiting lists</p> <p>Most hospitals require doctor's referral</p> <p>May impose restrictions on abortion services</p> <p>Can fall victim to anti-abortion politics</p> <p>Usually sterile and sometimes judgmental environment</p> <p>A 2005 Clinical model on abortion options in Ontario found that total costs were highest for hospital surgical abortion, followed by surgical abortion in clinics (Limacher 2006)</p>
	<p>There are proven models of self-contained clinics inside hospitals, that benefit from the advantages of a free-standing clinic, with a hospital's protection from political interference and denial of funding</p> <p>Ie: C.A.R.E Program at UBC Women's Hospital; Women's Services Clinic</p>	

	at Kelowna General Hospital in BC
Sources: CIHI 2012, Arthur 2002, Planned Parenthood 2012, Downie 2007	

Works Cited:

- “Abortion: What you need to know” Pregnancy Options Series. Planned Parenthood Toronto. Revised April 2012.
<[http://www.ppt.on.ca/userfiles//Abortion%20-%20What%20You%20Need%20to%20Know\(2\).pdf](http://www.ppt.on.ca/userfiles//Abortion%20-%20What%20You%20Need%20to%20Know(2).pdf)>
- “Access at a Glance: Abortion in Canada” Canadians for Choice. Online Publication.
<<http://www.canadiansforchoice.ca/Access%20at%20a%20Glance%20-%20Abortion%20Services%20in%20Canada.pdf>>.
- Arthur, Joyce. “Untangling the Canada Health Act.” *Pro-Choice Press*. Spring 2002. Online.
<<http://prochoiceactionnetwork-canada.org/prochoicepress/02spring.shtml#untangling>>.
- Arthur, Joyce and Jane Cawthorne. “The Benefits of Decriminalizing Abortion.” Abortion Rights Coalition of Canada. January 2013.
<<http://www.morgentaler25years.ca/wp-content/uploads/2013/01/benefits-decriminalizing-abortion.pdf>>.
- Bartlett et al., “Risk Factors for Legal Induced Abortion–Related Mortality in the United States.” *Obstetrics and Gynecology*, 2004, 103: 729–737.
- Best Start Resource Centre “Preconception Health: Awareness and Behaviours in Ontario.” *Health Nexus*. 2009. Online.
<http://www.beststart.org/resources/preconception/precon_health_survey1.pdf>.
- Black, Amanda, Qiuying, Yang, Shi Wu Wen, Lalonde, Andre B., Guilbert, Edith and William Fisher. “Contraceptive Use Among Canadian Women of Reproductive Age: Results of a National Survey.” *Women’s Health*. July. 2009: 627-640.
- “Canada Health Act Annual Report 2010-2011” Health Canada. 2011. Online.
<<http://www.hc-sc.gc.ca/hcs-sss/pubs/cha-lcs/2011-cha-lcs-ar-ra/index-eng.php>>. Accessed February 16, 2014.
- CARAL: Canadians for Choice. “Protecting Abortion Rights in Canada.” 2003. Online
< <http://www.canadiansforchoice.ca/caralreportshort.pdf>>.
- “CMA policy: Induced Abortion” Canadian Medical Association. 1988. Online
<<http://policybase.cma.ca/dbtw-wpd/PolicyPDF/PD88-06.pdf>>.
- Cross, Pamela. “Abortion in Canada: Legal but not accessible.” *YWCA Canada Discussion Paper*. 2009. Online.

<<https://www.ywcatoronto.org/upload/advocacy-2009%20policy%20abortion%20in%20Canada.pdf>>.

Downie, Jocelyn and Carla Nassar. "Barriers to Access to Abortion Through a Legal Lens." *Health Law Journal*. 2007. 15:143-174.

Dressler, Jennifer, Maughn Nanamma, Soon, Judith A. and Wendy V. Norman. "The Perspective of Rural Physicians Providing Abortion in Canada: Qualitative Findings of the BC Abortion Providers Survey (BCAPS)." June 2013. *PLoS ONE*. 8(6): e67070. <doi:10.1371/journal.pone.0067070>.

Dunn S, Wise MR, Johnson LM, Anderson G, Ferris LE, Yeritsyan N, et al. "Reproductive and gynaecological health. " In: Bierman AS, editor. *Project for an Ontario Women's Health Evidence-Based Report (POWER)*. Volume 2, 2010/2011 ed. Toronto; 2011:74-92. Online. <<http://powerstudy.ca/power-report/volume2/reproductive-gynaecological-health/>>. Accessed February 6, 2014

Echo: Improving Women's Health in Ontario. "Sharing the Legacy- Supporting Future Action 2009-2012." *Echo: Improving Women's Health in Ontario*. 2011. Online. Accessed February 6, 2014. <http://www.health.gov.on.ca/en/pro/ministry/research/docs/echo_improving_womens_health_in_ontario.pdf>.

Echo: Improving Women's Health in Ontario. "Improving Access to Abortion Services in Ontario: Ministry of Health and Long-Term Care". *Echo Advance*, January 2011. Toronto, Ontario. .Online. Accessed February 6, 2014. <<http://www.ontla.on.ca/library/repository/mon/25006/310394.pdf#sthash.5lMyxJdE.dpuf>>.

Eggerston, Laura. "Abortion Services in Canada: A Patchwork Quilt with Many Holes." *Canadian Medical Association Journal*. 2001. 164(6): 847-849.

Erdman, Joanna N. "In the back alleys of health care: abortion, equality, and community in Canada." *Emory Law Journal*. 2006-2007. 56(4): 1093-1156. <http://heinonline.org/HOL/Page?handle=hein.journals/emlj56&div=36&g_sent=1&collection=journals#1169>.

Ferris LE, Croxford R & Salkeld E. "Induced Abortion in Ontario: Case Scenarios". *ECHO Report*. 2011. Online. <<http://www.echo-ontario.ca/sites/default/files/SAAS-Scenarios-April-2011-final.pdf>>.

Jewkes, Rachel. "Intimate partner violence: causes and prevention." *The Lancet*. 2002. 359.9315:1423-1429.

- Kaposy, Chris. "Improving Abortion Access in Canada." *Health Care Anal.* 2010. 18:17-34.
- "Legal Abortion in Canada." National Abortion Federation. 2010. Online.
< <http://www.prochoice.org/canada/legal.html>>.
- Limacher, James J., Imtiaz Daniel, Isaacksz, Shiran, Payne, Gregory J., Dunn, Sheila, Coyte, Peter C. and Audrey LAporte. "Early Abortion in Ontario: Options and Costs." *Journal of Obstetric Gynaecology Canada.* 2006. 28(2):142-148.
- "List of Abortion Clinics in Canada" Updated Oct 13, 2013. ARCC. Online
<<http://www.arcc-cdac.ca/list-abortion-clinics-canada.pdf>>.
- Loutfy, M., Raboud, J., Wong, J., Yudin, M., Diong, C., Blitz, S., Margolese, S., Hart, T., Ogilvie, G., Masinde, K., Tharao, W., Linklater, G., Salam, K., Ongoiba, F., Angel, J., Smaill, F., Rachlis, A., Ralph, E., Walmsley, S. and the Ontario HIV Fertility Research Team "High prevalence of unintended pregnancies in HIV-positive women of reproductive age in Ontario, Canada: a retrospective study." *HIV Medicine.* 2012.13: 107-117.
- Norman, Wendy V. "Induced Abortion in Canada 1974-2005: trends over the first generation with legal access." *Contraception.* 2012: 85. 185-191.
- Ogilvie, Megan. "Ministry of Health to close provincial women's health agency." *The Toronto Star.* August 4, 2012 . Online. Accessed February 23, 2013.
<http://www.thestar.com/life/health_wellness/2012/08/04/ministry_of_health_to_close_provincial_womens_health_agency.html>.
- "Ontario Pregnancy Care Centres" Canada Association of Pregnancy Support Services.
- Palley, Howard A. "Canadian Abortion Policy: National Policy and the Impact of Federalism and Political Implementation on Access to Services." *Publis: The Journal of Freedom* 2006. 36:4. Pp. 565- 586.
- "Position Paper #1: Abortion is a "Medically Required Service" and Cannot be Delisted." Abortion Rights Coalition of Canada. January 2011. Online.
<<http://www.arcc-cdac.ca/postionpapers/01-Abortion-Medically-Required.pdf>>.
- "Position Paper #2: Abortion Clinics Must Be Fully Funded under Canada Health Act." Abortion Rights Coalition of Canada. June 2005. Online.
<<http://www.arcc-cdac.ca/postionpapers/02-Abortion-Clinics-Fully-Funded.PDF>>.
- "Position Paper #5: The Canadian Abortion Provider Shortage: Now and Tomorrow." Abortion Rights Coalition of Canada. October 2005. Online.
<<http://www.arcc-cdac.ca/postionpapers/05-Abortion-Provider-Shortage.PDF>>.

- Reid, Michelle Siobhan. "Access by Province" *The Morgentaler Decision: A 25th Anniversary Celebration*. 2013. Online.
<<http://www.morgentaler25years.ca/the-struggle-for-abortion-rights/access-by-province/>>.
- Ross, L. "Understanding reproductive justice". *SisterSong Women of Color Reproductive health Collective*. 2006. Online.
<<http://www.trustblackwomen.org/our-work/what-is-reproductive-justice>>.
- Sabourin, Jeanelle N. and Margaret Burnett. "A Review of Therapeutic Abortions and Related Areas of Concern in Canada." *Journal of Obstetric Gynecology of Canada*. 2012. 34 (6): 532-542.
- Sethna, Christabelle, Palmer, Beth, Ackerman, Katrina and Nancy Janovicek. "Chocie, interrupted: travel and inequality of access to abortion services since the 1960s." *Labour/ Le Travail*. 71 (Spring 2013).
- Sethna, Christabelle. "Travel to Access Abortion Services in Canada." World of IDEAS. Faculty of Social Sciences Publication. University of Ottawa. 2012. Online.
<http://www.socialsciences.uottawa.ca/sites/default/files/public/research/eng/documents/CSethna_WorldIdeas.pdf>.
- Shaw, Jessica "Reality Check: A Close Look at Accessing Abortion Services in Canadian Hospitals." Canadians for Choice. 2006. Online.
<http://books.scholarsportal.info.proxy.bib.uottawa.ca/viewdoc.html?id=/ebooks/ebooks1/gibson_chrc/2010-08-06/5/10309577>.
- Shaw, Jessica. "Full-Spectrum Reproductive Justice: The Affinity of Abortion Rights and Birth Activism." *Studies In Social Justice*. 2013. 7 (1): 143-159.
- White, Linda. "Federalism and Equality Rights Implementation in Canada." *Publius*. May 2013. Online.
<doi: 10.1093/publius/pjt019>.
- Wiebe, Ellen R. and Supna Sandhu. "Access to Abortion: What Women Want From Abortion Services." *Journal of Obstetrics and Gynecology Canada*. 2008. 30:327-31.
- Wu, Fanda, and Joyce Arthur. "A Survey of anti-choice protesting activity at Canadian abortion clinics" Abortion Rights Coalition of Canada. 2010. Canadian Electronic Library.
<http://books.scholarsportal.info.proxy.bib.uottawa.ca/viewdoc.html?id=/ebooks/ebooks0/gibson_cppc/2011-04-20/1/10448992>.
- 40 Days for Life Campaign. Online.

<<http://www.40daysforlife.com/>>.