

The Politics of Abortion in Canada After Morgentaler: Women's Rights as Citizenship Rights

by

Rachael Elizabeth Grace Johnstone

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Abstract

This dissertation explores the regulation of abortion in Canada following the landmark *R v Morgentaler* decision (1988), which struck down Canada's existing abortion law, causing the procedure's subsequent reclassification as a healthcare issue. The resulting fragility of abortion rights is still evident in the varying provincial regulations governing the nature of access to the procedure. While access has been accepted as the new terrain of abortion rights, research into this area to date has taken a largely national focus, surveying provincial barriers and compiling lists of potential motivations for differences in service. This dissertation builds on this work through the use of specific case studies of provinces representative of a spectrum of access in Canada – New Brunswick, Ontario, and Quebec. Through the use of original interview data, these cases are compared and contrasted on previously enumerated grounds believed to have an influence on the treatment of abortion. By isolating the impact of specific processes responsible for the regulation of abortion, through research into its treatment in politics, law, medicine, and public discourse, this study endeavours to offer a more nuanced explanation for varying levels of provincial access to abortion services. Ultimately it finds that a province's social climate, characterized by attitudes towards the ongoing rights versus morality debate championed by pro- and anti-choice social movements, has had the greatest impact in shaping public perceptions of the procedure. These attitudes in turn have a profound effect on the nature of provincial access.

Using a citizenship framework grounded in social reproduction, which understands anti-abortion politics as elements of backlash against progressive advances in women's citizenship, this dissertation argues for the need to understand abortion as a right of women's citizenship to address the precarious treatment of abortion services. Recognition of women's unique reproductive abilities through a citizenship paradigm is necessary before women can hope to

achieve equality. Only when abortion is entrenched as a right of citizenship and this understanding of the procedure is embedded in social perceptions, can women not only be treated as equal citizens, but also understand themselves to be equal citizens.

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Dedication

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Glossary of Acronyms

ARCC. Abortion Rights Coalition of Canada.

CARAL. Canadian Abortion Rights Action League.

CFC. Canadians for Choice.

CIHI. Canadian Institute for Health Information.

CLSC. *Des Centres Locaux des Services Communautaires* (Local Community Service Centres).

CMA. Canadian Medical Association.

CMQ. *Collège des médecins du Québec* (College of Physicians of Quebec).

CPSNB. College of Physicians and Surgeons of New Brunswick.

CPSO. College of Physicians and Surgeons of Ontario.

FQPN. *Fédération du Québec pour le Planning des Naissances* (Quebec Federation for Planned Pregnancy).

MPP. Member of Provincial Parliament.

MLA. Member of the Legislative Assembly.

NAF. National Abortion Federation.

NDP. New Democratic Party.

PM. Prime Minister.

TAC. Therapeutic Abortion Committee.

SOGC. Society of Obstetricians and Gynecologists of Canada.

Chapter 1. Introduction

Few issues have been as divisive in Canadian politics as abortion. In 1869, shortly after Confederation, abortion was prohibited without exception. This law was subject to a series of changes between 1939 and 1969, culminating in a highly restrictive law that required women to plead their case before a panel of doctors in the hopes of being granted access to a legal abortion.¹ When the *R v Morgentaler* decision struck down this law in 1988, a policy vacuum was created.² An unsuccessful attempt by the federal government to create a new law to restrict abortion services the following year led to a formal reclassification of abortion as a healthcare issue, shifting jurisdiction over the procedure to the provinces. The provinces responded differently to this change, with some effectively trying to recriminalize the procedure by blocking access. The variety of provincial reactions showcased the instability of the healthcare paradigm in the regulation of abortion. It was clear that abortion was not being treated as a straightforward medical issue; other factors were at play.

The treatment of abortion in politics, law, and medicine clearly echoes the ongoing debate between the pro- and anti-choice social movements, which position abortion as either a moral or rights issue.³ These conflicting frames have manifested differently in each province, resulting in a wide variance in the treatment of women's reproductive choices across the country. While not all women can become pregnant, reproduction is a process experienced uniquely by women, and this deeply gendered issue has real implications for their community membership. Using case studies of three provinces—Quebec, Ontario, and New Brunswick—that collectively

1. This history of abortion law in Canada is explored in detail in chapter 3.

2. References to the Morgentaler case in this dissertation refer to the 1988 case, unless an alternative case is cited by date.

3. The “pro-life” designation is misleading, as it is hostile to women in its failure to acknowledge their lives if they choose abortions. Moreover, its equation of abortion with murder does not fit either legal or political definitions of the procedure. As such, the pro-life movement will be referred to as the anti-choice movement.

represent a range of levels of access in Canada, this dissertation explores the nature of abortion regulation in parliamentary politics, law, medicine, and society, as well as in the Canadian provinces and in Canada as a whole. Ultimately, I argue for the necessity of recognizing abortion as a right of women's citizenship, in both formal regulatory bodies and in society at large, in order to create an enforceable right to access in Canada.

My goal in this dissertation is twofold. Firstly, I endeavor to establish the precarious nature of abortion rights as they exist in Canada today. The *R v Morgentaler* decision (1988) is often portrayed as the final battle for reproductive rights, which solidified women's reproductive autonomy, but this is a misleading assumption. The policy vacuum created when section 251 of the Criminal Code was overturned has led to the unpredictable and unstable regulation of abortion in Canada, both by the federal government and in the provinces. While much of the public has formed a tentative consensus on abortion as an issue central to women's rights, without formal acknowledgment this right is not enforceable.⁴ In an attempt to address the policy void, provincial governments have produced a wide variety of regulations, some of which threaten to violate women's constitutionally guaranteed right to equality. Variations in levels of access to abortion services across Canada, and continued conflict among those who argue that the procedure should be understood as a moral question, rather than a rights issue, are demonstrative of the ongoing fragility of abortion rights in Canada today.

The rights versus morality debate, premised on conflicting views regarding the expected roles of women in society, has strongly informed attitudes towards the regulation of abortion in Canada. Those who believe that abortion is a right consider women to be valued members of

4. The belief that abortion is a rights issue has grown steadily since the Morgentaler decision (1988). The "small majority" of support for "a woman's right to have an abortion" at the time of the case has increased: "three-quarters of Canadians now support this choice" (Environics Institute (EI) 2010, 6). This trend is addressed in more detail in chapter 6.

society unto themselves and are supportive of safe, public access to the procedure. Individuals who adopt a moral frame widely express a desire to return to traditional gender hierarchies, which value women primarily in regard to their roles as wives and mothers, by recriminalizing the procedure, either in whole or in part. Importantly, in the policy vacuum left by the *Morgentaler* decision, the rights frame has come to dominate; indeed, my research suggests that the widespread adoption of a rights frame has been foundational to the creation and maintenance of progressive treatments of abortion access to date. Despite more progressive attitudes towards abortion emerging in the wake of the procedure's decriminalization, however, these rights remain vulnerable. I argue that a formal acknowledgment of abortion access as a right of citizenship is necessary, though not sufficient, to the realization of women's equality. The need to understand abortion as a political question, and more specifically a question of rights, is a central theme of this study. In order to situate the pro- versus anti-choice debate in a larger discussion of women's citizenship rights in this dissertation, I have adopted a social reproduction approach that draws attention to expectations of women's social citizenship resulting from pregnancy and birth, as well the problematic nature of traditional gender roles.

The realities of social reproduction both emphasize the need for an understanding of abortion as a citizenship right, and explain anti-abortion politics as elements of backlash against progressive advances in women's citizenship. This research also draws attention to women's continuing struggle for control over their bodies, and the aim to redefine their roles in society with an eye to challenging the gendered and often damaging nature of ascribed roles. In sum, it is vital that abortion be understood as a citizenship right to ensure women's status as equal citizens.

The first section of this introductory chapter explores the rationale for the necessity of understanding abortion as a right of citizenship, through an engagement with the motivations and

tactics of the pro- and anti-choice movements, which each respectively embody the rights and morality frames. The relative influence of the specific institutions in the regulation of abortion in the provinces is then discussed. Notably, the policy vacuum left in the wake of the *Morgentaler* decision created difficulties in the regulation of the procedure for formal institutions (parliamentary politics, law, and medicine). Without clear guidelines, the regulation of abortion was left largely to the discretion of arbitrary forces and actors, which were prone to being heavily influenced by the dominant social constructions of the procedure. The social climate in each province has thus proved to be particularly influential, due to its ability to impose specific understandings of abortion on individuals and shape the nature of the discourse on abortion within formal regulating bodies and in the public.

The next section of the chapter gives a brief history of the regulation of abortion in Canada, specifically the central actors and dominant conceptualizations, to provide context for the discussion that follows in the body of the dissertation and to highlight the evolution of current framings of the issue. Next, the methodology section breaks down the approach taken for this research project, including some of the major obstacles I encountered during my attempts to gather information on this (unfortunately) still controversial subject. The chapter concludes with a breakdown of the remaining chapters in the dissertation.

Abortion as a Right of Citizenship

The nature of women's community membership has long been influenced by their ability to reproduce. Even women who are unable to become pregnant, either because of fertility issues or age, are characterized by gendered stereotypes related to reproductive capacity in both official and unofficial discourses. Thus, both expectations of women's citizenship and the rights they are afforded are tied to processes associated with social reproduction.

A social reproduction approach illuminates the underlying motivations of the pro- and

anti-choice movements, namely the desire to maintain or challenge specific social orders; this approach thereby highlights the political nature of specific gender arrangements. The theory focuses broadly on an analysis of the way individuals are reproduced and sustained on a daily and generational basis, and the necessity of these activities to society (Bezanson and Luxton 2006, 3). This approach stresses that these responsibilities, while essential to human survival, are also markedly undervalued, having been relegated to the domestic sphere and considered distinct from public concerns (Luxton 2006, 32). As a result, “reproductive activities, in which women have historically played a central role, have been neglected as sites for political struggle” (Ferguson 1999, 6). By drawing attention to the political implications of specific gender orders, this approach challenges naturalized assumptions about women’s roles and current conceptions of citizenship.

Traditional understandings of social reproduction in Canada assume a nuclear family model, which divides labour based on strict gender roles, essentially presuming the male ‘breadwinner’ and the female ‘homemaker’ model. The division of labour necessary for this traditional social structure requires that women internalize their roles as caregivers as part of a natural order. It is these roles that the anti-choice movement is attempting to reinstate through the implementation of a moral frame, which seeks to reaffirm women’s primary roles as wives and mothers by removing their reproductive autonomy.

Anti-choice advocates base their opposition to abortion on a portrayal of the procedure as “murder”—constructing the fetus as a “person”, and thereby attacking the so-named immorality of women who might seek an abortion. This group believes that a return to social traditionalism, including rigid gender roles, will resolve the alleged problems of modern society. Importantly, these assertions are based on idealizations of relationships and also ignorance of the realities of

illegal abortion. Moreover, the overt rejection of women's equality necessary for this understanding no longer fits easily into the values of Canadian society. Brodie explains that these anti-choice claims lost some power when their "grounding was successfully countered with the argument that it was inappropriate for the state to legislate morality" (1992, 78). In order to ensure that the moral frame remains in the public discourse, anti-choice advocates have been forced to change tactics, replacing overt campaigns against women with anti-feminist backlash.

Faludi defines backlash against feminism as "an attempt to retract the handful of small and hard-won victories that the feminist movement did manage to win for women," often resulting in more regressive policies (1981, xviii). While many of the victories of the feminist movement gained strength from their political groundings, the success of backlash in rescinding these victories depends on its ability to appear politically neutral while in fact serving to withdraw historic progressive gains (Faludi 1981, xxii; Bakan and Kobayashi 2007, 150). A prime example of backlash in anti-choice movements is their campaign to protect "fetal rights".

By focusing on the fetus as the most, or only, deserving subject in the context of public debates on abortion, anti-choice groups have attempted to remove women from discussions of pregnancy. The focus of the anti-choice movement has been to obscure the role of women in pregnancy by reducing conceptualizations of pregnant women to "pregnant bodies" rather than full human beings, with individual needs and aspirations (Brodie 1992, 86). To this end, these groups have campaigned for recognition of fetal personhood, which they believe will then necessitate the recriminalization of abortion. In so doing, the anti-choice discourse has attempted to depoliticize not only women's rights, but also the processes of social reproduction. So long as backlash is successful in portraying anti-choice activity as a kind of natural progression, or regression, it depoliticizes feminist gains and avoids engagement with a genuine rights discourse

where women are the principal subjects and women's equality is highlighted. While criminalizing abortion is only one aspect of this larger moral project, it has proven to be particularly symbolic as an issue that alters the terrain of public debate.

The treatment of abortion as a rights issue, alternatively, challenges the public/private dichotomy and politicizes the sexual and gender differences on which these spheres are founded. The rights frame recognizes the impact of social reproduction on women's choices—but rather than seeking to reinforce traditional structures, it seeks to reaffirm the value of women as citizens, and not just through their relationships with others, thereby challenging the naturalization of socially traditional family structures. A rights frame of abortion is thus also connected to larger concerns regarding the place of women in society. In recognizing the gravity of pregnancy, birthing, and care in women's lives, this frame asserts the right of women to choose whether or not to continue an unwanted pregnancy. In doing so, it also calls into question the naturalized foundations of women's ascribed subordinate role in social reproduction, which is still embedded in public discourse and policy.

The identification of abortion as a right of citizenship for women, through exposing the constructed nature of care roles and the responsibilities and expectations attached to reproduction which are reinforced through public discourse and formal institutions, provides new tools for critical feminist analysis. Indeed, public acceptance of abortion as necessary to women's rights has been part of a social shift that has begun to erode the rigid divisions between public and private domains. According to Vosko, "the male breadwinner-female caregiver model no longer dominates even at a normative level" (2006, 147). Women have gained control over many aspects of their reproductive lives, and many have entered the paid workforce, while men are increasingly seen as having a place in the domestic sphere.

The realization of women's equality in Canada thus requires the recognition of abortion as a right of citizenship. If women are not granted autonomy over their own bodies, they cannot operate as full members of Canadian society and are thus in effect second-class citizens. Importantly, as an overtly gendered right without any clear analogous grounds, abortion has posed difficulties for existing conceptualizations of citizenship, which are often based on a universalized male citizenship model. It is, arguably, the only human right to date that "does not involve the transfer or expansion of a right previously granted only to males" (Asal, Brown, and Figueroa 2008, 280). Women cannot hope to achieve equality if they are treated as equal only insofar as they are the same as men. The recognition of women's unique reproductive abilities as central to their experiences as citizens therefore necessitates a conceptualization of citizenship which accounts for women's unique abilities, while also moving beyond formal legal status to recognize the specific ways in which individuals experience their community membership.

Bakan and Stasiulis' work on migrant workers in Canada provides a useful conceptualization of this ideal. Recognizing the unique and varied ways that individuals experience their citizenship, and the ways in which lived citizenship fails to demonstrate the values presently associated with Canadian citizenship, namely "freedom, democracy and equality of treatment," they suggest an understanding of citizenship as a negotiated process (Bakan and Stasiulus 2005, 11). By recognizing citizenship as a dynamic concept, experienced by individuals in unique ways depending on a myriad of factors, including gender, race, class, and location, they contend that citizenship "exists on a spectrum, involving a pool of rights that are variously offered, denied, or challenged, as well as a set of obligations that are unequally demanded" (ibid., 2). Recognizing the "complex and multifaceted relationships of individuals to territories, nation-states, labour markets, communities and households" problematizes simplistic

legal categories and extends understandings of citizenship beyond the public sphere (11).

This dissertation adopts this notion of citizenship as a negotiated category, composed of multiple levels and extending beyond legal premises to encompass social conceptions of community membership. The way women experience their attempts to terminate unwanted pregnancies is, after all, the result of intersections between the formal regulating bodies governing their status, and the varied nature of access to abortion services. Parliamentary politics, law, and medicine, and informal regulatory bodies, such as social movements, public sentiment, and discourse, collectively shape individual attitudes and actions.⁵ These institutions provide the focus of the chapters in the discussion that follows. Each chapter deals with the motivations and actions of these bodies in relation to the three provincial case studies (New Brunswick, Ontario, and Quebec), with the exception of chapter three, which establishes the context with a close examination of the situation of abortion access at the federal government level, and chapter five, which addresses the context of abortion-related litigation.

While these various levels of regulation are each influential in determining abortion access in the provinces, the levels are deeply intertwined, with the actions and motivations of each informing the others. Importantly, absent clear federal policy regulating abortion access after 1988, the bodies now responsible for the provision of access have encountered problems. Without clear guidelines regarding its treatment, the regulation of abortion has become notably reliant on the contemporaneous social climate. This is particularly evident within provincial politics and medical regulations, where individual decision –making of practitioners dominates

5. While this study focuses predominantly on the construction and impact of the broader institutional climates in the restriction of abortion access, it recognizes the importance of the identity of individual women to the nature of their citizenship. Women's experiences are informed by their class, race, and sexuality, among a myriad of other factors, in combination with the institutions they must negotiate to access services. While an in-depth study of the impacts of, for example, sexuality and experiences of reproduction and citizenship, is beyond the scope of this dissertation, it attempts to lay the groundwork for future research into these more nuanced issues.

without clear policy requirements.

Individual views of abortion are highly influenced by the dominant conceptualizations of the procedure, championed and shaped by the pro- and anti-choice social movements. These groups have not only reinforced their respective approaches on abortion in the public discourse over time, but have also consistently engaged in political and legal activity, further shaping the nature of debates and interpreting outcomes for public consumption. As such, it is perhaps not surprising that social movement mobilization has been pivotal in the creation of uneven provincial access.⁶

In sum, this dissertation attempts to draw attention to the precarious nature of abortion rights as they exist in Canada today, arguing for the need to understand abortion as a right of women's citizenship in order to guarantee women's equality. To this end, it addresses the dominant rights and moral frames, which respectively attempt to challenge or reassert traditional structures of social reproduction. With the theoretical framework established, the following section discusses research methodology.

Methodology

In order to understand the motivations behind differing levels of abortion access in the Canadian provinces, this dissertation employs a mixed-method approach to analyze the different facets of the issue, specifically the conceptualizations and treatment of abortion in legal, social, medical, and parliamentary political contexts. These four central foci were selected because they are representative of the institutions through which abortion has traditionally been conceptualized and regulated. While every province could not be investigated in detail, my analysis focuses on three provincial case studies that broadly represent a spectrum of access to

6. Notably, pro-choice movements have been more successful when they have been able to create dialogue, while the anti-choice movements have been successful when they have been able to stifle it.

abortion services in Canada: New Brunswick, Ontario, and Quebec. These cases demonstrate a breadth of approaches to the regulation of abortion in Canada, while detailed analysis of each province provides depth to this research project.

The next section details the research design of this study, beginning with a broad overview of the project's goals, before breaking down the process through which the case studies were selected and the suitability of this format for the goals of this research. A more detailed discussion of the mixed methodological approach used to gather information on these case studies, as well as some information on Canada as a whole, follows. Document analysis and original interviews were the primary methods used to collect information. This section concludes with a discussion of the difficulties faced in researching this topic using both methods. Abortion continues to be a taboo topic for discussion in many areas of Canada, a reality that sometimes created unique challenges to accessing information.

Case Studies

In order to assess the varying degrees of access to abortion among the provinces, they were placed into high, medium, and low level access groups based on a typology of access. Factors considered included restrictions to funding, availability of facilities, a preliminary survey of political and social attitudes (both historical and contemporary), and the prevalence of historical and ongoing activity relevant to provincial regulation of abortion (including court cases and social movement activity).⁷ One province was then selected from each grouping for study, based both on its categorical prominence, which, given the similarities in the funding and facilities between provinces had more to do with notable attitudes and important events, and on practical constraints to field research (such as proximity and funding).

7. See appendix E for more information on prevalence of abortion by province and facility.

New Brunswick was selected as a low access province among the most restrictive provinces and territories in Canada, a group that included Prince Edward Island (PEI), Nova Scotia, the Yukon, Nunavut, and the Northwest Territories. PEI is in competition with New Brunswick for the most regressive policies, due to its history of abortion-related court cases and present lack of facilities. The territories also have virtually no access—an issue related more to a small, largely rural population than to political resistance. Nova Scotia was included in this list for its history of opposition to abortion clinics and its regressive policies; although changes to its policies, forced through a Supreme Court decision, have improved access in the province somewhat, arguably to a point where it can be considered a mid-level access province. New Brunswick was selected over the other provinces and territories in this grouping to represent the lower end of the spectrum because of its continuing resistance to providing effective abortion access for women, evidenced through an ongoing court battle with Dr. Henry Morgentaler, and the Human Rights Commission’s challenge of the province’s regulation of the procedure, both overseen by overtly anti-choice politicians. The potential for imminent change in the province and the ongoing activity regarding the issue of abortion access make New Brunswick a valuable case study, significant to the future of abortion regulation in Canada.

The selection of a province with mid-level access was more difficult, as many provinces had comparable funding regulations and facility access; British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, and Newfoundland all represent mid-levels of access. While each province also has notable traits, like British Columbia’s progressive legislation preventing demonstrators from practicing within a certain radius around clinics and a unique precedent-setting Manitoba court case which recognized abortion as an equality issue, Ontario was ultimately selected because of its historical importance in the decriminalization of abortion. As

Canada's largest province, Ontario plays an important role in setting the tone for the treatment of abortion in Canada as a whole. While the later gestational limit for therapeutic abortion in the province, in addition to its largely inclusive funding of abortion, might seem reason enough to locate it higher on the spectrum of access, the continued political and social taboos surrounding abortion and the prevalence of anti-choice interest groups indicate issues of backlash.

Finally, Quebec was selected as a stand-alone province at the high end of the spectrum. With its progressive policies, a unique social and political climate, and most importantly, a historic role in the legalization of abortion, it was an obvious choice as a high access case study. While the gestational limit of twenty-three weeks is comparable to Ontario's limit, and both hospitals and clinics in each province are similarly largely covered under provincial health insurance plans, the social and political climate of Quebec is more accepting of abortion as an equality right for women as citizens. Morgentaler's first legal battles were in Quebec, where he opened his first abortion clinic and was tried by a jury of his peers and acquitted, despite openly breaking existing law. While a judge overturned the decision and Morgentaler did eventually spend eleven months in prison, the social perception of abortion, even amongst religious groups in Quebec, has markedly changed. Abortion is publicly understood as an equality right in Quebec, and the limited number of barriers that women face to gain access make it arguably the most progressive of the provinces in this area.

The three case studies provide three of the four central chapters of this dissertation—the fourth addresses the federal context. Each chapter details a specific aspect of the regulation of abortion, and in keeping with the theoretical framework outlined above, the provinces are each situated on a spectrum of citizenship access. As will become evident, provinces that have adopted a rights frame in specific institutions rank higher on a spectrum of equal citizenship than

do those embracing a moral frame. Indeed, in some cases, the use of the moral frame effectively causes certain provinces to fall off the scale through lack of any attempt to acknowledge the impact of abortion on women's citizenship.

Mixed-Method Approach: Documents and Interviews

This study incorporates a mixed method approach to produce a more complete picture of each province. The primary research consists of document analysis, including relevant court cases, Hansard transcripts, and a review of provincial legislation. These documents shed light on the political history and present political climates of each province, including the views and actions of individual politicians and parties. Some media sources are incorporated where relevant to show the ways in which different policies and regulations have played out in the public forum.

This research also incorporates statistical information on abortion, including the availability of facilities and the gestational age up to which the procedure is available in each province. This information was primarily gathered from the Canadian Institute for Health Information (hereinafter cited as CIHI) which took over the *Therapeutic Abortion Survey* for Statistics Canada in 1995. Though originally Statistics Canada was in charge of the dissemination of this information, this responsibility was shifted to the CIHI in 2006 (Statistics Canada 2005a). The CIHI is funded by "federal, provincial and territorial governments, and guided by a board of directors made up of health leaders from across the country" (CIHI, 2011). Its relationship with Statistics Canada, the country's central statistics office, and the comparability of data each group provides, make the CIHI an important source of statistical information.

While this information is useful to provide general overviews, it is important not to overgeneralize statistical findings and their meanings. Many abortions still go unreported due to regulations surrounding the reporting of information, including differences in bureaucracy

surrounding provincial insurance coverage. The CIHI (2009) notes the uneven nature of statistical reporting on this issue:

Hospitals are mandated by their provincial/territorial ministry of health to report all hospital activity (not limited to abortions); therefore, coverage of abortions performed in Canadian hospitals can be considered complete. However, there is no such legislative requirement for clinics to report their activity (reporting is voluntary).⁸

The number of abortions “performed on non-residents and those performed on Canadians in the United States” is also unknown, which leads to incomplete statistics (Fowler 2008, 19). There may also be conflation of numbers in certain provinces, as only some abortions are accounted for in statistical measurements:

[Ontario and Quebec] include only induced abortions covered by their respective provincial health insurance plans. Data from all other provinces/territories (including Ontario hospital data) includes all induced abortions, whether paid for by the patient or by a different health insurance plan. For example, patients with coverage under Quebec’s health insurance plan receiving care in Manitoba are reported by Manitoba. However, patients with coverage under Manitoba’s health insurance plan receiving care in Quebec are not reported (by either Quebec or Manitoba). (CIHI 2009)

Thus, statistics are used only for overviews in this research, and interviews provide an extension of this project’s analysis.

Interviews are an integral part of this research because they allow for analysis that goes beyond formal practices by revealing insights into the social and political climates, individuals,

8. Some additional statistics compiled by the Abortion Rights Coalition of Canada are used in chapter 6 because they have access to clinical data the CIHI does not, which allows for more accuracy regarding the percentage of abortions occurring at specific gestational ages.

and institutions that have played a role in creating differing levels of access. Individuals were interviewed from three central groups: 1) politicians, legal theorists, and government officials; 2) members of the medical community, including physicians, nurses, and clinic staff; and 3) social movement activists. These groups were selected because they are representative of the groups responsible for the way abortion is, and has been, conceptualized and regulated. Interviews were conducted in each of the provinces as well as at the federal level in all of the above categories.⁹

Interviews were conducted for depth of knowledge and/or experience rather than for breadth. In total, twenty-nine interviews were undertaken: eight in New Brunswick, seven in Ontario, eight in Quebec, and six relevant to the federal context. The interviewees represent a diverse sample of leading voices in the abortion debate from a variety of backgrounds.

Interviewees were selected for their affiliations with relevant organizations, their professions (in the case of the medical community), and/or their involvement in legal, political, social, or medical action relating to abortion. The goal of these interviews was primarily to understand how each group conceptualized abortion, their motivations for involvement with the issue, the barriers they encounter, and their views on the social and political climates of their province, or, in the case of federal interviews, in Canada as a whole. Once interviewees were selected, they were contacted via email to request their participation (see appendix E). Interviews were conducted in person one-on-one (with the exception of one interview conducted via Skype, and one via email). Interviewees were asked both questions of a broad nature, based on a master list of questions asked of all participants (see appendix F), and questions tailored to their specific roles and experiences. Despite these central questions, interviews were open-ended to allow participants the opportunity to expand on the issues they deemed most important. For instance, if

⁹ The first appearance of each interviewee in text will be accompanied by a footnote detailing their position as well as the date and location of the interview. All subsequent mentions of the interviewees will be cited in text citation.

an interviewee was asked to discuss the political climate in their province and focused their answer on a specific policy or politician, they would then be asked follow up questions on the issues they raised to assess their significance. Also, all participants were asked if there were any issues not addressed that they would like to discuss relevant to the study.

In order to broaden the pool of interviewees, a snowball sampling technique was adopted, in which interviewees were asked to recommend other individuals to contact for this research. This technique is of particular use when attempting to expand a pool of contacts in a population which is largely hidden and difficult to contact. However, to eliminate undue bias in the recruitment process, only one such recommendation was pursued from each interview. While issues of sample bias are, to some extent, inherent in this method, previous contacts within the field helped to mitigate the risk of a limited pool of respondents. This method was used in conjunction with my original approach of contacting those prominent in the literature and those already publicly identified. While a roughly equal number of participants from each of the three categories (politicians, legal theorists, and government officials; members of the medical community, including physicians, nurses, and clinic staff; and social movement activists) was originally sought, there were difficulties in accessing some of these groups.

Politicians, legal theorists, and government officials proved to be the most difficult interviewees to recruit. In this interview category, politicians were the most likely to decline interviews; most of my requests were either politely refused or ignored. While government officials and legal scholars were generally contacted because they had some previous involvement with abortion-related issues, politicians were contacted both because they had spoken out on abortion in the past and because of involvement with related portfolios (for example, Ministers of Health). I made an effort to contact both known pro- and anti-choice

politicians; however, all those who agreed to be interviewed were resolutely pro-choice. In terms of the groups of legal theorists and government officials, whether or not they had personal stances which influenced their views was generally not public knowledge, and thus this information was difficult to ascertain before I conducted these interviews.

Some individuals in the medical field were also difficult to contact. When I placed requests through medical schools, hospitals, or clinics, I was generally directed to staff members who were able to answer my questions. Clinic employees were particularly helpful, as these facilities are normally staffed with pro-choice employees who are deeply involved in social activism as well as the provision of medical services. Individual physicians were the most difficult to access—particularly those involved in providing abortion services. The constant threats of violence many abortion providers in Canada still receive mean that they are often unlisted and their identities highly protected.¹⁰ It was necessary to go through many channels and vetting before speaking with them, and they required that their identities remain protected. Indeed, every practising physician interviewed insisted that their identity, and any information that could identify them, remain confidential. Despite the many prominent physicians interviewed for this study, in the interest of safety, none of their names or any details about their practises could be included; therefore, they are each referenced using a pseudonym.¹¹ It is important to note that medical professionals in both rural and urban areas were contacted in the hopes of receiving a variety of responses, but none of the physicians who responded held anti-choice views. This could reflect either an issue of response bias, or be demonstrative of commonly held views in the medical community. Attempts were made to mitigate this issue through the inclusion of questions about the views of the medical community as a whole on the

10. See chapter six for more on violence against abortion providers.

11. Pseudonyms were created by a third party with no knowledge of the interviewees to avoid risk of identification.

issue of abortion.

Social movement actors were the group most willing to participate, and were generally comfortable having their identities revealed. This is likely because they already have deep attachments to the issue and, in their efforts to spread information, are accustomed to their names being public knowledge. It is important to note that this is the only category in which efforts were not made to contact anti-choice representatives. This decision was made for a variety of reasons. First, given the highly organized nature of anti-choice groups across Canada, even without interviews, their viewpoints have been extensively documented and are widely available. Second, any association with these groups could potentially have made it difficult to make inroads into contacting politicians and doctors, who might have been made unsure of my personal affiliations. Finally, many anti-choice social movements are known to participate in acts of harassment and violence. Identifying myself to them as a researcher would require the provision of my personal contact information and in-person meetings that would have raised concerns regarding my own personal safety.

Interviewees who consented to having their interviews audio-recorded had their statements transcribed, while those who preferred not to be audio-recorded were paraphrased using written notes. The interviews were then tagged using *Zotero*, a web browser based research tool that stores and provides sorting tools for data. These tags were used to identify common themes. As a result of the open-ended structure of the interviews, the number of individuals mentioning a specific word or issue is not necessarily seen as significant in the findings noted in the following chapters, as other interviewees were not necessarily asked the same questions nor focused on the same aspects of the issue. While in some instances the repetition of an issue was deemed important, qualitative importance was also assigned to issues stated only once if they

were central to the arguments/views of particular interviewees.

Difficulties Accessing Information

The realities of the taboo nature of abortion in some areas meant that threats of violence and/or social stigma prevented some individuals from speaking out about their involvement in the fight to improve or maintain access. These difficulties also translated into problems with obtaining information. For instance, physicians and hospitals often were not forthcoming about whether or not they perform abortions, or under what circumstances they might do so; often, this secrecy means that their own staff members are uninformed, and that women seeking services are sometimes misdirected. More often than not, however, the difficulties in accessing information were not unique to abortion services, but related to greater problems due to a lack of publicly available information. New Brunswick, for instance, does not have Hansard transcripts or party billing information available online; scanned copies must be ordered. Also, the detailed billing arrangements between provinces for women seeking abortion services away from home are not publicly available and are virtually impossible to decode.¹² These shortcomings in public information have meant that women who seek abortions, physicians, and politicians all too often do not understand the rights of women, the responsibilities of doctors, or the impact of policy pertaining to abortion access. Research into the accessibility of abortion in the Canadian provinces has revealed a disturbing lack of available and reliable information in some areas, which only serves to reinforce one of the central premises of this research—namely, that legality is not tantamount to access and that abortion rights are still precarious in Canada.

Chapter Outlines

In total, this dissertation is composed of eight chapters. Following the introduction,

12. See chapter six for more on this issue.

chapter two reviews the relevant literature concerning the regulation of abortion in Canada to date, with the goal of situating the research in this dissertation in the canon. The four subsequent chapters address the various dimensions of abortion access in Canada, specifically the legal, political, social, and medical treatments of the procedure. Each chapter explores the barriers present in specific spheres, as well as their motivations, through an analysis of case studies of New Brunswick, Ontario, and Quebec. The final chapter synthesizes the culmination of these barriers in each province and the implications for women's citizenship. Ultimately, the dissertation argues for the need to recognize abortion as a right of women's citizenship, in both formal and informal practices, in order to improve access to abortion in the provinces.

Chapter two begins by defining the use of the terminology "rights frame" and "moral frame" in this dissertation, before moving into a discussion of the history of these concepts in the literature. Next, it addresses previous scholarship on abortion access in Canada and the major contributions of these works. Finally, it highlights the lacuna in the literature that this dissertation attempts to address.

Chapter three addresses both historical and emerging understandings of abortion in federal politics and the courts. It traces the evolution of the rights frame surrounding abortion access in Canada, specifically as it occurred in the courts and the House of Commons preceding and immediately following the *R v Morgentaler* decision in 1988. The chapter begins by looking at the events leading up to the *Morgentaler* decision, before moving on to an analysis of the nature of the ruling itself. The *Morgentaler* decision incorporated considerations of the realities of social reproduction when it struck down the existing law, though it did not go so far as to recognize abortion as a right of women's citizenship. Importantly, when the federal government attempted to create new legislation in response to the decision, the moral and rights frames

championed by social movements at the time were highly visible in their decision-making, with the moral frame being especially so. Regardless, the emerging rights frame was strong enough to make the passage of the law difficult; with no room for compromise on either side there were vehement disagreements about how to proceed.

After the first attempt at the creation of a new law failed to pass through the Senate, the federal government, concerned about engaging with such a divisive issue, decided to leave the regulation of abortion to the provinces, allowing it to be reclassified as a healthcare issue. While no federal government has since attempted to formally fill the policy gap left by this jurisdictional shift, activities by anti-choice activists in federal politics reveal a powerful backlash against women's reproductive rights. This backlash is evident in backbencher legislation, government actions, and statements from individual members of Parliament. Absent a formal commitment to women's citizenship rights which acknowledges abortion as central to women's experiences of community membership, politicians have been able to shift the tone of the debate and challenge hard-won victories by making advances in women's rights appear apolitical. The moral frame is still powerful in federal politics today, but an increasingly mainstream understanding of abortion as a woman's right has made overt challenges politically risky. The result has been the unpredictable treatment of abortion in federal politics, and the failure of Parliament to regulate the procedure, which has had serious implications for its regulation in the provinces.

Chapter four examines the interplay between provincial governments and the courts in their regulation of abortion; specifically, it focuses on their adoption, or failure to adopt, a rights frame that understands abortion as crucial to the realization of women's equal citizenship. Using case studies of New Brunswick, Ontario, and Quebec, this chapter highlights the unique

regulation of abortion in the three provinces. New Brunswick has had by far the most political and legal activity concerning abortion policies, which were created with a strong adherence to the moral frame. Consistent resistance to these policies has led to a multitude of court cases and the employment of delay tactics by the provincial government, with the intent of avoiding any interaction with the rights frame. Ontario, in contrast, has largely avoided any discussion of abortion politics. By attempting to treat abortion as a straightforward medical issue, it has created uncertainty regarding its approach to abortion regulation, leaving room for increased influence from social movements and the medical community in its treatment. Finally, Quebec, known for its embracing of the rights framework, while it has experienced some political and legal activity following *Morgentaler*, saw the most activity in the lead up to the landmark case. Quebec stands out amongst the provinces for its commitment to the rights frame, which is evident in the actions of the provincial government, up to the present time.

While chapters three and four cover some of the major court cases in Canada with respect to abortion access, in addressing their relationship to federal and provincial political activity, chapter five builds on this research with legal analysis. While the role of politics in the regulation of abortion is made apparent in the previous chapters, the importance of litigation and the way in which rights are interpreted through the courts necessitates further discussion. This chapter takes a broader look at abortion litigation in Canada through the lens of feminist legal scholarship, examining the apparent success of abortion-related litigation. Ultimately, it argues that the courts have been and continue to be a useful avenue to pursue progressive change but, as with political action, positive change cannot be achieved absent a favourable social climate.

A province's social climate has proven to be instrumental in the way women experience their citizenship, influencing both the regulatory decisions of institutions and individuals'

experiences when seeking abortion access. Chapter six looks at the social climates of the provincial case studies and their influence on the regulation of abortion. The realization of abortion rights is not only a political/legal question, but also relies on social acceptance of the procedure as necessary to women's citizenship. This chapter explores provincial social climates, through analysis of social movement activism and insights from interviewees. The findings presented in this chapter help to establish criteria for understanding which provinces have accepted abortion as a part of women's citizenship rights, and which have attempted to depoliticize reproduction.

Chapter seven moves to a discussion of the ways in which the medical community has regulated abortion following its decriminalization. When the procedure was classified as a medical issue, the medical community was given significant power in shaping access. This chapter looks at the way the medical community itself is regulated, both internally and by external forces, and how these forces shape access. In the absence of an enforceable rights frame, the medical community, which is highly atomistic in its organization, has allowed physicians a great deal of discretion in the way they handle patients seeking abortion services. Importantly, without a clear regulatory framework, the moral and rights frames have been imposed unevenly on medical professionals, further contributing to instability in the way abortion is regulated in the provinces.

The concluding eighth chapter shifts its focus back to a discussion of how women experience citizenship in the Canadian provinces as a result of differing levels of access to abortion services. First, it synthesizes findings from the case studies in chapters three through seven, to highlight the cumulative effect of the political, legal, social, and medical dimensions of citizenship in each province—the findings situate New Brunswick low on the citizenship scale,

Ontario somewhere in the middle, and Quebec on the high end of the spectrum. These findings are used to explore the ways women in these provinces likely experience their citizenship in regard to this issue. The chapter then moves to a discussion of how a citizenship framework could be used to fill the policy vacuum left by the *R v Morgentaler* decision, and bring women closer to realizing their equal rights and full community membership. The chapter, and the dissertation, concludes by identifying important areas for future research.

Chapter 2. Rights, Morality, and Abortion Access in Canada

This chapter situates this dissertation in the relevant literature. It begins by addressing work dealing with the central frames used in debates on abortion, namely the moral and rights frames. The specific use of the term “framing” in this work is also clarified. In keeping with the broader definition of frames provided in this chapter, it also surveys literature tackling some of the fundamental concerns of social reproduction, more specifically traditional gender roles and the public/private divide. Importantly, the study of abortion politics has strong links to second-wave feminism, which has been criticized for some of its exclusionary theories. In order to assuage concerns that my dissertation might fall into this trap, the chapter explores the role of intersectionality in my work. This section moves into an exploration of existing works dealing with the issue of abortion access in Canada. To date, there has not been a significant investigation of this subject in the literature, and what is available has tended to be national in focus. The final section addresses the attempts of this dissertation to fill lacuna in the literature, through its structure, unique theoretical framework, and use of original qualitative data.

The Moral and Rights Frames

The way abortion is understood is a central preoccupation of the literature. The most commonly cited conceptualizations of abortion in the post-Morgentaler era position it as either a moral or rights issue. In general, these understandings do not always link specific views on abortion to the larger political struggles they are part of; specifically, they do not engage with the strategic nature of the claims social movements make. I adopt the terms *moral frame* and *rights frame* to specify the dominant discourses and conceptualizations of abortion embraced by the pro- and anti-choice movements respectively, as they are informed by a discourse on citizenship. That is, these frames consider not only the justifications offered by specific groups, but the strategies they employ to achieve the underlying objectives central to their organization. In the

case of the moral frame, this includes the anti-choice movement's belief that abortion is murder, as well as their strategic work to limit women's citizenship rights in an effort to force a return to traditional gender roles. In reference to the rights frame, the goal of women's bodily autonomy during pregnancy is considered as part of the larger project of women's emancipation, which includes a challenge to social and political restrictions enforcing and naturalizing socially traditional understandings of appropriate roles. The works detailed below demonstrate the strong affiliations between the rights and moral frames and approaches to the regulation of abortion.

In *Gendered Citizenship: Women, Equality, and Abortion Policy*, Nossiff explains that “restrictive abortion laws are based on religious beliefs that life begins at conception, and therefore that abortion is tantamount to murder” (2007, 61). This describes the moral frame, with its strong religious roots which focus on traditional roles. However, Hartmann makes clear in her historical study of abortion that changes were also made to religious scripture to restrict women's autonomy: “Even the Catholic Church was relatively tolerant of early abortion—not until 1869 did Pope Pius IX declare all abortion to be murder” (1995, 259). The notion of “ensoulment” occurring at conception is, in fact, a relatively new idea, but one which has served as the basis for much of the anti-abortion crusade. In order to effectively conceptualize abortion as murder, the anti-choice movement presents the relationship between a woman and her fetus in terms that deny the unique reality of pregnancy: as either that of a mother and child or, alternatively, that of two strangers. In either case, the woman and fetus are viewed as separate entities with the fetus as the innocent party and the woman as the potential aggressor. Brodie echoes this analysis, stating that anti-choice framings of pregnant women rely on their degradation as morally bankrupt, selfish, and easily manipulated (1992). These traditional attitudes regarding pregnancy rob women of their autonomy and render them, according to feminist critiques, nothing more

than “walking wombs” (Brodie 1992, 94). The medical and physiological reality of pregnancy, moreover, can be more accurately constructed as parasitic rather than symbiotic or self-sustaining, though this presentation does not fit with culturally constructed models of motherhood.

Central to the moral frame is the traditional rhetoric that positions women first and foremost as “wives and mothers,” (Nosiff 2007, 61). While, for many women, the pressure to assume traditional gender roles is central to the moral frame of abortion, numerous women who participate in the anti-choice movement see re-criminalizing abortion as central to maintaining a perceived domestic power base. Their rationale is that women’s power in the private sphere is threatened along with traditional family structures if pregnancy is a process that can be chosen. Thus, if pregnancy and birth are not a natural consequence of intercourse, what is the value of marriage and a nuclear family model? In an effort to address this problematic logic, McDonnell’s (1984) study of the anti-choice movement explores the motivations of women involved in the movement, attempting to reposition them as intelligent and logical, if ultimately mistaken. McDonnell suggests that the self-worth of women participating in the anti-choice movement is misguided and representative of an abstract and misplaced nostalgia that advocates for the return to a time that “never existed” (1984, 91). McDonnell’s goal is to demonstrate the motivations for women’s participation in a movement endeavoring to remove their own rights. She concludes that their actions are motivated by fear: “fear of change, fear of liberated sexuality, fear of ambiguity and complexity, fear that life has no value, [and] fear of female autonomy” (ibid., 93).

Unlike the anti-choice movement’s use of the moral frame, the pro-choice movement has relied heavily on framing legal and safe access to abortion as an equality right. For most Canadians, the concept of equality has become synonymous with legal rights. This association is,

in part, strategic, as the *Charter* guarantees that are responsible for the decriminalization of abortion are seen as central to the leaps in equality that have been made.¹³ Still, while feminists hold that abortion is a right, it is clear that the use of the security of the person clause in the *Charter* used to decriminalize the procedure did not go far enough in ensuring women's equality. In her article "In The Back Alleys Of Health Care," Erdman critiques the mechanisms in Canadian society that define community membership, and alternatively calls for their re-evaluation (2007, 1154). She links reproductive health with broader projects of, "women's political, economic and social equality" (ibid., 1155). This sentiment echoes Justice Bertha Wilson's ruling in the 1988 *R v Morgentaler* case, when she stated that the Court's ruling would have, "profound psychological, economic and social consequences for the pregnant woman," and, moreover, "is a decision that deeply reflects the way the woman thinks about herself and her relationship to others and to society at large."¹⁴

The acknowledgment of abortion as greater than simply a medical issue is prevalent in this stream in the literature. Many authors draw attention to the origins of its unique treatment, positioning it as the result of a patriarchal society. In Persky's commentary on the Supreme Court, he suggests that, "it is still widely, though often unconsciously, assumed that a woman's sexuality and reproductive capacity is a male possession, not hers independently" (1988, 181). Justice Wilson echoes this sentiment in her decision, by first paraphrasing the arguments of Noreen Burrows, a lecturer in European Law at the University of Glasgow:

The history of the struggle for human rights from the eighteenth century on has been the history of men struggling to assert their dignity and common humanity against an

13. Abortion was decriminalized under the provision in Section 7 of the *Charter* that guarantees everyone "the right to life, liberty and security of the person" (Department of Justice 1982).

14. *R. v Morgentaler*. [1988] 1 S.C.R 30. (Can) at 11.

overbearing state apparatus. The more recent struggle for women's rights has been a struggle to eliminate discrimination, to achieve a place for women in a man's world, to develop a set of legislative reforms in order to place women in the same position as men.¹⁵

Burrows' work addresses the longstanding failure of the state to recognize the unique demands of women's rights, which come to a head in debates surrounding reproduction. A significant amount of energy by feminist movements at the time was placed on attaining equal legal rights, but as it became apparent that equality was often only recognized insofar as women were the same as men, their efforts began to broaden to include recognition of women's unique experiences. Incorporating this perspective, Wilson goes on to assert that:

It has not been a struggle to define the rights of women in relation to their special place in the societal structure and in relation to the biological distinction between the two sexes. Thus women's needs and aspirations are only now being translated into protected rights. The right to reproduce or not to reproduce which is in issue in this case is one such right and is properly perceived as an integral part of modern woman's struggle to assert her dignity and worth as a human being.¹⁶

The relationship between systemic inequality and reproductive autonomy is a well-established theme in the literature, as is the failure to establish reproduction as a site of inequality despite a plethora of evidence. Still, women's experience in obtaining abortions is not universal. Women from different classes, of different ethnic backgrounds, and inhabiting different regions have varied experiences. Thus, Haussman states that:

Women who have the advantages of time, money, providers, and geographical location

15. *R. v Morgentaler*. [1988] 1 S.C.R. 30. (Can) at 164.

16. *R. v Morgentaler*. [1988] 1 S.C.R. 30. (Can) at 164.

are still ‘okay’ under the current framework, while those lacking one or more of these crucial resources will either opt for an unsafe abortion, running a one-in-three risk of dying, as in Mexico, or perhaps opting out of having an abortion altogether. (2005, 185)

This theme, of experiences of oppression differing between groups of women, is prevalent in much of the pro-choice literature. Roberts, for example, builds on this premise, reflecting on the history of women’s oppression and drawing examples from the period of slavery of blacks in the United States to demonstrate the importance of bodily control to freedom. Her study looks at the use of rape as a tool of slave “owners”—used both to expand their workforces and to control the women through fear. In this way, women’s bodies are used against them to further their own oppression. Roberts feels that this phenomenon, “exemplifies the intimate connection between reproductive freedom and equality” (2003, 282). Moreover, it demonstrates the vulnerability of certain groups of women. Choice, then, is not as simple as decriminalization. Choice means more than: “the abstract ability to reach a decision in one’s mind. A true choice means an uncoerced selection of one course of action over another and the ability to follow one’s chosen course” (ibid., 284). For Roberts, choice is not necessarily simply a question of negative freedom.

Kelly builds on this notion when she suggests that a movement for reproductive choice needs to include “a wider array of claims including proper supports for domestic work and child care” (1992, 266). Here the rights frame is broadened, suggesting the need for positive rights surrounding care, further politicizing processes of social reproduction. While her more all-encompassing vision of choice raises some concerns regarding the limits of positive freedom, it nonetheless requires consideration. The freedom from reproduction seems to be a reasonably straightforward concept, but exactly what a full range of positive choices would resemble is not clear. Certainly some claims, like those for equal wages, are also compatible with general

equality, but does the general capacity for women to reproduce translate into a right? Should fertility treatments and surrogacy be publicly funded? Should these procedures be construed as offering women a fuller range of options, or positioning them as reproducers first and foremost and increasing the resultant social pressures or their adoption of these roles? The question of reproductive choice as a positive right is complex, and overlaps with questions of women's social roles in Canada today.

While a social reproduction approach challenges rigid divisions between public and private spheres, this divide continues to be a central issue in gender scholarship. Nowhere are the problems inherent in naturalized assumptions about women's labour more apparent than in studies of outsourced home and child care. The focus of Bakan and Stasiulis' research on migrant domestic workers, for instance, demonstrates widely held perceptions about the nature of women's domestic work. Women who perform domestic duties, like live-in nannies, are paid sporadically, and expectations regarding their work are based on stereotypes of motherhood. While hired to care for children, other expectations, such as cleaning, are often subsumed under childcare responsibilities (Bakan and Stasiulis 2005, 106). The "gendered, hierarchical, heterosexual, nuclear family structure" that Bakan and Stasiulis focus on continues to exist in Canada, and it positions the domestic sphere as primarily a women's sphere (ibid., 95). This is seen in the combination of "childcare and housekeeping as part of the same job description" (ibid.).

Ruddick's (1995) discussion of "maternal instinct" supports this premise. She discusses the nature of care work, particularly the responsibilities associated with raising children, and the rhetoric surrounding it. Motherhood is constructed as instinctual, as is the work associated with it. This work is seen as being prompted by love and nature, and is therefore not considered real

work. Ruddick challenges this notion, arguing that motherhood is the same as any other profession. Mothers, she explains, “are not any more or less wonderful than other people—they are not especially sensible or foolish, noble or ignoble, courageous or cowardly. Mothers, like gardeners or historians, identify virtues appropriate to their work” (1995, 25). Ruddick stresses the optional character of maternal work. This optional nature is critical to understanding women’s work as legitimate work, in need of recognition, remuneration, or both.

A social reproduction approach is useful for such a project, as it seeks to illuminate both the cultural and material roots of women’s oppression, including interrelationships between the state, markets, social movements, and the household. Underlying this approach is the need to understand these institutions as both informing, and being informed by, each other. Importantly, once certain institutions are in place they “provide the framework within which subsequent struggles take place and influence their shape, favoring some interests over others,” though they too are subject to change (Cameron 2006, 47).

Social reproduction has evolved from a fairly narrow focus on gender and the economy to an intersectional approach that acknowledges interplay between institutions and recognizes the importance of factors such as “socio-geographic location,” race, and experiences of community membership (Ferguson 2008, 47). Notably, these issues are no longer seen as secondary to class and gender, but as necessary to account for “in the beginning” (ibid., 48). Advances in intersectionality demonstrate the importance of a cohesive theory, able not only to account for social and material difference as afterthoughts, but to understand them as foundational to influencing social dynamics. Women’s oppression in Canada to date has, after all, not been solely a question of gender and class, but of race, sexuality, and location, among other factors.

Necessary Essentialism: Addressing Issues of Intersectionality in Body Politics

Much of the analysis surrounding abortion access to date has focused on the problems

faced by biological women, particularly those in their childbearing years, in conjunction with critiques of problematic social structures that harken back to second wave feminist concerns.¹⁷ Indeed, the politics of the body first emerged as a concern with the feminist second wave, of which abortion rights activism was a major component. Importantly, while a focus on women's bodily rights is still important, current research does not operate in the same marginalizing discourses for which the second wave was criticized; it has moved to a more intersectional approach, as evidenced by the literature reviewed in the next section. The focus on multiple sites of women's oppression culminating to influence existing policies is demonstrative of such a shift. This dissertation continues this trend by interpreting body politics through a theoretical lens which accounts for intersections of multiple oppressions in the way women experience their citizenship with regard to abortion access, as well as the impacts of institutions in shaping access, though with some obvious limitations.

First, the focus of this dissertation is on the impact of a variety of institutions on women's experiences of citizenship. Citizenship is understood as a dynamic, negotiated concept, which is experienced differently by women across Canada. While this research project does not attempt to isolate all of the factors impacting the way women understand their community membership, it does focus on the interplay between the dominant regulatory institutions, in both formal and informal capacities. In so doing, it considers "how different systems of stratification and their associated discourses and ideologies intersect [in order to] provide a more complex sense of the multidimensional nature of power, privilege and inequality" (Creese and Stasiulis 1996, 8).

Secondly, this research recognizes that the way women experience abortion is informed

17. The phrase "biological women" refers to individuals who are able, or presumed able by virtue of their female sex organs at birth, to bear children. This category excludes individuals who identify as being of the female gender and those who have changed their sex through surgical means.

by their class, race, and sexuality, among a myriad of other factors, and that these systems of domination “do not have identical effects on socially constructed categories of women and men” (ibid.). While addressing the impacts of these factors on individuals is beyond the scope of this study, it is nonetheless important to acknowledge this reality to set the stage for future research. The negotiating citizenship model applies seamlessly to varied individual experiences. This research recognizes that “members within a category are diverse” and that “dynamic interaction between individual and institutional factors” shapes the nature of individual experiences of community membership (Dhamoon 2011, 231). This research creates a foundation which could be enriched through the inclusion of individual identities and experiences of abortion.

There is, however, a degree of unavoidable essentialism in the way abortion is studied, given current limitations on reproductive technology. A focus on the acts of pregnancy and birth still necessitates an emphasis on the biological category of women who, while not all able to conceive, are the only group to date who can experience pregnancy. The citizenship framework from which this dissertation departs is not, however, limited by existing empirical realities; the arguments put forth in this dissertation are able to adapt to changes in reproductive technology, such as the elimination of biological womanhood as a necessary precondition to become pregnant. Importantly, issues of social reproduction and backlash, which form the foundations both for support and opposition to abortion, do not assume a static category of biological women; they apply instead to the gendered identity. However, the continued constructed exclusion of women’s rights means we are still, in a sense, dealing with second wave arguments.

Using social reproduction, this study makes a broader argument about the perceived roles and responsibilities of individuals identifying as women, and the problematic nature of different conceptions of society and the family for this paradigm. In so doing, it does not assume a dated,

white, heterosexual, middle-class nuclear family model when arguing for the necessity of access to abortion services. Arguments regarding the importance of abortion services to women's citizenship are made using an intersectional approach, which assumes a multiplicity of factors influencing individuals, causing them all to experience their citizenship differently.

The need to understand the multiple institutions impacting the regulation of abortion is a strong trend in the literature to date, as are emerging questions about the way different groups of women experience abortion access. The next section explores current scholarship on abortion access in more depth.

Abortion Access in Canada: The Literature

Numerous studies have been undertaken to isolate the severity of the issue of access to abortion in Canada (Brodie 1992; Kaposy and Downie 2008; Palley 2006; Hausman 2002, 2005; O'Neill 2002). Brodie's (1992) seminal chapter, "Choice and No Choice in the House," offers a thorough account of the battle over abortion between the pro- and anti-choice camps following the *Morgentaler* decision. She engages with the arguments of both camps, ultimately showcasing the reliance of the anti-choice movement on the degradation of pregnant women in their platform, presenting them as morally bankrupt and selfish (ibid., 94). Brodie also draws attention to the variance in provincial responses to their new jurisdiction over the procedure, rooted in decisions by the federal and provincial governments to treat abortion as unique from other political and medical issues, but she does not engage substantially with the details of these responses. This work has strongly informed this dissertation, which incorporates Brodie's analysis of social movements to better understand motivations for the continued support of improved access, and the manifestations of resistance.

Hausman has also conducted extensive work on abortion in Canada, including a study of abortion in Canada between 1969 and 1991 (2002), and a large-scale research project comparing

abortion policy in North America (2005). Her work provides a revealing history of the evolution of the rights frame of abortion in Canada, specifically its rise following the entrenchment of the *Charter*. Her work on social movement activism, particularly the influence that anti-choice groups from the United States have had within Canada, also informs this dissertation.

In his 2006 study, Palley highlights some of the central influences that may have shaped the present access situation in Canada. Provincially, he attributes a variation in policies to the prevalence of religious minorities, violence and threatening acts, the amalgamation of religious and secular hospitals, and insufficient sanctioning by the federal government for improper provincial actions. Federal policy, he explains, was clearly articulated when, in 1995, “federal health minister Diane Maclean declared that provinces must pay the full cost of abortions at clinics or face federal deductions from transfer payments to the provinces under the Canada Health Act” (2006, 578). Palley asserts that “provincial and territorial access to abortion services is significantly affected by bottom-up political implementation” which includes “the politics and pressures operative within provincial and territorial political systems and by other intense interest group pressures” (ibid., 565). This dissertation builds on these claims, attempting to assess the motivations and powers of both formal institutions, such as provincial and federal governments, and social forces, in the restriction of abortion access. By comparing responses to the decriminalization of abortion in multiple provinces, rather than broadly surveying the issue in Canada as a whole, this study endeavors to isolate the most influential factors in the regulation of the procedure.

O’Neil, whose work examines the status of women across Canada, also engages with women’s reproductive health issues. Her (2002) chapter examines four factors—economic independence, reproductive freedom, childcare services, and political representation—to

highlight the ways that the provinces perceive women. She identifies the way provinces differ in their treatment of these issues, drawing a correlation between perceptions of women and their reproductive health. This connection, between the social perception of women and the regulation of their reproduction, is echoed throughout the literature. Brodie explains that the public is more willing to accept abortion in “so-called ‘hard cases’ of rape, incest, the women’s health, and fetal deformity,” that is, in instances which portray the woman as a victim rather than an empowered individual with agency (1992, 61). Erdmann also notes the connection between “the larger project of women’s political, economic, and social equality” and their reproductive health (2007, 1155).

Joanna Erdmann’s (2007) piece, “In the Back Alleys of Health Care,” examines the treatment of abortion from a legal perspective. Her work focuses specifically on problems associated with its differential treatment as a healthcare issue, and the consequences of denying women a vital healthcare service on their status as citizens. Her citizenship narrative is discussed in more detail in the next section of this study (entitled Original Contributions), but central to her argument is the assertion that women must not only be “perceived as full members of Canadian society, but believe themselves to be” (2007, 1155). The priority she accords experiences of citizenship is echoed in Bakan and Stasiulis’ work *Negotiating Citizenship*, and is also a central theme adopted in this dissertation.

It is important here to include mention of Rosemay Nossiff, who also employs a citizenship narrative in her article “Gendered Citizenship: Women, Equality, and Abortion” to address the relationship between women and abortion services—though she does so in the context of abortion law in the United States. By analyzing the evolution of abortion policy from 1965 to 2000, Nossiff’s piece, discussed in more detail in the following section, demonstrates the

way “a politics of motherhood conflicts with women’s rights to full citizenship” (2007, 61). This dissertation focuses on similar themes in a Canadian context, using a model of social reproduction to unpack traditional gender roles and further positioning anti-choice activity as part of a politics of backlash against women’s rights.

Original Contributions

While access has been accepted as the new terrain of reproductive health, the research in this area to date has taken a largely national focus, surveying provincial barriers and compiling lists of potential motivations for differences in service. This research builds on these studies by focusing on specific case studies and comparing and contrasting them on previously enumerated grounds believed to have an influence on the regulation of abortion, such as the prevalence of violence against those providing and accessing abortion services.¹⁸ This research attempts to differentiate itself by limiting its analysis to a comparative study of specific cases and endeavouring to isolate the importance of various different factors. It highlights not only the barriers to abortion access still faced by women in Canada, but explores the rationale for their existence so that they might be more effectively challenged and guarded against.

To this end, this research employs a social reproduction approach to draw attention to expectations of women’s social citizenship, and further illumines anti-choice activities as elements of anti-feminist backlash against progressive gains in women’s citizenship. A citizenship narrative has previously been used to conceptualize women’s experiences of restricted abortion access in works by both Joanna Erdmann and Rosemary Nosiff. Erdman argues for women’s equal rights to access of medical services as full members of Canadian society, rejecting the utility of an individualistic approach to ensure their equality, like that used

18. Addressed further in chapter six.

in the security of the person argument in *Morgentaler* (Erdman 2007).¹⁹ Nossiff also takes up the question of women's standing as citizens, arguing that "the language of restrictive abortion laws [in the United States] is grounded in a tension between differing definitions of women's citizenship and gender roles" (2007, 63). Drawing on arguments made in both pieces, this dissertation argues for the need to understand abortion as a right of citizenship, but with some notable distinctions.

Taking up Brodie's critiques of the limitations of a medical understanding of abortion, I challenge elements of Erdmann's argument, suggesting that treating abortion as a medical issue is reductive and ultimately damaging to women's equality. Also, while I adopt Nossiff's claims regarding constructions of women's citizenship and imposed gender roles, through the adoption of a social reproduction approach, my conclusions are necessarily different, given the unique context of her claims. While my study concurs with her argument that "any restrictions on abortion inevitably have the effect of undermining their [women's] citizenship," the apparent solutions differ. Canada prides itself on having a universal healthcare system, a reality which simplifies arguments regarding the necessity of full access to abortion services, as a focus on gendered issues is easier when universal healthcare is already in place. Therefore, while Nossiff attempts to find middle ground for policy change, suggesting a limit on legal abortion and minimal state regulation, I propose change more in keeping with the belief that women's equal citizenship necessitates complete bodily autonomy.

Finally, the research undertaken for this dissertation contributes additional qualitative

19. Instead, Erdman appeals to the section of the *Charter* emphasizing the "dignity of equal community membership" (2007, 1129). She argues that the exclusion of women from Canada's universal health system through the denial of necessary reproductive health services violates women's dignity as equal citizens, a concept which includes the "self-respect and self-worth attained by relationships with others and the recognition of others" (Law v Canada. [1999] 1 S.C.R. 497 (Can) at 530, quoted in Erdmann 2007, 1129).

data on abortion access in the provinces, in the form of twenty-nine personal interviews with politicians, lawyers, members of the medical community, and social activists. These interviews, undertaken in New Brunswick, Ontario, and Quebec, cover the spectrum of access levels in Canada. I hope that these interviews can shed light on the ways in which attitudes and practices concerning the regulation of women's bodies have evolved since the *Morgentaler* decision of 1988.

Chapter 3. “Fragile, Incomplete, and Contradictory”: Abortion in Canadian Federal Politics and the Courts

*[The anti-choice movement] are really buoyed by the stance that this government [the Harper government] has taken, even though the government claims not to be taking a stance. That's the irony of it... The Conservatives are going to proceed incrementally and by stealth because the lesson they have learned is that, if they have an open attack on abortion, they cannot do it [succeed].*²⁰

Abortion has a long history of federal regulation. The procedure was criminalized in Canada two years after Confederation, in 1869, when Canada adopted a British law prohibiting abortion without exception. It remained a matter of federal politics, entrenched in the Criminal Code, for nearly a century before changes were made to it in response to a strong physician lobby group in 1939. The new law granted physicians the right to perform abortions with impunity in life-threatening cases. This law was modified again in 1969, this time in conjunction with a number of other laws as part of a large-scale Criminal Code amendment. The law was modified to create the short-lived and highly problematic Therapeutic Abortion Committees (commonly known as TACs),²¹ which had the power to grant legal abortions to women who successfully pled their case to a panel of physicians.²² It was in response to this iteration of Canada's abortion regulation that one of the best known legal cases in Canadian history, *R v Morgentaler* was launched. However, it was not until the implementation of the *Canadian Charter of Rights and Freedoms* in 1982 that any individual was able to successfully challenge the federal government's right to restrict abortion.

Dr. Henry Morgentaler first gained notoriety in Quebec in the early 1970s after opening

20. Michelle Robidoux, (Manager Ontario Coalition of Abortion Clinics, years unknown). Interview by author. 30 March 2011. Recorded and transcribed by author. Toronto, Ontario.

21. For more information on TACs consult: The Badgely Report (1977); Overby, Tatalovich, and Studlar 1988.

22. TACs were composed of four doctors, none of whom would perform the actual abortion, who assembled on a voluntary basis, subject to “a variety of provincial regulations” (Badgely 1977, 17). These panels ruled on whether or not women could access a legal abortion. They were given discretion over the criteria they used to render their decisions, in essence: “Parliament essentially said that abortion was legal so long as a therapeutic abortion committee said it was legal” (Overby, Tatalovich, and Studlar 1988, 34).

an abortion clinic and publicly announcing his practice, openly flouting Canadian law. He did so prepared to challenge the existing law in court, though he could not have been prepared for the extent of the legal battles yet to come. After three legal losses and one conviction, which was subsequently overturned, Morgentaler succeeded in effectively legalizing abortion in Quebec, only to set his sights on the rest of Canada. The extent of individual rights, and the powers of the federal government when he first began his fight, made such a task difficult, but his luck changed significantly with the creation of the *Charter*, which created new tools with which to challenge federal laws.²³

This chapter begins by tracing the history of abortion regulation in Canada, detailing the changing restrictions to the procedure in federal politics. It transitions to a discussion of Dr. Morgentaler's fight to decriminalize abortion in Canada, beginning with his decision to move to Canada from Poland to pursue a degree in medicine after surviving the Auschwitz concentration camp. This section focuses on litigation in Quebec, resulting from the provincial government's attempts to enforce the Criminal Code. These cases demonstrated a dramatic shift in public perceptions of abortion and foreshadowed the string of legal successes to come, including the Supreme Court's *R v Morgentaler* case, which is the focus of the following section.

The *R v Morgentaler* decision completely changed the landscape of abortion access in Canada when it struck down Canada's existing abortion law. This section explores the nature of this case and, most importantly, the consequences of the ruling. Importantly, while this case is often portrayed as the final battle for women's reproductive rights in Canada, the ruling actually validated some degree of state intervention in pregnancy. The perception that women's rights to

23. Before the *Charter* was entrenched, a *Canadian Bill of Rights* was in place (enacted in 1960), designed to protect human rights. Because it was a statute and not constitutionally entrenched, however, it did not supersede other laws, making it more of a guide than a guarantee. In this way, it was not seen as highly effective.

abortion access were validated in this case is the result of public discourse on abortion, strongly informed by pro-choice social movements, which were able to thrive in the wake of the Mulroney Administration's failure to create a new abortion law.

After the *Morgentaler* decision, the federal government quickly moved to create a new abortion law, but came up against significant obstacles. The next section addresses the difficulties the Mulroney administration faced in creating a new law, and why their first attempt was unsuccessful. Before moving to a discussion of their second attempt to create a new law restricting abortion, this section moves on to a discussion of the litigation taking place in the same time period, which tested the limits of the *Morgentaler* decision. These cases addressed issues of paternal and fetal rights, neither of which were recognized as reasons to use to prevent women from accessing abortions; indeed, the Court found that fetuses had no legal rights in Canada. Joe Borowski, an infamous anti-choice activist, is also mentioned here, with reference to his failed attempt to have fetal rights recognized under the *Charter*. It is necessary for these events to be addressed here in sequence, as they were all influential in Parliament's second attempt to create a new abortion law, discussed in the following section.

Bill C-43 would have once again banned abortion under the Criminal Code, but with exceptions to allow doctors to perform abortions at their discretion should they determine that the woman's health was compromised because of the pregnancy (Overby, Tatalovich, and Studlar 1988, 383). The *Bill* ultimately failed in a surprise tie vote in the Senate, and the government showed no interest in attempting a new iteration of the law, despite the continued activism of individual members of Parliament, specifically those in the so-called pro-life caucus. The politics of backlash, which emerged during the Mulroney administration, has continued through this organization and the activities of individual MPs. This chapter concludes with a

discussion of the continuance of a politics of backlash in federal politics in the Harper Administration.

The chapter will draw attention to the fragility of abortion rights in federal politics and as they have been interpreted in the courts. While litigation has been a successful tool of the feminist movement used to secure progressive change, the courts work with precedent and existing law, which have yet to fully recognize abortion as a right of women's citizenship. Their decisions, while often paving the way for positive change, are thus incomplete. Likewise, the federal government's treatment of abortion over time has not recognized abortion as a citizenship issue—rather, it has tried to avoid engaging with the potentially divisive topic. At best, it treats abortion as a straightforward healthcare issue; at worst, it embraces a politics of backlash, which attempt to reframe the procedure as a moral issue and rescind women's hard won rights. Failure of either institution to recognize abortion as a right of women's citizenship leaves women vulnerable.

The stage is set in this chapter for the broader institutional analysis of the treatment of abortion after *Morgentaler* detailed in subsequent chapters. While the federal government still has power to influence the nature of abortion access, following the *Morgentaler* decision abortion was reclassified as a healthcare issue and jurisdiction over the procedure shifted to the provinces. The influence of social movements evident in the activities of representatives in the federal government, who tend to employ either a moral or rights frame to justify their actions, is also apparent in provincial parliamentary politics and medicine. As chapter five demonstrates, litigation is also subject to these social influences, but in a less obvious way.

This chapter explores the evolution of the rights frame around abortion access, and the rise of anti-feminist backlash in the form of a moral rhetoric, as it occurred in the federal

government and in the language of those initiating legal action to influence the regulation of the procedure. These frames have come to dominate political, legal, social, and medical conceptualizations of abortion. Justifications for the use of both frames consistently reveal contradictory understandings of the role of women in society, rooted in differing beliefs about social reproduction. The policy vacuum currently surrounding abortion access has had a dramatic impact on public perceptions of women and their rights, creating room for the rights rhetoric to flourish more easily than it might have if Mulroney had been successful in implementing a new law immediately following the *Morgentaler* decision. Despite the success of the rights frame in this environment, backlash against these hard won rights is a growing concern. It has become increasingly important for the federal government to formally acknowledge the necessity of abortion access to women's equality to ensure that all women in Canada are treated as equal citizens.

Law and Politics: Abortion Regulation Before 1988

Canada's abortion law, like the majority of laws adopted at the time of Confederation, mimicked existing British law. Britain first adopted formal, universal restrictions to the procedure in 1803 with *Lord Ellenborough's Act*, which prohibited certain kinds of abortion following the "quickening" (Keown 1988, 15).²⁴ Notably, the intention of creating what might be assumed to be an anti-choice law today appears not to have been moralistic; rather, it was designed with a mind to protecting women from what were seen as unsafe medical practices (often associated with midwives) as well as safeguarding the domain of the medical profession (Gleeson 2011, 217).

In the years that followed, the British *Act* was broadened to include abortion at all stages

24. The quickening is the stage in pregnancy where fetal movements can be detected by the pregnant woman, normally occurring at the beginning of the second trimester.

and by multiple methods, though those performed before the quickening were only seen as felonies and not as destroying a human life (Keown 1988, 18–19). The maximum penalty for both the woman seeking the abortion as well as the provider was life in prison (Campbell 1977–1978, 223–224). The goal of these modifications, according to Keown, was to simplify the law, making it more easily enforceable, though these precautions did not have the desired effect (1988, 16). The public did not perceive abortion as a crime, and public sympathy for women seeking abortions made sentencing difficult (Keown 1988). The belief that abortion was immoral was not prevalent at the time, when the deaths of young children, as well as death in childbirth, were more commonplace. Indeed, the condemnation of abortion today, as constituting murder from the moment of conception, was a belief not yet adopted by today’s most fervent anti-choice organizations, including the Catholic Church (Hartmann 1995, 259).²⁵

In 1869, Canada inherited a more recent iteration of *Lord Ellenborough’s Act* when it mimicked Britain’s 1861 *Offences Against the Person Act*, which prohibited abortion without exception, in its Criminal Code (Hausman 2002, 63). Restrictions on other aspects of reproduction were also included in the Code; for example, the sale and promotion of contraception was banned in 1892 (Badgely 1977, 277). Indeed, abortion and contraception are both issues deeply tied to women’s roles in the processes of social reproduction, and progressive understandings of both share the same theoretical foundations. As such, it is not surprising that a campaign to decriminalize birth control was pivotal in paving the way for liberalized abortion laws.

The campaign to decriminalize Canada’s inherited abortion law is rooted historically in demands for birth control; indeed, the crusade to decriminalize birth control in Canada preceded

25. See chapter 2 for a discussion of the history of abortion in the Catholic Church.

that of abortion by more than fifty years. As in the *Morgentaler* decision, the campaign and subsequent court case regarding the legality of birth control centred on the actions of one individual: Dorothy Palmer.

In 1937, Palmer was charged for canvassing her Ontario community of Eastview (now known as Vanier, a neighbourhood of Ottawa) in order to share information on birth control, despite the illegality of promoting information on reproductive control (McLaren 1997, 92). While she was acquitted for her intent to serve the “public good,” what is most notable about this case is not the outcome, but the portrayal of contraception (ibid.). In order to endear the notion of birth control to the public, in a period immediately following the Great Depression, it was conceptualized as a tactic to combat economic and racial concerns. The language of eugenics was used to endorse birth control, but only for the “undesirable” groups in society. Birth control, if utilized by lower class families (a disproportionate number of whom were racial minorities), according to the logic of the time, had the potential to reduce the state’s welfare burden. Moreover, the upper classes would then have the potential to have more children and thus outnumber the lower classes. The new birth control campaigners, “succeeded in presenting family planning as a force that would support rather than subvert existing social, political, and sexual relationships” (ibid., 93). In this way, it was made more palatable through assurances that it would not challenge existing social structures, like traditional gender roles.

The desire to protect existing power structures likewise played a central role in subsequent changes to Canada’s abortion law. The first change to the law took place seventy years after the original law was implemented. A provision protecting physicians against prosecution for performing an abortion to save the life of a pregnant woman was incorporated into Canada’s Criminal Code in 1939 (Hausman 2002, 63). As in the case of birth control, this

change was incorporated to maintain a specific power hierarchy; it was created not to protect women, but in defence of doctors.

The focus on physicians began to fade in the 1960s, as the women's movement gained strength and pro-choice groups began to organize, though it was not yet gone. Interestingly, student activists played an important role in subverting existing birth control laws, which prohibited the provision of educational materials promoting birth control, most notably in Quebec. McGill students famously compiled the *Birth Control Handbook* that included, among other things, information about access to abortion services (Sethna 2006, 95). The book was published and widely distributed, due to extreme demand, by students openly flouting existing laws. While student activism decreased in the wake of an increasingly powerful women's movement, their actions, however briefly, "united left-wing student and second-wave feminist politics" (ibid.). It was not long after that the very legislation they stood in opposition to was struck down.

In 1969, the Trudeau administration, still largely motivated by a desire to protect physicians, made significant changes to the Criminal Code (Hausman 2002, 66). The Criminal Code was amended to permit abortions only if they were "performed in an accredited or approved hospital and approved by a three-physician therapeutic abortion committee (TAC) from that hospital as necessary to protect the woman's life or health" (Brown and Sullivan 2005, 287). The motivation was the protection from prosecution of medical professionals, for instances in which they deemed abortions necessary. Interestingly, physicians rejected the full legalization of "abortion on demand" where a woman would have a right to control her pregnancy (Hausman 2002, 66). Once again, while reproductive rights were modified in a manner that would pave the way for women's autonomy, the intent was to modify them in such a way as to

maintain, “concepts of hierarchy and scientific and male privilege” (ibid., 67).

TACs operated at the discretion of hospitals, and only one in five hospitals across Canada actually established them (Rebick 2005, 157). Those that were in operation were seen as highly discriminatory against certain groups of women (ibid.). For instance, some committees “required the consent of a husband from whom the woman was separated or divorced and the consent of the father where the woman had never been married” (Gavigan 1992, 134).²⁶ These committees were widely criticized, and a powerful feminist lobby eventually led to a government study of their operation. The *Report of the Committee on the Operation of the Abortion Law*, commonly known as the *Badgely Report*, commissioned in 1977, “told the government what many Canadian women knew first-hand,” namely, that the “procedure provided in the Criminal Code for obtaining therapeutic abortion is illusory for many Canadian women” (Rebick 2005, 157).

Ultimately, however, the 1969 amendment to the Criminal Code as it pertained to the legality of abortion would prove to be relatively short-lived. A series of legal challenges against the 1969 law by Dr. Henry Morgentaler, whose name is now synonymous with the fight for women’s bodily autonomy, dramatically changed the landscape of abortion access in Canada. Indeed, the battle waged by Morgentaler, and the legislative and social responses to it, would set Canada apart from the rest of the world.

Dr. Henry Morgentaler

Dr. Henry Morgentaler, a Polish immigrant and survivor of the Auschwitz concentration camp, moved to Montreal in 1950 on a medical scholarship to McGill University.²⁷ After

26. For additional information on TACs, consult: The Badgely Report (1977); Brodie (1992); Gavigan (1992).

27. In his capacity of keynote speaker at a conference honouring the twentieth anniversary of his landmark Supreme Court victory, Morgentaler spoke briefly about his history in Auschwitz saying: “I am a survivor of the Nazi Holocaust, that orgy of cruelty, brutality and inhumanity. I have personally experienced oppression, injustice and suffering inflicted by those beholden to a racist, dogmatic and irrational ideology. To have had the opportunity to diminish suffering and injustice has been very important to me” (Morgentaler 2008, 5).

obtaining his degree, he opened a small family medicine practice. It was in this practice that Dr. Morgentaler first encountered women seeking abortion services, however he was legally required to turn away many women. Without any safe options available some women attempted to self-abort or commit suicide. As a medical professional, Dr. Morgentaler felt that turning women away violated his sworn oath to do no harm.²⁸ He closed down his family clinic and set up an abortion clinic.

The conditions under which a legal abortion could be performed were still regulated under the Criminal Code when Morgentaler's first clinic opened in 1968 in "complete illegality" (FQPN and CFC 2010, 16). Two years later, his clinic was raided and Dr. Morgentaler was arrested, but the charges of "conspiracy to commit abortion" and "procuring abortion" were later dropped due to the "improper use of a search warrant" (NAF 2010; Dickens 1976, 230, 232). Despite the raids, Morgentaler made no attempts to conceal his actions—rather, he broadcasted them, publicly announcing in 1973 that he had performed five thousand abortions (Pelrine 1975, 104). It was clear that the government was not sure how to handle Morgentaler's decision to publicly defy the law and at first it tried to keep his actions from public attention. It was, however, only able to ignore his activism for so long. Police re-entered the Morgentaler Clinic later that same year (1973) and arrested Dr. Morgentaler. The resulting court case, now well known in Quebec, led to a surprising verdict that both shed light on the changing social climate in the province and foreshadowed Morgentaler's lifelong pursuit of women's rights through the courts.

The "French Canadian, [and] predominantly Roman Catholic jury," who heard the case

28. When asked about the impact of his experiences in Auschwitz in an interview, Morgentaler stated: "I was sensitized to injustice and when I was in a position to do something about it, I felt it was a duty to do so, at whatever risk there was" (National Review of Medicine 2008).

consisted of eleven men and only one woman. At the time, the social shifts from the Quiet Revolution were still settling in Quebec and the influence that personal religious beliefs might have on the jury was uncertain. Ultimately, it seemed that class interests played a larger role in the jury's decision. The testimonies from women who had gone to the Morgentaler clinic to terminate their pregnancies—often desperate to regulate their reproduction in the face of poverty—had swayed the jury just as the women seeking abortions had swayed Morgentaler years earlier. Indeed, “class interests were never absent and often quite transparent” in debates surrounding women's rights to bodily autonomy in Quebec during that period (McLaren 1997, 141).²⁹

The crown appealed the verdict, and the Court of Appeal of Quebec who cited “jury error” subsequently overturned the decision (Arthur 1999). Morgentaler was sentenced to eighteen months in prison. He appealed to the Supreme Court on the grounds that the Criminal Code was rendered “inoperative by virtue of the Canadian Bill of Rights,” that he was entitled to use the defence of necessity to defend his actions, and that the “Court of Appeal could not substitute a conviction for an acquittal in a jury trial.”³⁰

Morgentaler's Supreme Court appeal (1975) was grounded in the assertion that the Criminal Code was, in this instance, rendered “inoperative by virtue of the Canadian Bill of Rights,” and that he was therefore entitled to use the defence of necessity to defend his actions despite the lower court's dismissal of this claim.³¹ To this end, he claimed that the “Court of Appeal could not substitute a conviction for an acquittal in a jury trial”.³² His charge that the *Bill*

29. The nature of Quebec's changing social climate and its influence on the Morgentaler cases in the province will be discussed in more detail in chapter six.

30. *Morgentaler v The Queen*. [1975] 1 S.C.R. 616. (Can.) at para 73.

31. *Ibid.*, at para. 73.

32. *Ibid.*

of Rights rendered section 251 of the Criminal Code moot was based on the argument for women's right to privacy and security of the person guaranteed under the *Canadian Bill of Rights*. He argued that section 251 infringed on these rights predominantly because it was so vague as to prompt unequal treatment before the law: "Since there is a right to abortion under certain conditions without risking criminal penalty, there is a right to a fair hearing thereon in accordance with the principles of fundamental justice established by section 2(e) of the *Bill of Rights*" (Dickens 1976, 237). The government did not require that hospitals form TACs, and even when they were assembled they were not subjected to review, nor were they required to justify their decisions. Further, women were not provided with counsel before or during their appearance in front of TACs. This arrangement, he argued, denied women equal treatment and due process to access a safe procedure. Morgentaler felt that these restrictions constituted "cruel and unusually treatment" both for women and physicians (ibid.).

His appeal was rejected with three of the eight judges dissenting. The dissenting opinion was that the acquittal be restored on the grounds that section 45 of the Constitution was not necessarily trumped by section 251, which restricted access to abortion. This decision also stated that the jury was provided with ample evidence to consider on the matter and that the trial judge "properly left the matter with them" (ibid., 238). The majority, however, ruled that section 45 "cannot in law apply so as to relieve criminal liability under s. 251" (ibid.). They did not feel the evidence of necessity presented demonstrated the level of urgency necessary to "justify a violation of the criminal law" (ibid.).

Public outrage at the court's unusual decision to overturn the verdict of a jury prompted then Federal Minister of Justice, Otto Lang, to propose an amendment to the constitution (Dickens 1976, 241). The amendment, commonly known as the *Morgentaler Amendment*,

prevents appeal courts from nullifying a jury verdict. It was ratified, and Morgentaler was released from his incarceration eight months early, but not before he reentered court on new charges.

In 1975, while still in prison, Morgentaler was charged with performing an illegal abortion. The defence once again used the defence of necessity, drawing attention to the difficult and occasionally impossible nature of receiving TAC approval in a timely manner. While the jury was instructed that the defence of necessity could not be used, they promptly returned with a verdict of not guilty. The prosecution once again appealed the ruling but was denied. The Court of Appeal upheld the lower court's verdict, this time finding evidence for the use of necessity as a defence (Dickens 1976, 241).

The decision on behalf of the appeal court to allow for the defence of necessity led then Federal Minister of Justice Ronald Basford to set aside Morgentaler's 1973 conviction, and a re-trial was ordered. The jury once again voted to acquit Morgentaler (1975). The next year (1976), shortly after his release from jail, Morgentaler was charged again and had to return to court. A jury once again found him not guilty.

Following Morgentaler's third acquittal, the Parti Quebecois took power in Quebec and promised not to pursue further legal action against him. This action effectively legalized abortion in Quebec. The procedure was not only legalized but also funded, with the exception of funding for clinic fees.³³

In 1976, in the wake of the Quebec Morgentaler trials and under pressure from "consistent organizing and lobbying by feminists", the Minister of Justice created a Committee on the Operation of the Abortion Law (Rebick 2005, 157). The goal of the committee was to

33. Quebec's refusal to fund clinic abortions is discussed in detail in chapter four.

report on whether “the procedure provided in the Criminal Code for obtaining therapeutic abortions [was] operating equitably across Canada” (Badgely 1977, 17). The committee’s report, commonly known as the *Badgely Report* after its chair Dr. Robin Badgely, was submitted the following year. Their findings vindicated Morgentaler’s portrayal of TACs in court, demonstrating that “the procedures set out for the operation of the Abortion Law [were] not working equitably across Canada” (ibid., 17). Specifically they found that, in almost every aspect dealing with induced abortion which was reviewed by the Committee, there was considerable confusion, unclear standards, or social inequity involved with the procedure. In addition to the terms of the law, a variety of provincial regulations governed the establishment of hospital therapeutic abortion committees, and there was a diverse interpretation of the indications for this procedure by hospital boards and the medical profession. The result was extreme disparity in access to services and delays in obtaining the procedure, as well as women going to the United States to terminate their unwanted pregnancies. The report made apparent what feminists had been aware of since the law was implemented, namely, that “in some parts of Canada the liberalized abortion law was a dead letter.”³⁴

While issues of rights and morality were not central to the Morgentaler cases, which like the previous modifications to Canada’s abortion regulations were fought on medicalized grounds, they nonetheless spurred public discussion of abortion. The feminist movement influenced the nature of the discourse using a rights framework, which saw abortion as necessary to women’s bodily autonomy. Indeed, it was in response to the growing influence of the rights frame that the anti-choice movement began to mobilize. Before this period, the anti-choice movement was virtually non-existent, with those opposed to the procedure largely sated by

34. Carol White, [pseud.] (Prominent feminist legal scholar and former social activist, more than ten years). Interview by author. 8 June 2010. Recorded and transcribed by author. Canada.

existing criminal restrictions on abortion and limited medical intervention. When it became apparent that legal challenges to abortion were successful, if not in a strictly legal sense then in the social and political responses to them, a backlash was triggered. At issue was not merely the belief that abortion was immoral, but that its availability would corrupt women and threaten the sanctity of the family; in essence, traditional understandings of social reproduction were at risk. Control over reproduction signaled a shift in social relations, which could easily influence other power relationships and disrupt the patriarchal social order. The emerging power of these frames would only become more apparent as the battle for improved access to abortion services raged on.

Expanding Westward

Despite his Supreme Court loss, Morgentaler had made a great deal of progress in Quebec and decided to expand his practice to meet demand outside the province. In 1983, Morgentaler opened an abortion clinic in Toronto alongside doctors Leslie Smoling and Robert Scott, and another clinic in Winnipeg, also with the help of Dr. Scott. According to Ellen Kruger, founder of the Manitoba CARAL (Canadian Abortion Rights Action League), “Henry came here [to Winnipeg] because we had an NDP government” (Rebick 2005, 164). Despite the more favourable political climate, the clinic was raided a total of three times (once in 1983 and twice in 1985) (National Abortion Federation 2010 [hereinafter cited as NAF]). The pro-choice movement expected then Attorney General Roland Penner to intervene, but he claimed that he “could not interfere with the role of the police” (ibid., 165). Penner refused to involve himself despite the disturbing manner in which the raids were carried out. Kruger recounted witnessing a raid, explaining that “there was the horror of them parading seven women out and arresting them, women who had just had abortions, three of them still in recovery. It was horrible, horrible” (ibid.).

Meanwhile, the Toronto clinic was likewise raided in 1983 and Drs. Morgentaler, Scott, and Smoling were charged. The doctors employed the same defence previously used by Morgentaler in Quebec, challenging “the constitutional validity of s. 251 of the Criminal Code” (NAF 2010). As in Quebec, the jury refused to convict the doctors and they were acquitted.³⁵

Following the trial, the Ontario Attorney General appealed the verdict but, in the interim, the clinic reopened. In 1985, the Ontario Court of Appeal set aside the acquittal and ordered a re-trial. The doctors appealed the decision to the Supreme Court of Canada. In response, the province promised “not [to] seek to shut down the Toronto Clinic while the appeal was pending” (NAF 2010).

Dr. Scott opened a second Toronto clinic in 1986 while the appeal was still pending. The clinic was raided and new charges were laid against Scott as well as against Morgentaler and their colleague Dr. Colodny, but the case was stayed by the Attorney General pending the Supreme Court appeal. The charges were eventually dropped in 1987 before the preceding case made it to the Supreme Court.

The Supreme Court agreed to hear the appeal of Drs. Morgentaler, Smoling and Scott. This was Morgentaler’s second appearance in the Supreme Court to fight the constitutionality of section 251 of the Criminal Code, but this time new tools were at his disposal.

R v Morgentaler (1988)

When Morgentaler entered the Supreme Court for the second time, the *Charter of Rights and Freedoms* (1982) had been newly implemented by the Trudeau administration. The *Charter* guaranteed extensive individual rights to Canadian citizens, dramatically changing the tools

35. Later that same year (1983), an arsonist attacked the Toronto clinic. While the clinic was not irreparably damaged by this attack and reopened in 1984, the women’s bookstore housed in the same building was “seriously damaged” (NAF 2010; Pelrine 1983, 221).

available to the women's movement to secure change. It is important to note here that these changes were hard won, as the original *Charter* was not designed with women's equality at the forefront. Feminist groups mobilized to ensure that the wording of the *Charter* would be favourable to women's interests. They successfully had the wording of section 15 changed from "non discrimination" to "equality rights" in order to "emphasize that equality means something more than non-discrimination" (Morton 1992, 111). They were less successful in altering the wording of sections 7 and 12. Section 7 guarantees that "[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice," while section 12 guarantees that "[e]veryone has the right not to be subjected to any cruel and unusual treatment or punishment" (Department of Justice 1982). Despite lobbying to have "everyone" changed to "every person" to ensure that fetal rights could not be read in the above women's rights, the section was not changed. The Canadian Abortion Right Action League (CARAL) opposed the final draft of the *Charter* because it has the potential to threaten women's rights to access abortion (Morton 1992,112).

Despite these shortcomings, never before had individual rights had such force in Canadian policies. The process of integrating these rights into existing Canadian laws, however, despite its ratification, was not immediate, and different sections came into force at different times. As a result, Morgentaler did not have every section at his disposal, but he had to act quickly as competing challenges were emerging.³⁶

The criminal charge that eventually led to the landmark *R v Morgentaler* originated in

36. Joe Borowski, an anti-choice activist seeking legal protections for fetal rights, was effectively racing Morgentaler to try his case before the Supreme Court first. Morgentaler was able to try his case more than a year before Borowski though. Interestingly, it was actually the Tremblay v Daigle case, which entered court in 1989 that addressed the limits of the Morgentaler decision that ultimately rendered Borowski's case moot when it entered the Supreme Court only a few months later.

Toronto following the arrest of Drs. Morgentaler, Smoling, and Scott in 1983. This case reached the Supreme Court in 1986, but the only legal tools available to Morgentaler were those already in effect at the time of the original charge. According to a prominent legal scholar, Carol White, while the *Charter* was entrenched in 1982, section 15 “did not come into force until three years after that, 1985, so the only section of the *Charter* that was available at the time of the Morgentaler case was section 7” (Interview.). Morgentaler went ahead with the section 7 defence. A similar clause had been successfully used in the United States’ landmark *Roe v Wade* case, which legalized abortion under certain parameters in 1973. Using this defence, Morgentaler argued that the requirement that a woman must seek permission from a therapeutic abortion committee before having access to a legal abortion violated her security of person through “[s]tate interference with bodily integrity” and through the increased risk that “any unnecessary delay” could have on both “physical and emotional well-being.”³⁷ While the Court agreed, finding that the constitutionally guaranteed right to privacy and personal liberty included women, they stopped short of acknowledging women’s full bodily autonomy.³⁸

The Court found that women’s interests were in competition with the state’s interest in the fetus. While a woman’s privacy was guaranteed in her first trimester, in “the second and third trimesters, the state would demonstrate an increasing ‘compelling interest’ in regulating abortion procedures, based on the mother’s health in the second trimester and that of the fetus in the third” (Haussman 2005, 47).

37. *R. v Morgentaler*. [1988] 1 SCR 30. (Can) at 35–36.

38. For more information on issues of privacy and the courts, see Catherine MacKinnon’s book *Toward a Feminist Theory of the State*. In it, she highlights the tensions between state conceptions of the public and private spheres, arguing that privacy protection “translates traditional liberal values into the rhetoric of individual rights as a means of subordinating those rights to specific social imperatives” (MacKinnon 1989, 187). For MacKinnon, abortion is fundamentally a question of the “social and political inequality of the sexes” (1989, 189). She argues that privacy is an insufficient lens through which to understand abortion because it ignores the role of the state in other aspects of women’s oppression; it purports to be gender neutral in a deeply gendered reality.

The Court's decision, which was split 5–2, did hint at considerations of an equality frame, but never so strongly as to validate these claims. Justices Brian Dickson and Antonio Lamer famously wrote that, “[f]orcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman’s body and thus a violation of security of the person.”³⁹ Justice Wilson further stated that “[T]reating them [women] as means to an end,” means “depriving them of their ‘essential humanity.’”⁴⁰

While the ruling struck down the existing abortion law, it also reinforced the apparent legitimacy of outside interests in women’s bodies. In response, Gavigan, a prominent legal scholar at Osgoode, warned that the *Morgentaler* decision “was fragile, incomplete and contradictory” (1992, 126). The ruling validated the interest of the state in the fetus and “invited Parliament to limit women’s access to abortion (and indeed other medical procedures) in the later stages of pregnancy” (ibid., 126–127).

For many, *Morgentaler*’s success signified the final victory for the pro-choice movement, guaranteeing Canadian women the inalienable right to control their reproduction.⁴¹ Unfortunately, it soon became apparent that legality was not tantamount to access. The ruling in *R v Morgentaler* invited the Legislature to respond with new legislation and the Mulroney government immediately obliged.

The Mulroney Administration

The only attempt by a government to implement a new law on abortion following its

39. *R. v Morgentaler*. [1988] 1 SCR 30. (Can) at 3.

40. *R. v Morgentaler*. [1988] 1 SCR 30. (Can) at 12.

41. Dr. Morgentaler was awarded the Order of Canada in 2008, Canada’s highest civilian honour, for “his commitment to increased healthcare options for women, his determined efforts to influence Canadian public policy and his leadership in humanist and civil liberties organizations” (Governor General of Canada 2008, 10).

decriminalization was by the Mulroney administration. In power at the time of the *Morgentaler* decision, the government sought to recreate some criminal restrictions on abortion in 1989, with the Prime Minister announcing “on the day of the decision that the federal government would not leave this dimension of Canadian life unregulated” (Brodie 1992, 64).

In his first attempt to begin the process of creating a new bill to regulate abortion, it became clear to Mulroney that his caucus was divided, and so he announced that “a new abortion law, like the capital punishment issue before it, would be put to a free vote in the House of Commons” (ibid., 67). This decision meant that the MPs would be allowed to vote “according to their conscience” and this was a “tacit admission on the part of the government that abortion was a moral issue to be decided by individual conscience” (ibid.).

In order to deal with the contentious issue “as painlessly and quietly as possible,” the government suggested the adoption of a new procedure:

...a complex motion which would have the MPs vote on the abortion issue in three stages. The first stage would be to debate a motion that would suspend the normal rules of debate and create special rules for this subject. If the motion was adopted, MPs would then vote on a three-option abortion resolution. The options were to take a moderately pro-choice route, which the government preferred, to be entirely pro-choice, or to be moderately antiabortion. After the vote was tallied, the government would draft legislation expressing the most popular of the three options. (Gray 1988, 327–328)

The proposed legislation, which would have been at the heart of this debate, favoured “a gestational approach in which access to abortion would be relatively free during early pregnancy and more restrictive later” (Brodie 1992, 68). It also contained two “contradictory amendments,” one prioritizing fetal rights, and the other women’s rights (ibid.). This strategy was met with

immediate resistance from the House, which believed it was a “threat to Canadian parliamentary democracy,” and which subsequently “refused the government the unanimous consent it required to introduce its motion and follow the unconventional procedure” (ibid.).

The next attempt at introducing legislation occurred later in the summer of 1988 when the government, rather than introduce new legislation, opted to take the pulse of the House by once again introducing its restricted abortion bill, but without amendments, to allow MPs “to air their views and to introduce their own amendments” (ibid., 69). The speeches that followed demonstrated a strong division based on party lines. Conservative MPs delivered the majority of anti-choice speeches (ibid.). In the end, there was no agreement in the House. The pro-choice MPs were not satisfied with serious restrictions on the procedure, while the anti-choice MPs felt the restrictions did not go far enough; the bill and all five amendments were voted down (Brodie 1992, 87).

While the Mulroney government had not made its last attempt at creating a new abortion law, “the events of the summer of 1989,” which included two crucial legal decisions, namely *Tremblay v Daigle* and *Borowski v Canada*, put increasing pressure on them to pass a new law (ibid., 96).

Testing the Limits of the *Morgentaler* Decision (1988)

Immediately following the decriminalization of abortion in Canada, the limitations of the decision were tested in court. The most pressing issues for the anti-choice movement were the extent of men’s rights over their potential future offspring and fetal rights. The first case addressing these issues to enter the Supreme Court was *Tremblay v Daigle*.

Following the *Morgentaler* decision, men in four provinces (British Columbia, Manitoba, Ontario, and Quebec) attempted to get injunctions against their pregnant former partners to

prevent them from accessing legal abortion services.⁴² Of the three, only two injunctions were granted and only one went to court. The case of Jean-Guy Tremblay and his former girlfriend, Chantal Daigle, was widely followed and changed the course of abortion regulation in Canada.

The case originated in Quebec in 1989 when Tremblay was granted an interlocutory injunction to prevent his former girlfriend, Daigle, from accessing a legal abortion. He sought the injunction on the basis that “under Quebec law a foetus has a right to life and a potential father has a right of veto over a woman’s decision to have an abortion” (Greschner 1990, 656). These claims were based on his own interpretations, and were not explicitly stated in either the Quebec or Canadian *Charter*. Injunctions are intended only to ensure “substantive rights and neither the right to life of the foetus nor the potential father’s rights could be found in Quebec legislation,” meaning that the granting of the injunction itself was not explicitly legal (ibid., 656–657).

To the horror of the feminist movement, the Quebec lower court found in Tremblay’s favour, ruling that “‘a foetus is a ‘human being’ under the Quebec *Charter of Human Rights and Freedoms* and therefore enjoys a ‘right to life’ under s. 1” and that this right should prevail over those guaranteed to the woman under the *Charter*.⁴³ Daigle appealed her case all the way to the Supreme Court, but, while the Court agreed to hear the case, the time elapsed since the beginning of the injunction continued to push her unwanted pregnancy along, adding to the potential risk associated with a termination. Daigle decided to travel to the United States to access an abortion before the trial was over. Despite her actions effectively rendering the Court’s decision in her particular case moot, the Supreme Court decided to rule on the case “in order to resolve the important legal issue raised so that the situation of women in the position in which Ms. Daigle

42. *Murphy v Dodd*. [1989] 63 D.L.R. (4th) 515. (Can.); *Diamond v Hirsch*. [1989] M.J. 377. (Can.); *D.D. v VF.* [2001] 94 B.C.L.R. (3d) 191. (Can.).

43. *Tremblay v Daigle*. [1989] 2. SCR 530. (Can) at III.

found herself could be clarified”.⁴⁴

Daigle’s defence was rooted in the “irreparable psychological and moral harm” she felt that continuing her pregnancy would have.⁴⁵ She felt that Tremblay’s sole motivation in pursuing the case was to “maintain his hold” over her.⁴⁶ She wished never to see him again and had no desire to raise a child in a violent environment. The Supreme Court accepted her argument and ruled in her favour, overturning the rulings of the lower courts. They found that the Quebec *Charter* “does not display any clear intention on the part of its framers to consider the status of a foetus” and that, “if the legislature had wished to accord a foetus the right to life, it is unlikely that it would have left the protection of this right in such an uncertain state.”⁴⁷ It was this landmark case that found that the fetus has no legal status in Canada.

Attempts to control women’s bodies through litigation were not limited to women wishing to terminate their pregnancies. The rights of women choosing to carry their pregnancies to term have also been in dispute. The case of a pregnant Manitoban woman with a drug addiction is perhaps the most infamous. In *Winnipeg Child and Family Services (Northwest Area) v D.F.G. (1997)*, the group in question was seeking legal backing to allow them to incarcerate a woman against her will during her pregnancy to prevent her from potentially endangering her fetus. The Supreme Court ultimately ruled that, “an addicted woman could not be detained against her will in order to protect the health interests of her fetus” (Kaposy and Downie 2010, 300).

The difficulties in criminalizing any aspect of pregnancy, including its voluntary termination, come to the forefront in the above cases. Problematic interpretation of choice and autonomy are present in each case, exemplified by the notion that women must forfeit their

44. Tremblay v Daigle. [1989] 2. SCR. 530. (Can) at 45.

45. Ibid. at 10.

46. Ibid. at 10.

47. Tremblay v Daigle. [1989] 2. SCR. 530. (Can). at 3.

autonomy as soon as they become pregnant, regardless of whether or not they want to carry the pregnancy to term. These troubling understandings of women's place in society demonstrate deeply rooted views of women's roles and the fear associated with their equality. The reality of backlash against women's rights is clearly illustrated by the man who served as the figurehead for fetal rights in Canada: Joe Borowski.

Borowski

When Morgentaler was in court with the Ontario government, in the early stages of the case that would decriminalize abortion in Canada, an anti-choice activist named Joe Borowski, a former MPP and MP for the NDP, was in a Saskatchewan court arguing for public standing to challenge Canada's abortion regulations. Borowski felt the therapeutic abortion committees created by Trudeau's 1969 Criminal Code amendment were too lenient because, he argued, the fetus has a "right to life."⁴⁸ His case was shifted between courts, due to uncertainty about which court should be trying the case, and was appealed numerous times. The case was eventually appealed to the Supreme Court in 1981—but not to try the case itself; rather, Borowski had to appeal to the highest Court in an attempt to secure standing.

The issue of standing was central to his case, as Borowski, neither a woman nor a doctor, was not directly affected by abortion policies in any sense. In a surprise ruling, the Court found, with a vote of seven to two, that Borowski did have standing. Justice Ronald Martland found, in his ruling for the majority, that Borowski could bring the case forward on the grounds that those who were directly affected by it (i.e. women, physicians, and hospitals) were unlikely to challenge a law that protected them from criminal sanctions (Morton 1992, 102). Justice Martland also found, forecasting cases like that of *Tremblay v Daigle*, that the partners of women

48. Borowski v Canada (Minister of Justice). [1980] 5 WWR 283. (Can) at 2.

seeking abortions would not be able to make it through the court system before, through abortion or birth, their claims were rendered moot, and that a fetus, whom the defendant argued was the most interested party, could not speak for itself (ibid.). The dissenting opinion of Chief Justice Bora Laskin regarding Borowski's standing was that, "mere distaste has never been a ground upon which to seek the assistance of a court."⁴⁹

With his standing officially approved, Borowski's case was promptly retried. The lower courts dismissed his claims and, once again, his case was appealed all the way to the Supreme Court. His appeal reached the Court in 1989, but they refused to hear his case on the grounds that the *Tremblay v Daigle* ruling rendered it moot.⁵⁰

Borowski's case, had it been tried by the Supreme Court, could have significantly changed the landscape of abortion in Canada today. The fact that the case was not tried was simply a matter of fortunate timing—rooted as it was in one man's black and white view of society, which, disturbingly, is reflective of the views held by many members of the anti-choice movement even today. Borowski saw fetuses as highly vulnerable, innocent members of society, and as the ultimate underdogs—a simplistic view rooted in moralistic language which, unsurprisingly, he also applied to women. One particular memo he sent to members of his Ministry staff exemplifies his undeveloped and sexist views of morality and women. He urged his staff members not to contribute to an organization that funded clinics:

'We are being asked to be accomplice in this medieval act of barbarism,' read the memo, by 'forcing our doctors and nurses to commit murder... so a handful of cheap, third-rate tramps (and also some good women) can escape the consequences of their actions.'

(quoted in Morton 1992, 65–66)

49. *Borowski v Canada (Minister of Justice)*. [1981] 2 SCR 575. (Can) at 4.

50. *Borowski v Canada (Attorney General)*. [1989] 1 SCR 342. (Can).

When the Court ruled that fetal rights had no legal standing in Canada, and the moralistic claims of Borowski were not granted the federal stage, the pro-choice movement breathed a sigh of relief, even though these victories were hard won and by no means complete. The losses for the anti-choice movement were, however, devastating. The Court's failure to recognize moral claims and their reaffirmation of women's autonomy were seen as threatening the foundations of Canadian society. The pressure on the Mulroney government to create a new abortion law to restrict women's rights, and to engage with the anti-choice language in a way that the courts were increasingly unwilling to, was mounting.

Bill C-43

In the wake of the Supreme Court's latest rulings, the Conservative caucus set to work on the creation of a new abortion bill—one that they hoped would represent “the party's pro-choice, moderate, and pro-life factions” (Brodie 1992, 97). Unfortunately, any nuance in the legislation, including the use of varying restrictions by gestational age, pleased no one, and was particularly problematic for those who held that “life began at conception” (ibid.). *Bill C-43*, which was presented by the government on 3 November 1989, was met with resistance from all sides (ibid., 98). The *Bill* would once again ban abortion in the Criminal Code, but with exceptions to allow doctors to perform abortions at their discretion should they determine that the woman's health, defined loosely as her “physical, mental and psychological health,” was compromised because of the pregnancy (ibid., 98). In sum, these changes would have “recriminalized abortion unless procedures were performed by a doctor and the life and/or health of the mother were threatened” (Overby, Tatalovich, and Studlar 1988, 383).

On its second reading, cabinet MPs were required to side with the party to pass the bill, while backbenchers were allowed a free vote. The *Bill* passed with a vote of 164–114 and went to committee (Brodie 1988, 99). Despite vehement protest from pro-choice and anti-choice

advocates, the committee was pressured not to alter the *Bill* and threaten the balance it struck between meeting the “requirements of the Morgentaler decision and the state’s interest in protecting the foetus” (Brodie 1992, 107–108). On its third and final reading on 29 May 1990, the *Bill* passed with a vote of 140 to 131 (ibid., 109–110).

Bill C-43 moved on to the Senate for its final vetting. In the meantime, abortion providers across Canada began to resign in preparation for the impending criminal sanctions they might face. The predictions of the pro-choice movement, “that the mere threat of criminal prosecution would deter many doctors from performing abortions and thereby cause needless delays as well as denying access to women in many regions of the country,” were beginning to manifest themselves (ibid., 111). While anti-choice groups had “remained silent” on the impact of this new bill on doctors, during committee hearings “they now readily admitted that they would try to persuade women, like-minded doctors, and ordinary citizens to lay charges against doctors performing abortions” (ibid., 112). Their actions challenged the assurances made by then Justice Minister Kim Campbell that the law would not impact physicians (ibid.).

While previous challenges to abortion laws in Canada had sided with the medical community, the increasingly powerful pro- and anti-choice social movements forced legislation to conform to further demands. The views of the latter two groups were however, irreconcilable, and the result was a law that no one was satisfied with since it was rooted in a multiplicity of views regarding women’s place in society.

After more hearings and deeply troubling reports of the impact the *Bill*, not yet passed, was already having on access, it went to a Senate vote on 31 January 1991 (ibid., 115). The Senate, still deeply divided on the legislation, tied with a vote of 43 to 43, which constituted a defeat (ibid.). This monumental decision made *Bill C-43* “the first government bill that the

Senate had defeated in thirty years” (ibid.).

The government made no further moves to present a new bill. Victory was declared by both the pro- and anti-choice movements. While the anti-choice movement felt the defeat provided them with a clean slate “to bring forth good legislation that will protect the *pre-born* child” the pro-choice movement saw its defeat as “an affirmation of women’s rights” (ibid. 116; emphasis mine). Since the Mulroney administration’s attempt to find a compromise on an issue which both pro- and anti-choice groups understood as a matter of life and death, no government has attempted to engage with the abortion debate, at least not overtly. Over time, this inaction has solidified the functionality of the status quo and rendered any future attempts at legislating restrictions to the procedure difficult. No government has wished to risk their mass appeal by attempting to engage with such a deeply divisive issue. Still, the anti-choice movement has not been silenced by the change in climate; rather, they have changed tactics from overt offence to stealth.

In the decades following the *Morgentaler* decision, the belief that abortion is a woman’s right has grown (Herman 1994, 268; EI 2010, 6). Access to abortion services is legal and, in many areas, widely accessible. The normalization of these services has come, in large part, from the policy vacuum surrounding the issue, which allowed discourse on the issue to be structured by the feminist movement. The view that abortion is an equality right, necessary to women’s citizenship, is widespread, but by no means secure. The backlash against abortion rights is still going strong—it has simply moved underground.

Unable to attack women’s equality rights head on, anti-abortion advocates have attempted to change the tone of the conversation on abortion, pushing for a moral framework which recognizes fetal rights in an effort to render women’s bodies and rights invisible in the

discussion. Overt attacks on the morality of women and their place in society have largely disappeared from the debate, which is now fought almost exclusively on the grounds of fetal rights. Anti-choice activity in the federal government, which gained momentum when Mulroney was in power, continues through the so-called *pro-life caucus*.

Anti-Choice Caucus

MPs like Keith Martin (Reform Party), Garru Breitkreuz (Conservative), and Ken Epp (Conservative) were all part of the original group known as the *pro-life caucus*. This group was originally organized by Progressive Conservative (PC) MPs following the party's 1984 election victory with a view to protecting "the right to life of a child" (Farney 2009, 247). The caucus held weekly meetings, which were attended by approximately "12 to 15 back-bench MPs"; notably, all of the members were male (ibid.). MPs who took pro-life stances claimed to do so because "they were fathers" (ibid.). The caucus has since expanded to include members of both the Conservative and Liberal parties, though its exact composition is unclear because it remains a secretive organization. The New Democratic Party (NDP) and the Bloc Quebecois (BQ) run on platforms of choice, and do not have any known members in the caucus (New Democratic Party 2011; Bloc Quebecois 2008).

Both pro- and anti-choice organizations have attempted to monitor who might be part of this caucus. A list of anti-choice MPs composed by the Abortion Rights Coalition of Canada in 2011 identifies a total of 106 overtly anti-choice MPs, up from 100 following the 2006 election (Abortion Rights Coalition of Canada 2006b [hereinafter cited as ARCC]). Anti-choice MPs are defined as those who "had an anti-choice voting record, or had publicly spoken at or attended events organized by anti-choice groups, or had publicly stated they are 'pro-life' or would support abortion only in limited circumstances" (ibid.). MPs who stated an anti-choice stance but said they "would not vote to restrict abortion," and those with uncertain stances, do not appear on

the list (ibid.). Despite these attempts at identification, an anti-choice stance does not necessarily signify membership in the caucus so these numbers remain speculative.

While no government has since attempted to legislate the procedure, there have been forty-two attempts by backbenchers to introduce bills since 1988, meant to restrict or recriminalize abortion (ARCC 2010b).⁵¹ None of these motions passed, but their content is demonstrative of deeply problematic views of women and the nature of their decisions (ibid.).

Many bills overtly challenged the decriminalization of abortion, but carefully avoided the language of women's rights, focusing instead on fetal rights. In April of 2002, Conservative MP Garry Breitkreuz called for a new definition of "'human being' in the Criminal Code to see if the law needs to be amended to provide protection to fetuses and to designate a fetus/embryo as a human being" (Bennett 2008, 58).⁵² Overt attempts at establishing fetal rights were also made in March 2004 and November 2007 by Conservative MPs Garry Breitkreuz and Ken Epp respectively (ibid.). Both acts would have made it "an offence to injure, cause the death of or attempt to cause the death of a child before or during its birth while committing or attempting to commit an offence against the mother" (Parliament of Canada 2007). These proposals did not take into account the status of women during their pregnancies. Notably, Epp's so-named *Unborn Victims of Crime Act*, did not protect women from violence while pregnant, which is a serious concern, particularly in domestic violence situations. Moreover, there is no evidence that such legislation would have "any deterrent or beneficial effect" in terms of violent acts (ARCC 2008). Identical legislation in the USA has been opposed on the grounds that it is "a flawed response to violence against women" (Mans 2003–2004, 304–305).

51. See appendix G for a complete list.

52. This challenge has arisen once again as motion M-312, which asks Parliament to convene a committee to study the definition of human life in the Criminal Code, it goes to vote in Parliament in the fall of 2012 (Parliament of Canada 2012).

Other bills attempted to criminalize the behaviour of pregnant women. In 1997, Reform MP Keith Martin proposed a bill that would have imposed criminal charges against pregnant women for fetal endangerment if their lifestyle choices had a negative impact on their fetus (ex: alcohol abuse, drug use) (Bennett 2008, 58).⁵³ Once again, this bill did not engage with the real choices of women or the consequences of monitoring their behaviour during pregnancy. Any such attempt would interfere with women attempting to receive help for drug and alcohol addictions, for example, who might then be forced underground or risk criminal sanction. Moreover, such a bill would encourage a culture of surveillance and, once again, threaten the autonomy of women, give new rights to the fetus, and challenge the status of abortion in Canada.

While the pro-life caucus is composed of individuals from multiple parties, the anti-choice movement itself has strong ties with the Conservative Party. Indeed, the pro-life caucus is overwhelmingly made up of Conservative MPs. The treatment of abortion as an apolitical issue is a longstanding tactic of Conservative parties, often linked to social conservatism, though James Farney explains that this is not an accurate depiction. The treatment of abortion by Conservatives, “during the late 1960s to the early 1990s,” he explains, “while deeply conservative—was not *socially* conservative, as the term is now understood” (2009, 243). By this, he means that Conservatives have not accepted social issues as political questions—rather, they are consistently portrayed as moral issues. Social conservatism, according to Farney, “accepts that the personal has become politicized and seeks to use political means to promote traditionalist notions of correct sexual behavior and family structure” (ibid.). The Conservatives

53. Keith Martin has since changed parties, defecting to the Liberal Party in 2004. He has also changed his views on abortion access and become a pro-choice advocate. Notably, he pushed for the inclusion of abortion in the G8 maternal health-care initiative stating that, “People here [in Canada] are perplexed and wondering why Canada is rolling back the clock and depriving women in developing countries from having the same rights to basic health care and access to abortion as women in Canada” (CBC News. “How the abortion debate has reared its head in Parliament.” April 26, 2012.).

have certainly attempted to depoliticize abortion to a large degree through the denial of a citizenship rights frame on the issue, adopting a moral framework instead, which has its roots in traditional framings of women. The impact of the regulation of abortion on women's status is considered secondary to the enforcement of certain individual belief systems, if it is considered at all.

Abortion has been largely ignored in federal politics since Mulroney, and the status quo of a policy vacuum maintained; but the issue has once again begun to surface in the Harper government. Efforts to de-politicize abortion and reframe it as a moral issue are apparent in the treatment of the issue by many in the Harper administration. While Harper himself has spoken out about his desire to avoid the abortion issue in favour of other pursuits, individuals in the Conservative caucus have continued to raise the topic of abortion; importantly, both the actions of individual anti-choice representatives and the inaction of his administration threaten the hard fought framing of abortion as a rights issue in Canada. The empowerment felt by the anti-choice movements is evidence of this shift.

The Harper Administration

In his bid to become Prime Minister, and during his subsequent years in office, Stephen Harper has consistently reiterated his vow "that a Conservative government will never endorse anti-abortion legislation while he is in power".⁵⁴ In doing so, he has attempted to distance his administration from conflicts associated with social conservatism that could cost him power. Despite his tactics, controversy has continued to plague his administration and the nature of his government's approach to women's reproductive health has come under repeated attack.

In June of 2010, Canada played host to the G8 summit, an annual meeting of world

54. Andrew Mayeda, and Althia Raj. 2011. "Harper vows not to reopen abortion debate as prime minister." *The National Post*, April 21.

leaders, representing eight of the world's most powerful economies, to discuss prominent economic and political issues. The Harper administration announced its plans to take up the focus of past summits on "Maternal, Newborn and Child Health" in developing countries (Harper 2011). Exactly what was meant by *maternal health* was not made explicitly clear, and specifically, it was not evident whether or not abortion would be included in this definition. Pressure for the government to clarify their stance on abortion increased when Foreign Affairs Minister Lawrence Cannon claimed that the initiative did "not deal in any way, shape or form with family planning." He further explained, "the purpose of this [initiative] is to be able to save lives".⁵⁵ Public outcry followed from the Canadian public, many of whom, embracing a rights frame, take issues of reproductive freedom for granted. In response, Harper made attempts at damage control, stating that the government "would not be 'closing doors against any options, including contraception'".⁵⁶ Despite such vague assurances, the government eventually adopted the definition of the World Health Organization (WHO), which defines maternal health as "the health of women during pregnancy, childbirth and the postpartum period" (WHO 2012). While this definition does not explicitly list contraception and abortion services, they are by no means precluded by it. In fact, the World Health Organization lists "unsafe abortion" as one of the major direct causes of maternal morbidity and mortality (ibid.).

Despite Harper's assurances that his government supports women's health and rights issues, his Conservatives have not included abortion in either category. This deliberate omission is demonstrative of their attempts to depoliticize the procedure, denying its categorization as a rights issue. The strength of this backlash is apparent. Representatives of international aid groups

55. Clark Campbell. "Birth Control Won't be in G8 Plan to Protection Mothers, Tories Say." *The Globe and Mail*, March 17, 2010.

56. CBC News. "No Abortion in Canada's G8 Maternal Health Plan." April 26, 2010.

who showed up in Ottawa in the weeks preceding the G8, for example, were warned by Conservative Senator Nancy Ruth to “Shut the fuck up on [abortion]” lest there be more backlash against women’s groups.⁵⁷ Ruth, a woman that Michelle Robidoux, manager of the Ontario Coalition of Abortion Clinics describes as “a pro-choice Senator who people relied on as a kind of an ally,” claims to have meant these comments to be helpful, not as a threat, citing an insider’s understanding of the politics surrounding the issue in the Conservative Party caucus (Interview.).⁵⁸ However, the idea that the best way to ensure protection of existing rights is through the “the silencing of anybody who disagrees with the government” is a disturbing trend (Robidoux, Interview.).

Perhaps the most notable case in recent years is that of Conservative MP Brad Trost, who was recorded speaking to a Saskatchewan anti-choice organization congratulating them on their part in cutting funding to International Planned Parenthood (IPP).⁵⁹ The group had been awaiting news of their funding for over a year and assumed that it been “cut off” (ibid.). The day after the story broke in the media, Dimitri Soudas, Director of Communications for the Conservative party, in an effort to avoid backlash, announced that the government would, in fact, be funding the organization, though they were awarded only \$6 million of the proposed \$18 million dollar grant (ibid.).⁶⁰ Moreover, Soudas was clear that abortion was not part of the government’s “funding criteria,” meaning that the organization can only work in countries with Canadian funds where abortion is highly restricted or illegal.⁶¹ Thus, the Harper administration has clearly continued to push anti-choice and anti-women’s policies quietly, backtracking only when

57. Susan Delacourt. “Aid groups advised to ‘shut the f--- up’ on abortion.” *The Star* [Toronto, ON], May 3, 2010.

58. Ibid.

59. CBC News. “Tories defunding Planned Parenthood, MP says.” April 20, 2011.

60. Laura Payton. “Planned Parenthood’s Canadian funding renewed.” *CBC News*, September 22, 2011.

61. Ibid.

exposed. It is this careful approach, which accounts for backlash and attempts to placate groups with small victories while openly working to challenge women's rights, that has so many worried.

Numerous interviewees expressed concern about the use of stealth tactics by the Harper administration. Abby Lippman, a Professor of Epidemiology at McGill University, has conducted research into reproductive technologies. She explained that, “[Harper has] certainly already shown his muscle in not funding groups that are pro-access, pro-choice, whether they are in Canada or outside of Canada”.⁶² Specifically, she noted the “whittling away at the funding of groups that are progressive in all ways” (ibid.). This trend of removing the foundational institutions supporting women's rights seems to be part of a process of setting the stage for more dramatic change, possibly with the eventual goal of some degree of recriminalization of abortion. Catherine Megill, a former abortion clinic employee in both Canada and the United States, working towards a degree in medicine at McGill University at the time of the interview, echoed these views. She explained that, “what they have been able to do by cutting funding to groups will do a lot more [than an overt attack on abortion]”.⁶³

These cases demonstrate the impossibility of the Harper administration's alleged neutrality on abortion; the assertion that his government will not attempt to recriminalize the procedure is not tantamount to neutrality, as the realization of abortion access necessitates active support. Views on abortion exist on a spectrum, with the anti-choice (no abortions for anyone) at one extreme and a non-existent pro-abortion stance (mandatory abortions for all) at the other,

62. Abby Lippman (Professor of Epidemiology, Biostatistics and Occupational Health at McGill University, years unknown, and member of the Canadian Women's Health Network's Expert Review and Advisory Committee, years unknown). Interview by author. 16 January 2011. Recorded and transcribed by author. Montreal, Quebec.

63. Catherine Megill (Medical Student, years unknown, founder of Haven, years unknown, and former abortion clinic employee in Canada and the United states, years unknown). Interview by author. 12 June 2011. Recorded and transcribed by author. Montreal, Quebec.

with pro-choice views taking up the middle of the spectrum. Moreover, access to abortion services requires funding and political support because the withholding of either compromises women's autonomy. Thus, the failure to challenge violations of the *Canada Health Act*, the removal of funding from local and international aid agencies, and a failure to acknowledge the importance of abortion for women's citizenship rights cannot be constructed as neutrality—rather, they are demonstrative of a backlash against women's hard-won rights to bodily autonomy.⁶⁴

Robidoux stressed that anti-choice groups “have access to this [the Harper] government in a way that they probably have not had for some time in previous governments” (Interview.). Indeed, the empowerment felt by anti-choice groups and individuals because of the Harper administration was repeatedly noted in interviews completed for this study. In the context of the G8 summit, a representative of the FQPN (*la Fédération du Québec pour le planning des naissances*)⁶⁵ related the story of Cardinal Marc Ouellet, who was quoted in reference to a discussion of abortion in the case of rape saying “there is already a victim [the woman], must there be another one [the foetus]?”⁶⁶ Marilyn Ross, a representative of FQPN interviewed for this study, suggested that, “the reason he felt comfortable talking so publicly about it was that he sensed an opening in Ottawa that he had never sensed before.”⁶⁷ Under Harper, anti-choice sentiment has been allowed to flourish, and while the Conservative Party does not have a monopoly on this viewpoint, as is evidenced by the members of the pro-life caucus, they are nevertheless one of its most powerful backers.

64. The *Canada Health Act* is premised on five central pillars: public administration, comprehensiveness, universality, portability, and accessibility. Denying funding to abortion services in clinics is thus a direct violation of the Act.

65. The English translation of their title is The Quebec Federation for Planned Pregnancy.

66. CBC News. “Cardinal's Abortion Remarks Anger Politicians.” May 17, 2010.

67. Marilyn Ross [pseud.] (Representative of *la Fédération du Québec pour le planning des naissances*, years unknown). Interview by author. 12 May 2011. Recorded and transcribed by author. Montreal, Quebec.

Conclusion

Resurgence in anti-choice sentiment in federal parliamentary politics, manifesting itself through a politics of backlash, continues to pose a real threat to women's equal citizenship. Politicians utilizing a moral frame of abortion have worked hard to recreate Canada's historic ban on abortion access. They have not, however, done so using the same justifications with which these laws were originally implemented. Rather than a desire to preserve the authority of physicians, the anti-choice movement seeks to restrict women's autonomy in order to preserve a traditional, patriarchal social order, which has long oppressed women. To this end, the political nature of abortion rights are denied in favour of a moral frame of the issue, which naturalizes women's primary roles as wives and mothers.

These regressive understandings of women's citizenship, championed by the anti-choice movement, have been able to take root in the absence of formal protections for women's rights. Politicians have been able to deny women's rights to bodily autonomy because they have never been formally acknowledged. Importantly, the policy vacuum that still surrounds abortion access in Canada has not only created opportunities for the anti-choice movement to influence abortion policy, it has also created the same opportunities for the pro-choice movement to promote their belief that abortion is a woman's right, and they have done so with greater success. Much of the Canadian public has come to widely acknowledge the right to abortion as necessary to women's equality. The prevalence of this belief is made apparent through the difficulties the federal government has faced in attempting to implement any anti-choice laws.

Despite the public consensus on abortion as a woman's right, this chapter has attempted to demonstrate the continued instability inherent in the policy vacuum that now surrounds abortion. The continued prevalence of the moral frame demonstrates the fragility of women's abortion rights. If women are to be equal members of Canadian society, their bodily autonomy

must be guaranteed; its treatment as a controversial, hot button issue, to either be avoided or subverted quietly, showcases the continued power of the moral frame. Without formal recognition by the federal government that access to abortion services is a right of women's citizenship, women's rights will continue to be unprotected, subject to the whims of sitting governments. While the policy vacuum around abortion has given the rights frame in Canada room to grow, it is now crucial to entrench these rights to ensure their universal applicability, thereby recognizing women as full Canadian citizens. Indeed, the consequences of failing to recognize women's rights to abortion access have already begun to manifest in the provinces, where a woman's citizenship varies dramatically depending on her home province.

Chapter 4. Political and Legal Responses to *R v Morgentaler* (1988) in the Provinces: Along a Spectrum of Citizenship

We had a sense even before the Morgentaler decision came down that the provinces were going to be exploring ways to limit access and constrain women's choices. (White, Interview.)

When abortion was decriminalized in Canada following the *R v Morgentaler* decision it fell to the provinces, as a health care issue, to regulate. The responses of provincial governments to their new authority over the procedure were not, however, in keeping with abortion's new status as a clear-cut medical issue. Provincial responses largely echoed the sentiments of the ongoing pro- versus anti-choice debate—some demonstrating a deep commitment to the moral frame, effectively trying to recriminalize the procedure by blocking access. Others took a more rights-based approach, one province even going so far as to publicly state that abortion is a rights issue. Even provinces that attempted to avoid taking a stance on the potentially divisive issue have had to contend with resistance from social movements and the medical profession in the implementation of their policies, demonstrating the impossibility of neutrality on issues of women's citizenship.

Widespread attempts to restrict abortion access immediately following the *Morgentaler* decision would not have seemed as extreme a response then as they are today. The rights frame was still relatively new for many Canadians in the late eighties, and the realities of legal abortion not yet known. Many provinces attempted to restrict the procedure in response to the federal government's failure to do so, to fill the policy vacuum. As the majority of these policies were subsequently struck down in court, however, sentiments began to change. Attempts by individuals seeking validation of fetal and fatherhood rights kept the issue active in public discourse. The stories brought publicly forward in these cases, and the increasingly obvious benefits of the decriminalization of abortion to women's rights and health, over time began to

strengthen the rights frame in Canada. It is not surprising that the provinces originally reacted to the decriminalization of abortion by attempting to create new restrictions for the procedure; it is, however, shocking that some of these reactionary policies are still in place today.

Using case studies of New Brunswick, Ontario, and Quebec, this chapter explores the interplay between provincial governments and the courts in their regulation of abortion. Specifically, it focuses on the adoption of, or failure to adopt, a rights frame, which understands abortion as a right of women's citizenship. Where such a frame is not apparent, the chapter investigates manifestations of anti-feminist backlash, in order to assess the motivations and tactics of groups attempting to de-politicize abortion.

The three provinces in question all reacted in markedly different ways to the *Morgentaler* decision. Of the three, the response from the New Brunswick government was most in keeping with a moral understanding of abortion. There, the government moved to restrict their healthcare regulations dealing with abortion, by restricting the facilities in which legal abortions could be performed in anticipation of an impending court case by Dr. Morgentaler, long before Morgentaler entered the Supreme Court for the second time. The province also refused to change these regulations even after abortion was decriminalized in Canada. Since 1988, New Brunswick has been the site of multiple legal battles challenging their regressive regulation of abortion, as well as attempted federal interventions and even an ongoing human rights inquiry. The strength of backlash in the provincial government is evident in the way politicians justify their activities, through the use of strong moral language, and through their responses to those attempting to dispute their authority to treat abortion as a moral question. The continuing struggle between those advocating for pro-choice policies and those defending anti-choice values has meant a long and complex legal and political history in the province. As such, the case study of New

Brunswick is notably longer than those of the other two provinces, which had more moderate responses to the *Morgentaler* decision. The New Brunswick government's consistent efforts to challenge women's rights to equal citizenship, denying the existence of rights to abortion access at every turn, also mean the province effectively falls off the citizenship spectrum.

Ontario was one of only a few provinces not to restrict abortion services following *Morgentaler*'s landmark victory.⁶⁸ Indeed, the provincial government attempted to avoid any engagement with the pro- versus anti-choice debate, treating abortion as a simple healthcare issue wherever possible. Legal activity on abortion in the province has been rare since *Morgentaler*, and attitudes towards the procedure in politics have remained largely neutral. Interestingly, Ontarians are generally less attuned to their province's decisions regarding the regulation of abortion, and are more concerned about the actions of the Harper government. Attempts by the provincial government to distance itself from the abortion issue have created an atmosphere in which the status quo is assumed to be stable, and attitudes towards abortion are largely ambivalent. In this atmosphere, despite reasonably high levels of access, at least in urban areas, women may have access to services, but their citizenship rights remain vulnerable. If the government continues to avoid the issue because it is deemed controversial, women's rights are likewise being presented as such, and understood as exceptional rather than foundational. This hesitancy on the part of the Ontario government, which has largely still erred on the side of improved services, means the province falls fairly in the high-mid range of the citizenship spectrum.

Quebec, which also maintained funding for abortions after the *Morgentaler* decision, has done so with an actively pro-choice agenda. Having already effectively decriminalized abortion

68. Ontario and Quebec were the only provinces not to limit or withdraw financial support "for abortion under public health insurance schemes" (Erdman 2007, 1094).

in 1976, when the provincial government announced that it would stop pursuing action against abortion providers, attitudes in the province had more time to shift.⁶⁹ The commitment to a rights frame in the province has continued to grow, and its government's actions reflect this commitment; in 2010, the National Assembly of Quebec affirmed "the rights of women to freedom of choice and to free and accessible abortion services," in an attempt to encourage the federal government to do the same.⁷⁰ The commitment of the National Assembly of Quebec to women's rights places the province high on the citizenship spectrum, because women not only have excellent access to abortion services, but they also have consistently had these rights reaffirmed and safeguarded by their government.

This chapter draws attention to the instability in abortion access resulting from the failure of the federal government to recognize abortion as an issue of women's citizenship rights. Without an enforceable right to access, women experience their citizenship differently across the country; while some provinces have worked hard to realize equality by treating abortion as a rights issue, others have effectively recriminalized the procedure by blocking access. By examining the interactions between the provincial government and the courts in each province, this chapter highlights the way abortion is understood and treated in the existing policy vacuum. The three case studies are addressed in the order in which they fall on the spectrum of citizenship access, from lowest to highest: New Brunswick, Ontario, and Quebec.

New Brunswick: Falling off the Spectrum

Evidence of anti-feminist backlash was apparent in New Brunswick even in the years leading up to the *Morgentaler* decision of 1988. The potential realization of increased reproductive freedom for women was enough to spur politicians into action. Indeed, the

69. For a more complete discussion of *Morgentaler*'s previous legal action in Quebec, see chapter 3.

70. Hansard Parliamentary Debates. National Assembly of Quebec. (19 May 2010).

government of Richard Hatfield (Progressive Conservative) moved to alter New Brunswick policy to restrict abortion services before the *Morgentaler* case had reached the Supreme Court. The province's historical and current embrace of a moral frame of abortion access denies women the right of equal citizenship—thus treating women as second class citizens.

Unlike Ontario and Quebec, New Brunswick was not home to an abortion clinic before 1988, though Morgentaler did make his intent to open one known. In 1985, Morgentaler sent a letter to the legislative assembly, notifying the province of his intent to set up a clinic in the province. In response, then Premier Hatfield amended the province's *Medical Act* to provide that “physicians could be found guilty of professional misconduct if they were involved in performing an abortion elsewhere than in a hospital approved by the Minister of Health” (Dunsmuir 1989). While abortions at this time were still illegal in Canada, unless first approved by a Therapeutic Abortion Committee, this change to the provincial *Act* empowered the provincial government to remove Morgentaler's license if he attempted to open and practice in a private clinic in the province. By so doing, they would be able to interrupt his practice rather than having to wait for a hearing concerning Morgentaler's breach of the Criminal Code, which provincial precedent from Ontario and Quebec suggested would only legitimize his attempts to challenge the provision.

While these actions suggested strong backlash against women's rights in the Progressive Conservative Party, Alison Brewer, former Leader of the New Brunswick New Democratic Party, saw this actions as highly strategic, but not necessarily demonstrative of anti-choice views by Hatfield himself. She explains:

Hatfield had created a hole in the legislation you could drive a truck through... Hatfield was a smart man and a lawyer and he had recorded in Hansard that he was setting up a

bill against the Morgentaler clinic. You cannot set up a piece of legislation that is directed at one person and Hatfield would have known that but, at the same time, he was a political animal and he was pandering to a certain portion of the electorate.⁷¹

Shortly after this amendment was entrenched, abortion was decriminalized in the Supreme Court, and jurisdiction over the procedure shifted to the provinces. Dr. Morgentaler swiftly launched a legal challenge to the province's 1985 regulation. The way in which the provincial government chose to deal with this, as well as with subsequent litigation, is demonstrative of the manifestation of new anti-choice strategies.

Morgentaler's first challenge to the New Brunswick government occurred in 1989, less than a year after his Supreme Court victory, when he sought reimbursement for performing abortions on three New Brunswick women in his Quebec clinic. At the time, there was no formal legislation regulating the performance of abortions by doctors outside of the province. The only legislation in place was Hatfield's 1985 amendment restricting the performance of abortions outside registered hospital facilities upon pain of professional misconduct. Morgentaler argued that he should be reimbursed under New Brunswick Medicare for his services because the policies in place restricting abortion access did not explicitly apply to services rendered outside the province.⁷²

The newly formed McKenna government, like the Hatfield government before it, also resisted the creation of improved access to abortion services.⁷³ The government asserted that, despite Morgentaler's claims, they did indeed have a policy in place restricting the classification

71. Alison Brewer (former leader of the New Brunswick New Democratic Party, 2005-2006 and former Director of the Fredericton Morgentaler Clinic, 1993-1999). Interview by author. 30 January 2011. Recorded via Skype and transcribed by author. Halifax, Nova Scotia.

72. *Morgentaler v New Brunswick (Attorney General)*. [1989] 98 NBR (2d) 45. (Can).

73. Interestingly, when McKenna opposed the creation of an abortion clinic by Morgentaler, he was in the exceptional position of having an entirely Liberal legislature. The only other province ever to experience single party dominance in a legislature was Prince Edward Island in 1935 when the Liberal Party won all 30 seats.

of abortion as an entitled service under Medicare: “unless it is determined by two doctors to be medically required and is performed by a specialist in an approved hospital.”⁷⁴ While this policy was in effect, the government was forced to concede that the policy was not legally defensible because it was never formally adopted “under the Act deeming an abortion not to be an entitled service.”⁷⁵ The court explained that “[w]hether such a regulation would be valid cannot be determined unless and until it is made.”⁷⁶ Moreover, the existing regulation in the *Medical Act* was found to have “no application to members of the profession in other provinces.”⁷⁷ As such, the policy was declared invalid for doctors practicing outside of the province.

Rather than appealing the decision, the government moved to fill the legal loophole in their policy. In 1989, the McKenna administration made an amendment to the *Medical Services Payment Act*, which mimicked the policy successfully challenged by Morgentaler. Abortion was included in Regulation 84-20 under the *Medical Services Payment Act* as an unentitled service, save under certain circumstances:

unless the abortion is performed by a specialist in the field of obstetrics and gynaecology in a hospital facility approved by the jurisdiction in which the hospital facility is located and two medical practitioners certify in writing that the abortion was medically required.
(Government of New Brunswick 1984, 38)

This amendment gave the province control over the policy found insufficient by the court. According to former Liberal MLA James Lockyer:

The objective [of the amendment] is to give proper regulatory authority to the existing policy of the government of New Brunswick. These regulations will ensure that the

74. *Morgentaler v New Brunswick (Attorney General)*. [1989] 98 NBR (2d) 45. (Can) at 4.

75. *Morgentaler v New Brunswick (Attorney General)*. [1989] 98 NBR (2d) 9. (Can).

76. *Ibid.*

77. *Ibid.* at 15.

conditions under which payment is made for services provided within New Brunswick will be the same as for payment for service provided to New Brunswick residents outside the province.⁷⁸

This restriction is still in place over two decades later. Indeed, there is significant resistance to altering it in the political sphere, though this opposition is often masked in the denial that women face undue barriers as a result of the amendment. Brewer explained that the government's officials have been "always quite disingenuous in their responses to abortion access in the province" suggesting that there is no need for a clinic so long as "abortions are being performed in at least one hospital" regardless of the hospital's ability to meet demand (Interview.). Interviewee Rosella Melanson, former Executive Director of the New Brunswick Advisory Council on the Status of Women, which was dismantled in March 2011, also commented on the unwillingness of the government to discuss abortion access, explaining that, in response to any suggestions made by the NB Advisory Council on the Status of Women, the most they were told was that the government was "satisfied with the policy" as it stood.⁷⁹

Despite the outwardly anti-choice actions of both the Hatfield and subsequent McKenna government, the creation of new regulations by the McKenna administration was viewed in a different light than Hatfield's amendment, in no small part due to McKenna's public declarations of opposition to Morgentaler. McKenna was singled out as an anti-choice figurehead by interviewees, rather than a politician simply pandering to an anti-choice legislature. When questioned about the motivation for his administration's actions, Brewer suggested that they were based on both his personal convictions and those of his party: "I think it was personal. I

78. Hansard Parliamentary Debates. Legislative Assembly of New Brunswick. (5 May 1989).

79. Rosella Melanson (Former Executive Director of the New Brunswick Advisory Council on the Status of Women, 2001-2011). Interview by author. 10 January 2011. Recorded and transcribed by author. Fredericton, New Brunswick.

think it was his religious beliefs clashing with the issues” (Interview.). Brewer also noted the large contingent of anti-choice MLAs in the House, whose vocalizations would only become more pronounced when Morgentaler resolved to open an abortion clinic in the province’s capital city of Fredericton.

When Morgentaler did eventually set up a freestanding clinic in the province in 1994, six years following the decriminalization of the procedure, Premier Frank McKenna (1987–1997) threatened him with “the fight of his life.”⁸⁰ Other MLAs supported this declaration. Then Progressive Conservative MLA Brent Taylor, for example, spoke about his own participation in an anti-choice protest:

We who did go to that march were there to tell all of New Brunswick about our attachment to the rights of the unborn child. We quietly marched in front of the proposed site of the clinic, of the abortuary, and we then dispersed peacefully. I hope our witness there on Saturday will, at the very least, help give other members of this House and of the government the courage that they may lack as they prepare to join in the battle for the sake of the unborn child.⁸¹

His use of anti-choice language, including inflammatory terms manufactured by the movement, such as “abortuary,” and his willingness to demonstrate in front of a medical facility, showcase the depth of his commitment to blocking abortion access. His words and actions come from one who holds a position of political power, as a representative of the New Brunswick people. Moreover, while his beliefs are certainly not universally held within the assembly, they demonstrate a clear dismissal of women’s citizenships claims and the vulnerability of women’s rights against backlash.

80. Hansard Parliamentary Debates. Legislative Assembly of New Brunswick. (22 February 1994).

81. Hansard Parliamentary Debates. Legislative Assembly of New Brunswick. (22 February 1994).

Other members of the Legislative assembly also made no attempts to conceal their personal opposition to abortion and the denial of the rights frame. MLA George Jenkins (Liberal) was clear that he would oppose abortion even if he were alone in this viewpoint. He explained: “to me, abortion involves an absolute moral value” and went on to say that “in debate on moral issues the judgment supersedes interests, be they political or otherwise.”⁸² Thus, he understood his personal convictions as outweighing the interests of women, and he was not alone in this view.

Public displays of the government’s vocal anti-choice contingent have sent a clear message to pro-choice groups not to push for advances in policy. Even the position of Minister for the Status of Women (a position no longer in existence, since the office was defunded in 2011) is known to have been filled by an anti-choice MLA.⁸³ This barrier was particularly serious as this was the minister whose job it was to act as the main vehicle to advance discussions of gender issues in the Legislature. This barrier has meant that, among others, the New Brunswick Advisory Council on the Status of Women could not “really take a pro-choice stance to the governmental table if their own Minister in charge is anti-choice” (ibid.). The strategic placement of anti-choice MLAs has prevented the normal “counter balance” within politics and further stifled criticism of existing policies (ibid.).

Despite resistance from the Legislature, Morgentaler’s clinic did eventually open. The McKenna government responded immediately, invoking Hatfield’s 1985 amendment the day the clinic opened, thereby forcing the clinic to close and pressuring the New Brunswick College of Physicians and Surgeons to suspend Morgentaler’s license, which they promptly did.

82. Hansard Parliamentary Debates. Legislative Assembly of New Brunswick. (2 December 1993).

83. Dr. Jula Hughes (Professor of Law at the University of New Brunswick, 2006-Present). Interview by author. 17 January 2011. Recorded and transcribed by author. Fredericton, New Brunswick.

Predictably, Morgentaler immediately challenged the constitutionality of the amendment.

Later that same year, Morgentaler took the New Brunswick government to court. The Court of Queen's Bench, taking into consideration the fact that the amendment in question dated from a point in time when abortion was considered a criminal offence, ruled that the amendment was unconstitutional.⁸⁴ The ruling stated that the creation of the amendment was not in the interest of ensuring the highest quality of care for women in the province, but that it was designed to "prohibit the establishment of free-standing abortion clinics and, particularly, the establishment of such a clinic by Dr. Morgentaler."⁸⁵ The decision was "upheld on appeal to the New Brunswick Court of Appeal, and leave to appeal to the Supreme Court of Canada was denied" (Richer 2008, 8). Morgentaler's license was reinstated and his clinic was permitted to remain open. The regulation was removed, but as far as the government was concerned, it was not the only one on the books: McKenna's amendment to the *Medical Services Payment Act* was still in effect.

In 2002, Morgentaler made a public statement in which he accused the New Brunswick government "of being sexist, male chauvinists [and] of victimizing and oppressing women" (quoted in Moulton 2003, 700). He went on to assert that, through their continued failure to pay for all abortion services, "the New Brunswick government has been saving money on the misery of women" (ibid.). In response, then Justice Minister Brad Green expressed his confidence in the government's position and his willingness to defend it "as far as the Supreme Court of Canada" (ibid.). Morgentaler officially filed his case in 2003, appearing in court in July of 2004.

Morgentaler sued the Government of New Brunswick again, this time challenging its funding restrictions within the province on the grounds that their amendment to the *Medical*

84. *Morgentaler v New Brunswick*. [1994] 117 DLR (4th) 753. (Can).

85. *Ibid.* at 44.

Services Payment Act was unconstitutional.⁸⁶ Specifically, he argued that the *Act* “violates rights guaranteed by sections 7 and 15 of the *Canadian Charter of Rights and Freedoms*.”⁸⁷ His use of a rights frame was apparent in the nature of his challenge as well as in the statements he released prior to undertaking the case, but the government and anti-choice groups worked to ensure that his rights challenge would not be heard in court. They seemed aware that they could not win a straightforward court case against Morgentaler so, instead of preparing their defence, they attempted to stall the case. Dr. Jula Hughes, Professor of Law at the University of New Brunswick, explains:

The provincial government know perfectly well that they have not got a legal case, so they do what governments sometimes do when they do not have a legal case they throw their litigation resources at delaying it, in this case with the evil intention of waiting for Dr. Morgentaler to die, or for him to run out of money, and I do not have a lot of sympathy for that. It seems to me that, if the government has a case, why not put it forward and be done with it? (Interview.)

The government’s delay tactics became apparent as the case continued.

In 2004, the Coalition for Life⁸⁸ applied for intervenor status in the Morgentaler case.⁸⁹

They were denied on the grounds that they have “no more direct interest in issues pleaded than

86. In 2009, once the standing issues in the case had been resolved, Morgentaler elaborated on his case, arguing that the *Act* “erects a barrier to abortion services that violates rights guaranteed to women under s. 7 (“Life, Liberty and Security of Person”) and s. 15 (“Equality”) of the *Canadian Charter of Rights and Freedoms*.” He also challenged the amendment as “inconsistent with, and in violation of the *Canada Health Act*” because the province was not providing services, which were “an integral component of women’s necessary reproductive-related health care” (*Morgentaler v New Brunswick*. [2009] 306 DLR (4th) 679. (Can).).

87. *Morgentaler v New Brunswick*. [2004] 49 CPC (5th) 134. (Can) at 27.

88. The Coalition for Life is composed of eight groups: New Brunswick Right to Life Association Inc., Roman Catholic Diocese of Saint John, Focus on the Family (Canada), REAL Women of Canada, Canadian Physicians for Life, Catholic Civil Rights League, Christian Legal Fellowship of Canada, and Evangelical Fellowship of Canada.

89. *Morgentaler v New Brunswick*. [2004] 49 CPC (5th) 134. (Can).

any other taxpayer and demonstrated no special expertise not otherwise available.”⁹⁰ The Coalition for Life appealed the case in 2005, but the verdict held. They were subsequently denied leave to appeal to the Supreme Court.

In 2008, the province challenged Morgentaler’s standing to bring the case forward, arguing that a woman bringing such a case forward would be “a more effective way of bringing the issue to the Court.”⁹¹ In response, the court argued that, “although there are persons who are more directly affected by the legislation than he, these persons for a variety of reasons are unlikely or unable to challenge it.”⁹² The court looked to precedent set in other cases involving vulnerable populations, stating in its ruling: “There are many valid reasons why women who have had abortions at the Fredericton Clinic would not or could not bring this challenge. Dr. Morgentaler is therefore a suitable alternative person to do so.”⁹³ Morgentaler was subsequently granted public interest standing.

The government appealed this decision in 2009, but the verdict was upheld.⁹⁴ Since then, the government has taken no action on this case and it has not moved forward. It appears that the case has quietly come to a close, likely due to Morgentaler’s advanced age and failing health. If Morgentaler was too unwell to continue the case, it would have to be begun again from scratch. The government was aware of Morgentaler’s poor health, and many interviewees in the province suggested that they employed delaying tactics to drag the case out until he was too ill to continue. The government’s reluctance to engage with the accusations Morgentaler was attempting to bring forward, namely that their policies are unconstitutional because they operate

90. *Morgentaler v New Brunswick*. [2004] 49 CPC (5th) 134. (Can) at 17.

91. *Morgentaler v New Brunswick*. [2008] 295 DLR (4th) 694. (Can) at 18.

92. *Ibid.* at 19.

93. *Ibid.* at 26.

94. *Morgentaler v New Brunswick*. [2009] 306 DLR (4th) 679. (Can).

contrary to women's rights and the *Canada Health Act*, was not unique to this case; they also failed to engage with similar criticism a few years earlier, when the federal government disputed the legitimacy of their policies.

In 2005, the federal government made its own attempt to intervene in the province's regulation of abortion. Then Federal Health Minister Ujjal Dosanjh (Liberal) initiated a dispute avoidance resolution (DAR) action against the province concerning their refusal to "reimburse the cost of abortions carried out in private clinics" (Eggertson 2005, 862). DAR was a process created in 2002 meant to resolve "disputes related to the interpretation of the principles of the *Canada Health Act*" (Health Canada 2010a, 169). This process is launched in the event of disagreements relating to the application of the *Canada Health Act* by the different levels of government. The process begins with "government-to-government fact-finding negotiations" which can be taken over by a third party upon the request of either the federal or provincial Minister of Health, although the "final authority to interpret and enforce the *Canada Health Act*" falls to the federal minister (ibid.). In the event that the levels of government cannot come to an agreement relating to the issue in question, the non-compliance provisions of the *Act* can come into effect. Non-compliance can result in a "deduction from federal transfer payments under the CHT [*Canada Health Transfer*]" proportional to the "gravity of the default" (ibid., 6).

The response from the New Brunswick government, then under the leadership of Bernard Lord (Progressive Conservative), was not conducive to productive negotiations. Indeed, Judy Burwell recalls the difficulties faced by the federal government in their dealings with the province, explaining that "the New Brunswick government was just the most arrogant... they wouldn't return calls, they just ignored them, because they know they can."⁹⁵ Then New

95. Judy Burwell (former Director of the Fredericton Morgentaler Clinic, years unknown). Interview by author. 24

Brunswick Minister of Health Elvy Robichaud (Progressive Conservative) publicly stated that the provincial government would not “bow to pressure” from the federal Liberals.⁹⁶ The province failed to comply with the fact-finding component of DAR, and Dosanjh said he would appoint a third party panel. Before any resolution could be achieved, however, a Federal election took place and the Federal Liberals lost to Harper’s Conservatives. The new Conservative Minister of Health Tony Clement, appeared “reluctant to continue [the] dispute resolution process with New Brunswick” and soon announced: “the federal government does not intend to pursue the matter of abortion funding at the NB clinic” stating that the “issue is ‘off the radar’” (ARCC 2007, 3). Since then, the incumbent Conservatives have not used DAR to sanction any province restricting abortion access services.

Importantly, challenges to the province’s regulation have not been limited to the courts. In October of 2008, a female doctor, referred to only as A.A. for her protection, filed a complaint with the New Brunswick Human Rights Commission.⁹⁷ The complaint was twofold: first, it alleged sex discrimination with respect to her ability to provide patient care as a female physician “who regularly provides primary care services for adolescents and young adults, including sexual health services,” due to the “procedural hoops” she must contend with to help her patients access funded care.⁹⁸ Regulation 84-20 forces physicians to provide services which are not in keeping with the Canadian Medical Association’s position on abortion, which suggest that there “be no delay in the provision of abortion services” and, most importantly, that “induced abortion should be uniformly available to all women in Canada” (CMA 1988, 2).

January 2011. Recorded and transcribed by author. Fredericton, New Brunswick.

96. Don Richardson. “N.B. stands firm on abortion policy.” *The Daily Gleaner*, January 30, 2011.

97. New Brunswick Labour and Employment Board. 2011. HR-005-10: A.A. v Province of New Brunswick – Department of Health.

98. *Ibid* at 2.

Central to her claim was her perception that, as a female doctor providing sexual healthcare, she is subject to uniquely negative treatment as a result of the regulation. The second claim centred on sex discrimination by the province on behalf of women seeking pregnancy termination services. A.A. argued that women are “being denied a service on the basis of sex,”⁹⁹ as pregnancy is an inherently gendered issue, and furthermore that the provincial regulations cause “psychological harm.”¹⁰⁰

A preliminary hearing found that A.A. could only proceed on the first complaint, because the *Human Rights Act* only allows individuals from a specific group who are being discriminated against, in this instance women, to bring forward a claim themselves. Because A.A. does not “allege that she is a member of the class of persons who have made a decision to have an abortion,” she cannot represent women in her complaint. Despite the fact that other cases, including *Morgentaler v The Province of New Brunswick* (2009),¹⁰¹ allowed an individual outside of the immediately affected group to act as a representative, on the grounds that it would be difficult for a member of the group in question to bring a case forward, the Board of Inquiry enforcing the *Human Rights Act* is “a creature of statute” and does provide for representative complaints.¹⁰² A.A.’s complaint regarding discrimination she faced as a physician, however, can be considered. Only half of the original claim will now be decided on, though the case has not yet proceeded to a full hearing due to government intervention.

On 2 August 2011, the Province of New Brunswick filed an action against the New Brunswick Labour and Employment Board, the New Brunswick Human Rights Commission,

99. Ibid at 5.

100. Ibid at 3.

101. *Morgentaler v New Brunswick*. [2009] 306 DLR (4th) 679. (Can).

102. New Brunswick Labour and Employment Board. 2011. HR-005-10: A.A. v Province of New Brunswick – Department of Health at 17–18.

and A.A in order to challenge the board's standing to render a decision on the case; the case was heard on 29 March 2011.¹⁰³ Interestingly, the province challenged the Board's authority to rule on either one of A.A.'s original complaints, despite the fact that her claim of discrimination against women was found to be outside of the board's purview to try. In the case that followed, A.A. and the Commission used this platform to argue that both cases should be heard before the Board. While the judge upheld the original finding of the Board on A.A.'s ability to represent women, because the Board does not have the power to grant public interest standing and does not expressly allow for representative claims, she did grant the validity of the Board's involvement in the second claim.¹⁰⁴ While the decision has not yet been officially rendered, even if the court finds in favour of A.A., the case is unlikely to be over yet; given the government's history of avoidance, it is likely that they will continue to appeal the decision to prevent it from being heard as long as possible.

In the event that the case does go through and the regulation is found to be inconsistent with the *Human Rights Act*, according to Dr. Jula Hughes, "that would be the end of that regulation," though the government would still have the ability to create new restrictions. Hughes explains that the major difference between the use of the courts and the Commission is that a publicly funded body would be responsible for ensuring that the government complied with the ruling, rather than placing this burden on a private citizen who would bring the case forward (Interview.).

The success of this case could dramatically change the landscape of abortion access in New Brunswick, though the province still would have power to create new regulations restricting the procedure. The nature of the victory would pose serious problems for the moral frame,

103. Ibid.

104. Ibid. at 18.

however, because a human rights decision necessitates a rights discussion which the government clearly wishes to avoid. To date, the province has attempted to keep challenges to the regulation of abortion access within strictly jurisdictional terms, avoiding the rights debate altogether where possible and choosing to engage with a moral frame to justify their activities in the Legislature and in public statements.

The comfort that MPs have demonstrated in expressing anti-choice views has not changed in the years following the *Morgentaler* decision of 1988. In December of 2004, Liberal MLA Stuart Jamieson asked of the House: “Why are we allowing the rights of mothers to outweigh the rights of that human life inside a womb?”¹⁰⁵ The normalization of such rhetoric demonstrates the dismissal of women’s rights as human rights in the province. Personal belief systems have been allowed to supersede women’s citizenship rights regarding their own bodies. It is apparent that the absence of federal enforcement of abortion as a right of women’s citizenship has allowed moral arguments to justify restrictions to abortion in the province.

Ontario: Citizenship Rights on Precarious Ground

Political and legal activity surrounding abortion access issues in Ontario has been markedly less prevalent than in New Brunswick, effectively ceasing after the 1988 *Morgentaler* decision, but the province’s actions have nonetheless been instrumental in shaping the landscape of abortion access in Canada today. While it has not adopted a clear stance on the issue as a matter of rights, the government’s treatment of the procedure is demonstrative of pro-choice leanings.

The *Morgentaler* decision originated from a legal challenge in Ontario, where

105. Hansard Parliamentary Debates. Legislative Assembly of New Brunswick. (8 December 2004).

Morgentaler opened an illegal clinic in 1983.¹⁰⁶ When the procedure was decriminalized, the response of the Ontario government was not defiant, as in the province of New Brunswick, but compliant. Coverage for abortion services was promptly included in the provincial health insurance program, for both hospital and clinics, and facilities were made available.

While there was a small amount of overt anti-choice sentiment in the Legislature immediately following the *Morgentaler* decision, it has since become a non-issue. Concerns regarding the way abortion is regulated in the province tend to focus on the distribution of services. Interestingly, concerns regarding the future of abortion regulation in the province focus strongly on federal, rather than provincial, politics.

Abortion is not an issue commonly raised in the Ontario Legislature. The only substantive statements on abortion issues in the Legislature came about in response to the *R v Morgentaler* decision (1988) and the *Murphy v Dodd* case (1989), the latter of which was clearly the most inflammatory; both the rights and moral frames were openly used by representatives in these discussions. Members of the Provincial Parliament (MPPs) McClelland and Dietsch, for instance, both spoke out in February of 1988, encouraging the federal government to create new legislation “to provide protection for the unborn,” though these views were not widely expressed in the Legislature.¹⁰⁷

The most impassioned speech in the Legislature was certainly that of MPP R.F. Johnston in response to *Murphy v Dodd* (1989). This case, which was the Ontario equivalent of *Tremblay v Daigle* (1989), concerned an Ontario man, Gregory Murphy, who sought an injunction to prevent his former partner, Barbara Dodd, from getting an abortion. Mr. Murphy claimed to be the undisputed biological father of Ms. Dodd’s fetus, despite his knowledge that she had been

106. See chapter three for more details on this case.

107. Hansard Parliamentary Debates. Legislative Assembly of Ontario. (8 February 1988).

intimate with another man. He also signed a sworn affidavit that he had “conferred with Ms Dodd’s gynecologist who was of the opinion that a ‘third abortion’ could represent a serious risk to [Ms Dodd’s] life’ while ‘a pregnancy did not constitute such a risk to her’” (Shaffer 1993–1994, 59n2). Ms. Dodd subsequently provided “an affidavit from her doctor who swore that the alleged conversation never took place” (ibid.). Ultimately, the case never went to court, as the injunction was found to have been granted on fraudulent grounds, but there was some discussion in the Legislature preceding this dismissal (ibid.).

In response to the court’s decision to grant Murphy an injunction, MPP Johnston stated that it was, “an outrage to women in the province [and], an affront to their sense of autonomy” that “a third-party male should be able to make a decision which would hamper a woman’s right to have an abortion.”¹⁰⁸ He compared the decision to a “reversion to notions of women as chattels.”¹⁰⁹ In response, MPP Dalton McGuinty reiterated the *Morgentaler* decision’s allusion to “the need to achieve the socially imperative balance between the rights and interests of women and the equally important rights and interests of unborn children.”¹¹⁰ While this kind of language draws clear attention to the ongoing rights versus morality debates in provincial legislatures, these statements were neither connected to legislation nor other political activity; they appear as isolated statements. It is apparent that neither a strong rights nor anti-choice position has been pushed in the Ontario Legislature, which continues to remain relatively neutral on these debates, attempting to treat abortion as a straightforward medical question. This approach, however, neither resolves abortion access issues nor successfully achieves neutrality; these issues are

108. Hansard Parliamentary Debates. Legislative Assembly of Ontario. (5 July 1989).

109. Ibid.

110. Hansard Parliamentary Debates. Ontario. (24 July 5 1989).

merely offloaded onto abortion providers and patients.¹¹¹

The greatest political concerns in the province pertaining to abortion access relate to deregulation of services and the enactment of policy at a service level. The actions of the Harris government (Progressive Conservative) in 1995 are a prime example. The government took dramatic steps to curb healthcare spending, delisting many services, particularly those which dealt with quality of life issues (Armstrong and Armstrong 2001).¹¹² There was fear amongst pro-choice advocates that abortion might also be de-listed. The positioning of abortion as a health issue related to lifestyle, rather than foundational to women's citizenship, leaves women's rights vulnerable. Anti-choice groups push for an understanding of abortion as a procedure of convenience, chosen frivolously by women, rather than as a rights issue. In the end, abortion was not cut by the Harris government, but healthcare cuts are a concern that continues to occupy pro-choice activists.

The belief that abortion services in the province are "fragile," has been reinforced by an expert panel on abortion service provision in Ontario, assembled by Echo, an agency of the Ministry of Health and Long-Term Care focusing on women's health (Echo 2011, 2). Due to the shift from a healthcare model relying on hospitals to a model relying on clinics, there is concern that these services and their importance are "poorly understood and [are] dependent upon a relatively small group of providers" (ibid.). Without formal recognition as a women's citizenship right, abortion can be treated like all other healthcare services; if this is the case, its importance to women's rights and the unique barriers women face in accessing services, including anti-choice physicians, harassment, a lack of information, and timelines issues, can be ignored.

The report makes a number of recommendations based on the continuing stigma

111. Shortcomings of a medical understanding of abortion will be discussed in more detail in chapter seven.

112. See chapter seven for further discussion.

associated with the procedure, including improvements to the system of reproductive healthcare designed to increase the quality of services, as well as better training for providers to ensure their “alignment and adherence to [the] ethical and legal obligations” they must meet as healthcare professionals (ibid., 3).

While the abortion services in the province must be guarded against delisting, relegation to limited facilities, and a lack of providers, overall services in the province are quite good relative to the rest of the country. Indeed, the stability of abortion provision in Ontario has meant that individuals within the province have felt that access to abortion services is relatively secure. When interviewees in Ontario articulated their concerns for the future of abortion access in the province, they were most often focused on external threats; namely, the actions of the federal government. Of particular interest was the consistent reference to Prime Minister Harper when interviewees were asked to discuss the political climate, as it relates to abortion, in Ontario. While provincial policies were seen as relatively stable and as protecting existing services, although generally not making attempts to improve delivery, increasingly vocal anti-choice sentiment in the federal government was a real concern.

A representative of Planned Parenthood Toronto interviewed for this study explained that while the organization personally felt relatively secure in the notion that abortion access was “here to stay” in previous years, this view was threatened by the current federal government.¹¹³ “Within the political atmosphere,” she elaborated, “a lot of the political leaders still see it [abortion] as murder and they still see it as wrong. It’s always going to be jeopardized as long as there are people with that mentality running the country” (ibid.). Robidoux, manager of the Ontario Coalition of Abortion Clinics, echoed this sentiment, stating that she believes that the

113. Felicia Wilson [pseud.] (Representative of Planned Parenthood Toronto, years unknown). Interview by authors. 31 March 2011. Recorded and transcribed by author. Toronto, Ontario.

Harper government “has a quite uniform and quite dominant opposition to abortion in their caucus” (Interview.). She drew particular attention to the role of Conservatives in anti-choice legislation, relating that, on recent backbencher bills designed to restrict women’s rights to abortion “the bulk of the people who voted for those laws were Conservatives” (ibid.). Despite the fact that “Conservatives stand out on the political landscape” in terms of anti-choice policies, Robidoux did not express trust in the Liberal party either (ibid.). She explained that, “historically, the laws that existed which restricted abortion were probably in place as long under Liberal governments as they were under Conservative governments,” stressing that she does not “have any great faith that we are protected from such things just by the fact of a Liberal government” (ibid.). She did, however, clarify that, while she had no “confidence that the Liberals have a strong commitment to it [abortion access], in the sense of really fighting for it” the Conservatives are of particular concern because they are “really, really opposed to it” (ibid.).

Thus, the absence of enforceable citizenship rights for women is an ongoing concern in Ontario, despite the absence of any provincial restrictions on the procedure and litigation since *R v Morgentaler*. While the province has not been subject to widespread backlash, it has failed to fully embrace a rights framework, attempting instead to depoliticize abortion by treating it as a healthcare issue. While its policies are far from regressive, without formal recognition of abortion as necessary to women’s citizenship, women’s rights remain vulnerable.

Quebec: Women as Equal Citizens

Quebec has seen more political and legal activity than Ontario concerning the regulation of abortion, both before and after the procedure’s decriminalization. What is notable about its approach following the *Morgentaler* decision, however, is the province’s commitment to a rights frame. The progressive treatment of abortion in Quebec began long before it did in the rest of the country; Quebec was the only province to liberalize their regulation of abortion *before* the

Supreme Court struck down the existing law. The acknowledgment of abortion as a matter of women's rights is evident in all aspects of Quebec society, including in their National Assembly. While some legal and political activity on the subject has taken place since 1988, the result has always been a re-assertion of abortion as necessary to women's citizenship rights.

The majority of legal activity in Quebec relating to abortion access occurred before the *R v Morgentaler* decision.¹¹⁴ Indeed, it was the refusal of Quebec juries to convict Morgentaler that contributed to public acceptance of the assertion that abortion is a woman's right; a belief even more deeply held in the province today. The evolution of this belief is also evident in the political activity of the time.

The Parti Québécois (PQ) was first elected in 1976, the same year Morgentaler was granted his third acquittal for the performance of illegal abortions in Quebec. The new Justice Minister, Marc-André Bédard, wasted no time in granting "immunity to doctors who were qualified to practice abortion," effectively decriminalizing abortion in the province (FQPN and CFC 2010, 15). He claimed to do so on the basis of "jurisprudence that recognized the defense of necessity," the same defence that Morgentaler used when he challenged the regulation of abortion in Quebec courts (*ibid.*). This immunity prevented legal action against doctors "who performed abortions without the consent of a TAC [Therapeutic Abortion Committee] and outside of hospitals," the requirements put into place in 1969 by the federal government which women had to meet before accessing legal abortion services (*ibid.*). Minister Bédard explained that, "the abortion law had become inapplicable, as evidenced by Morgentaler's multiple jury acquittals," and the law could not stand (Desmarais 1999, 142; translated by author). The PQ even went so far as to vote for "free abortions upon request" for Quebecois women at their party

114. Detailed descriptions of these cases can be found in chapter three.

convention, but Premier René Lévesque vetoed the action (ibid.).¹¹⁵

Lévesque was clear that he was “not opposed to abortion.” Indeed, he spoke out the same year his government granted physicians performing abortions immunity in 1976, saying that abortion would “eventually [be] decriminalized,”¹¹⁶ and that it was time to “get out of the dark ages, admit that abortion exists, and start to do something positive in the area”.¹¹⁷ When questioned about his lack of support for the motion, he explained that “public opinion had not been prepared for discussion of the issue” and suggested that he did not wish to be divisive.¹¹⁸ He also pointed to the fact that the Criminal Code fell under federal jurisdiction and his government could not remove the procedure from it (ibid.). It was reported that his opposition to the motion may have been “connected to the government’s planned referendum on Quebec independence” and the need to stress his party’s view that separation was necessary (ibid.).

While the government did not engage further with the abortion issue, when the procedure was decriminalized at the federal level in 1988 little changed in Quebec, as the province had already adjusted its policies following its own legal battles. The lack of political backlash may be due in large part to the dominance of more left leaning parties. Since 1976, the provincial government has shifted between the Liberal party and the Bloc Québécois; no right wing party has held power in Quebec since the Union Nationale lost power in 1970. While the political parties in power are not a clear determinant of political regulation of abortion, as evidenced in New Brunswick, a lack of socially conservative values seems to have contributed to openly pro-choice views in government, which recognize women as full citizens.

The province did come under some serious criticism, however, for its failure to fund

115. The Ottawa Citizen. “But Rene Levesque doesn’t feel bound.” May 30, 1977.

116. Ibid.

117. The Gazette. “Face facts, Levesque says: Update abortion view, MDs told.” May 14, 1976.

118. The Ottawa Citizen. “But Rene Levesque doesn’t feel bound.” May 30, 1977.

abortions performed in private clinics. While the government was not clear on its rationale for restricting funding to clinics, this move is likely in keeping with Quebec's support of more socially-conscious policies. The government may have been attempting to prevent the proliferation of a two-tiered healthcare system, at least to some degree—a cause which has also been central for many feminists. A representative of the FQPN explained that, “there was some division within the movement about whether or not this [the lawsuit victory] was a good thing, whether this was going to lead to a greater privatization of our healthcare system, things of that sort” (Ross, Interview.). In the end, the province's response to a legal challenge to its policies was very much in keeping with an understanding of abortion as a right of women's citizenship.

When abortion was effectively legalized in Quebec in 1973, it was also funded, in most cases. Abortions were covered in hospitals, but limitations were placed on funding in private clinics and women's health centres; women were required to pay the supplementary fees, which ranged from \$40 to \$350 in the early 2000s, when accessing abortions (FQPN and CFC 2010, 32). As increasing numbers of women began accessing services in clinics to avoid the serious wait times in the public sector (of approximately three to four weeks) pressure to fund services in all facilities grew (ibid., 33). In 2006, *L'association pour l'accès à l'avortement* (The Association for Access to Abortion) filed a class action lawsuit against the government of Quebec for their failure to pay these fees in private clinics and women's health centres between 1996 and 2005. Their challenge was successful, and the government was required to reimburse women who were required to pay for their abortions during those nine years (ibid., 32).

Unlike funding cases in other provinces, like New Brunswick, the government did not appeal the decision (ibid.). In total, they were required to pay thirteen million dollars. A program was set up to reimburse women but was generally unsuccessful. Ross explained that “most

people didn't ask for a refund, probably didn't even know that they could or didn't understand exactly how they could go about doing that so most of that money is still left over" (Interview.). In an effort to reach more women, the reimbursement program was reopened in the fall of 2010 until mid-January but much of the money has yet to be claimed (ibid.). Once the exact amount still remaining has been determined, the FQPN has plans to encourage the creation of a special fund with the remaining money. This fund would be used to cover the cost of abortions for women in difficult situations.

The women targeted in the class action suit, who had received abortions between 1996 and 2005, were granted reimbursements, but future Quebecois women were not guaranteed free services. In an effort to address this issue, the Quebec Ministry of Health and Social Services first attempted to "increase the public system's capacity to meet the demand for abortion" through an increase in the number of facilities performing abortions and an increased budget (FQPN and CFC 2010, 34). The intention was to "reimburse abortion services provided in private clinics and at the CSFM [Centre de santé des femmes de Montréal] in cases where the public sector was not able to provide services within a reasonable time" (ibid.).¹¹⁹ A coordination centre was created to guide women seeking first trimester abortions to the appropriate facilities. At the same time, an agreement was negotiated with private clinics and CSFM, which would allow them to provide services covered in full under their provincial health care coverage. When the agreement took effect in January of 2008, women were able to access abortions covered under their health insurance plans at hospitals, clinics, and the CSFM.

Not only did the province take pains to ensure that women would have access to abortion services in future, going beyond the requirements set out by the courts, but unlike other

119. Translation: Women's Health Centre of Montreal.

provincial governments, the National Assembly of Quebec has not remained silent on the issue of abortion. Most recently, the 2010 G8 summit was a catalyst for provincial outrage, for its exclusion of abortion as a maternal health consideration.¹²⁰ In response to the federal government's treatment of abortion, a motion was put forward in the Assembly, which read:

THAT the National Assembly reaffirms the rights of women to freedom of choice and to free and accessible abortion services and asks the federal Government and the Prime Minister of Canada to put an end to the ambiguity that persists in relations to this question; and that the National Assembly reaffirms the fact of supporting the rights of women to an abortion must in no way be adduced by the federal Government as a reason to cut subsidies to women's groups.¹²¹

The motion passed unanimously and received national coverage. This symbolic gesture reaffirmed the pro-choice political climate in Quebec for many, and their adherence to a rights framework to understand the importance of abortion access.

It is perhaps not surprising that Quebeckers expressed more faith in their government to respond progressively to issues relating to reproductive rights than interviewees in New Brunswick and Ontario. For example, a representative of *le conseil du statut de la femme* (The Council for the Status of Women), a Quebec governmental organization which consults on issues of women's equality and rights interviewed for this study, explained that they did not see how the government could have a vision that does not recognize the autonomy of women.¹²² Even those who expressed concern regarding the ease with which the political climate could shift, for example, the dramatic federal win of the New Democratic Party in the province in 2011, seemed

120. See chapter three for a more detailed discussion.

121. Hansard Parliamentary Debates. National Assembly of Quebec. (19 May 2010).

122. Catherine Stettin [pseud.] (Representative of *la Conseil du statut de la femme*, years unknown). Interview by author. 13 June 2011. Written notes. Montreal, Quebec.

optimistic about the outcome. A Quebec clinic representative explained that, despite “everything that has happened [the outcome] has always been positive.”¹²³

This faith, however, was not universally expressed among interviewees. There were also those who felt that the provincial government is opportunistic and does not have the most progressive history when it comes to reproductive health issues. Lippman, Professor of Epidemiology at McGill University, cautioned that, while the provincial government may speak as if they are progressive on reproductive health issues, “in the action plans they are really not” (Interview.). She pointed to the problematic nature of which services are funded and which are not. For example, as of 5 August 2010, Quebec covers the cost of some *in vitro* fertilization (IVF) while women still do not have guaranteed access to midwives (*Santé et Services Sociaux Québec* 2010). Unstable policies surrounding reproduction are still apparent in some situations. While the widespread availability of IVF does contribute to more positive freedom for women to make reproductive choices it does not, Lippman explained, “ensure the kind of attention to determinants of health that do make it possible or not possible for women to have or not have babies” (Interview.). For instance, has the fertility rate dropped? Why? Are women waiting longer to have children? Are there other ways to create choice that allow women more reproductive freedom without medical intervention? Lippman identified the failure to pay attention to these more fundamental questions as a reason to question the government’s intentions. The central question, in short, should be whether or not IVF is “a priority for public funding when you cannot find other kinds of really basic services for women?” (ibid.).

Patrick Powers, former President of the Board of Planned Parenthood Montreal and current member of the Abortion Rights Coalition of Canada, expressed similar distrust of the

123. Suzy Brown [pseud.] (Quebec abortion clinic representative, years unknown). Interview by author. 13 June 2011. Recorded and transcribed by author. Quebec.

government. He explained that even their declaration of solidarity with the pro-choice movement was not the powerful message it has been seen as elsewhere. He explained that, “they would move the other way if the winds blew that way,” suggesting their nature was opportunistic rather than inherently progressive.¹²⁴

More general fears were even expressed by those who expressed trust in the government. A Quebec clinic representative interviewed for this study explained that, despite the large pro-choice movement in the province, the “the rise of the right in the States, [and the subsequent] rise of the right in Canada” could lead to a similar situation in Quebec (Brown, Interview.). As in Ontario, concerns with the federal government’s interference with the regulation of abortion were greater than fears of provincial action. The fear is that “with the rise of the right comes less access for abortion, or less support for abortion rights” (ibid.). Despite these concerns, the general sentiment was that any real anti-choice activity would have to occur at the federal level—and if it did, Quebec would fight it.

When asked to describe the political climate relating to abortion, many of interviewees drew attention to the Harper administration. Some felt strongly that government would attempt to reopen the debate, likely through stealth. Quebec interviewees expressed not only fear that the Harper administration would attempt to restrict abortion federally, but also awareness that his government had already taken action against pro-choice views. While the work of the administration for anti-choice causes seems apparent, the rhetoric of non-interference with abortion has become so prevalent that many of its actions have been ignored.¹²⁵ Interviewees generally recognized the politics of backlash in the Harper government, and suggested that, if his

124. Patrick Powers (Vice-President of the Sexual Health Network of Quebec, years unknown and former President of the Board of Planned Parenthood Montreal, years unknown). Interview by author. 14 February 2011. Recorded and transcribed by author. Montreal, Quebec.

125. See chapter three for a more detailed discussion of anti-feminist backlash in the Harper administration.

government were to take more action on abortion, it would continue to be through the backdoor.

Powers explained that it was unlikely that Harper would reopen the debate, even with a majority government because “he’s realized that it is a political hot potato, it could hurt him in the polls, and he’s a coward. He’s an out and out coward” (Interview.). Powers also said that Harper’s desire to stay in power is stronger than his socially conservative values, especially those that could harm him in the long run. He did, however, note the work that Harper’s administration has done to cut funding of progressive groups in Canada and abroad, even though he feels that, ultimately, “he [Harper] couldn’t touch Canada,” at least not without threatening his position (ibid.). Regardless of the nature of the actions taken by the government, the response from Quebec to any federal actions restricting abortion was made clear, according to a representative of *le Conseil du statut de la femmes*: “We would fight” (Stettin, Interview.).

It is apparent that the Quebec government has adopted a resolutely pro-choice stance on abortion since the mid-1970s, and, while its policies are not always ideal, has worked to achieve progressive change. The rejection of the moral frame in Quebec is strong, and has only been solidified in the decades following the *Morgentaler* decision. As a result, citizens showed widespread trust in the province’s actions relating to abortion when interviewed for this study. Overall, Quebec has recognized women’s equality in a more outspoken and active way than any other province in the country, treating women as full citizens.

Conclusion

The dramatic variation in provincial responses to jurisdiction over abortion reveals the power of the moral and rights frames to influence policy. Moreover, it demonstrates the problems inherent in the assumption that treating abortion as a medical issue can fill the policy vacuum left in the wake of the *Morgentaler* decision of 1988. While abortion itself is a medical procedure, the ability to choose whether or not to carry a pregnancy to term is a deeply personal

decision rooted in social expectations of women and their place in society. To deny women the right to make this choice, under the guise that it is not a political question but a moral one, is an attempt to obscure the power relationships inherent in such a choice—not only those at play during pregnancy and birthing, but also expectations of sacrifice and care roles. Examples of such a politics of backlash, in which the primacy of women’s roles as wives and mothers is stressed and naturalized, are still evident in some Canadian provinces like New Brunswick, reinforcing a view of women as second class citizens. This frame has been able to thrive in a climate of silence in which the topic of abortion, and thus women’s equality, remains taboo. Even provinces like Ontario, that provide abortion services but refuse to adopt a language of rights, threaten women’s equality by positioning issues central to their lives as controversial, fringe issues not worthy of political protections.

Despite the failure of the majority of Canadian provinces to embrace a rights frame, the issue is still considered one of rights in the country at large, at the level of public discourse. Indeed, many Canadians are unaware that access to abortion services varies so dramatically across the country, and may not believe the issue is still important until they, or someone they know, is unable to access the procedure easily. Quebec’s culture of rights has no doubt been a part of this widespread affirmation. While other provinces have attempted to avoid the issue or remove it from political discussions, Quebec remains vocal about the importance of abortion to women’s community membership. By recognizing women’s rights to abortion access in writing in the National Assembly, they took steps towards the formal entrenchment of these rights. Moreover, they reaffirmed the value of women as equal citizens and created a more secure environment in which they can exercise their rights and internalize their value to society.

While the policy vacuum surrounding abortion access in Canada has allowed abortion to

remain legal without criminal restrictions, resulting in the widespread belief that abortion access is a woman's right, it has also created a patchwork of services across the country. These variations in service are the result of provincial governments choosing to embrace either a moral or a rights frame of abortion. The endorsement of one frame above the other has serious implications for the way in which women experience their citizenship. While some Canadian women feel secure in their right to choose, others are treated as if they have no rights to bodily autonomy and are forced to endure degrading treatment, serious financial and bureaucratic barriers, and harassment in the hope of accessing services.

The regulation of abortion in the absence of a clear policy framework has produced a variety of responses, many of which operate with the goal of rescinding women's hard won rights to bodily autonomy. While the lack of regulation has also created room for highly progressive understandings of women's rights, without federal acknowledgment these rights are not universally enforceable. If women are truly equal members of Canadian society, it is time for the federal government to entrench these rights. Absent such a guarantee, this patchwork of services can continue to operate across Canada, in many cases reinforcing outdated beliefs about the role of women in society.

Chapter 5. The Courts in Context: the Case of Abortion Rights in Canada

I've never been persuaded that the route to social justice is through the courts... there isn't a substitute for on the ground organizing and keeping this issue alive front and center. (White, Interview.)

Since the 1998 *R v Morgentaler* decision, in which the Supreme Court struck down Canada's existing abortion law, removing all criminal sanctions on the procedure, litigation has been understood as an important tool to the realization of progressive changes to the regulation of abortion. When the limitations of the decision were subsequently tested in court, claims to fetal and fathers' rights were brought forward; both were subsequently denied. Later, when provinces took over the regulation of abortion as a healthcare issue, litigation shifted to address the roles of provincial governments in limiting access to abortion services. The success of abortion rights cases in the courts since *Morgentaler* has led pro-choice movements to emphasize litigation as a tool to realize women's rights to bodily autonomy. It is therefore important to address the role of the courts in the regulation of abortion in Canada.

The previous two chapters have addressed some of the major court cases in Canada and the provinces with respect to abortion access. This chapter, however, revisits some of these cases in the context of a number of additional cases, to look more specifically at their potential role in the realization of a formal reclassification of abortion access as a right of women's citizenship. More pointedly, it addresses the ways in which engagement with the courts can pose questions of reproductive rights that are incompatible with feminist understandings of the issues. This chapter examines the apparent success of abortion-related litigation in Canada, through the lens of some of the foremost feminist critiques of law, in order to assess the utility of litigation as a channel through which to pursue progressive change to the regulation of abortion in Canada.

This chapter argues, ultimately, that the courts provide an effective venue to secure positive change to the regulation of abortion in Canada, but that legal success cannot be achieved

in isolation. Litigation does not take place in a vacuum, but both informs and is informed by the political and social climates in which it operates. It is thus essential, when evaluating apparent legal successes, not to ignore the contexts in which cases were decided or how they were enforced.

As the argument demonstrates, despite virtually undisputed legal success, court decisions alone do not account for the growing acceptance of abortion as a woman's right in Canada; these advancements must be understood in the context of social movement activism and political activity through which these rights are understood and enforced. The validation of rights claims in the courts is thus only one aspect of a larger social and political rights project. This reality highlights additional avenues feminists have used to ensure that feminist ideals are not lost in the implementation of women's rights, even when they are muted for the sake of legal victories.

The following discussion begins with an overview of some of the dominant feminist critiques of the courts, which focus on issues ranging from the use of language to the myth of neutrality. These challenges will then be used to analyze legal cases that have shaped the nature of abortion access in Canada. Focusing on the strategies employed by Dr. Henry Morgentaler, as well as cases concerning paternal rights, fetal rights, and restrictions on provincial access, this chapter draws attention to the compromises that feminists have had to make in order to engage with the courts and how they understand legal victories and losses. The chapter also draws attention to the social and political climates in which decisions were reached, and their impact on the implementation of the rulings. While the courts continue to provide an effective means to secure positive change to the regulation of abortion in Canada, they cannot do so in isolation. Thus, the realization of women's rights to abortion necessitates legal, as well as political and social recognition; legal decisions alone can neither guarantee nor eliminate women's

reproductive rights.

Feminist Legal Scholarship

An extensive literature addressing the interplay between gender and the law has brought a multitude of feminist legal critiques to the fore, challenging both the theoretical foundations of law and understandings of what constitutes successful litigation. Feminist scholars are divided on the value of litigation as a means through which to secure progressive change; some understand it as an influential strategy, but caution against idealizing the successes it has yielded (Mortin and Allen 2001; Gavigan 1992), while others feel it distorts feminist principles and should be subverted wherever possible (Smart 1989; Greschner 1990). Issues associated with the regulation of reproduction, and specifically regarding the unique challenges posed by abortion and the law, have been central to this scholarship (Gavigan 1992; Smart 1989; Greschner 1990). The liberalization of abortion access through litigation is therefore an area of contention amongst feminist scholars. Some are wary of the use of law as a tool to liberate women when it has been historically instrumental in the oppressions they are challenging, while others, without denying these realities, nonetheless understand the courts as an institution offering real potential for change. Importantly, the relationship of the courts to the feminist movement has not been static. Feminists were originally distrustful of the courts, but changes to the public perception of the legal system, brought on by a major overhaul to the courts' function through the entrenchment of the *Charter of Rights and Freedoms* (1982), created new avenues for positive change. While these changes generated a considerable increase in the volume of feminist litigation cases, it is important not to discount the power of the courts before these changes took hold. A brief historical overview is therefore merited.

Litigation was used as a tool for feminist advancement in Canada long before the *Charter* was entrenched, but substantial rights decisions by courts were few and far between. The courts

dealt largely with jurisdictional issues, and issues of substantive rights, like abortion, were redirected to the political sphere. Successful litigation for feminism was measured more in terms of political and social responses to decisions rather than through the decisions themselves; the original *Morgentaler* cases in Montreal are prime examples.¹²⁶

Morgentaler was charged with performing illegal abortions in his Montreal clinic, in direct violation of Canada's abortion law, but was acquitted in all three cases because no jury would convict him (details of the cases are presented below). When the government announced it would no longer pursue legal action against him in 1976, it was demonstrative of a major political and social victory, rather than a legal triumph. Indeed, the positive changes made to ensure improved abortion access in Quebec were the result of the public discourse spurred by the trial, rather than of the outcome of the trial itself. In a sense, public support for Morgentaler gave women already committed to protecting their reproductive autonomy a stronger voice. Lippman explains:

When I first came here, which was pre-Morgentaler, the Quebec women wanted to be able to have some control over their pregnancies, they just didn't want to have seventeen children, so they knew how to get what they needed and where to go to get what they needed. I think that there was sort of an undercurrent that we just never discussed.

(Interview.)

While the value of public discourse remains, strategies of engagement with the courts, and the manner of measuring legal success, changed dramatically following the entrenchment of the *Charter*. The detailed list of individual rights protections created new avenues to pursue change and, according to Morton and Allen, "no group has been more active in using litigation

126. *R. v Morgentaler*. [1973] Que SC 824, 42 DLR (3d) 424. (Can.); *R. v Morgentaler*. [1975] 64 DLR (3d) 718 (Can.); *R. v Morgentaler*. [1976] 1 SCR 616 (Can).

than organized feminists” (2001, 56). While the courts responded to some rights claims before the *Charter*, its entrenchment signaled what Smith characterizes as a “shift in the ideological framing” of human rights (2005, 346). Rather than being seen as one institution through which rights could be legitimated, the courts became the epitome of recognition; that is, “[t]he desire for human rights recognition was no longer placed in the broader context of social and political inequality but rather was defined solely as a question of law and public policy change” (ibid.).

The reduction of broad concepts, such as equality, to simple legal questions, creates the misleading impression that these issues are solely the result of formal inequality and thus can be effectively resolved through the courts (Smart 1989, 144). In this way, for many feminist scholars, choosing to engage with the courts to secure change necessitates tacit acceptance of a problematic status quo, particularly the legitimization of liberal rights claims and the limitations of legal resolutions. Gavigan, for example, points out that *Morgentaler* “was a ringing restatement of an *individual* right to life, liberty, and security of the person,” which reinforced liberal notions of a clear public and private divide (1992, 127). Thus, while the legal victory decriminalized access, it also emphasized an understanding of abortion “as a private and individual matter” (ibid.). This understanding requires feminists to defend the court’s framing of abortion as a health issue, rather than a rights issue, to protect access. Such an understanding, however, contradicts some feminist understandings of the issue (ibid., 128). Put simply, engaging with legal conceptions of rights encourages the strategic use of “liberal rights-claiming” which is at odds with feminist perspectives and can produce counter-productive solutions (Smith 2005, 347).¹²⁷

127. For more information see Kellough’s book *Aborting Law: An Exploration of the Politics of Motherhood and Meidcine*. Kellough focuses on the hegemonic discourse informing the treatment of abortion in law, politics, and medicine. She premises her book on the assertion that cultural understandings of abortion are informed by what

Donna Greschner focuses on the use of accepted legal language to draw attention to the potential shortcomings of feminist interactions with the courts, arguing that the “terms and the vocabulary of the abortion debate predetermines its outcome” (1990, 633). These issues are rooted in the fact that the language of the law and courts far precedes women’s citizenship; women have been historically absent and continue to be underrepresented in the formation and interpretation of law. Greschner questions the legitimacy of both the way the courts and political institutions regulate women, stating that “the continuing political regulation of abortion by itself raises questions about the legitimacy of democratic practice” (ibid., 640). The use of past precedents to defend the status quo and challenge existing laws also presents problems for some feminist thinkers. The prioritization of “patriarchal precedents” can create an unequal playing field for women, in which historical precedent is prioritized despite its often overtly sexist origins, over feminist discourse (Smart 1990, 138). For Smart, these issues are most apparent when women seek recognition of rights that “are not intended (in the abstract sense) to create equal rights with men, but where the demand is for a ‘special’ right (e.g. women’s right to choose) for which there has been no masculine equivalent” (1990, 139). A strictly liberal rights framework can fall short of acknowledging the necessity of “special” rights.

These critiques of the legal system are rooted in a fundamental rejection of the ideal of law as a “rational, objective, fair, gender-neutral arbiter in disputes over rights” (Hillaire 1998, 5). Gavigan echoes this understanding of the courts, explaining that “law within Western capitalism is principally, but not exclusively, an ideological form”—that is:

It sets normative standards and informs, shapes, and constraints the content of collective

appears to be contradictory rhetoric that actually reflect the absence of women’s voices to define this issue. “Ideas about rights and responsibilities,” she explains “are inherently inscribed with culture, but at issue is whose culture?” (1996, 5).

and conventional thinking about social structure and the possibilities and necessity for change, and it is simultaneously informed by these conventional ideas and beliefs about social relations. (1992, 121)

White echoes this statement, cautioning against a reliance on law to achieve progressive changes to abortion access. She explains that “the law doesn’t operate in just one way, there are some contradictions in it, there is some unevenness” (Interview.). In sum, law cannot be understood in its ideal form; rather, the nature of its role is deeply rooted in existing social and political climates, which it both shapes and by which it is in turn shaped.

Many feminist scholars believe that litigation is beneficial to feminist projects, but only when contextualized. Understanding the law as one aspect of rights recognition, while simultaneously challenging the problematic nature of some aspects of its foundations, is crucial for constructive feminist engagement with the courts. Moreover, this view recognizes the need for continued social and political activism, and identifies the impact of litigation outside of the courts, creating new grounds to assess what constitutes legal success.

Applying these critiques of litigation to some of the most influential abortion-related cases, both before and after the *R v Morgentaler* decision, sheds light on the nature of feminist litigation. Through an analysis of the strategies employed and the wording of the decisions, as compared to the views of the feminist movement at that time, the following section re-evaluates the success of these cases.

Abortion in the Courts Before the Charter

It is worth revisiting the context of the *Morgentaler* decision, first outlined in chapter three, to evaluate the success of the case. When Morgentaler set up his first clinic in Montreal in “complete illegality” he was raided twice before his case went to court in 1973 (FQPN and CFC 2010, 16). While no jury would convict him, Morgentaler was sentenced to eighteen months in

prison following his first trial, when the Court of Appeal of Quebec overturned the decision on appeal, citing jury error.¹²⁸ Morgentaler then appealed his conviction all the way to the Supreme Court, who upheld the charges.

Public outrage expressed at the dismissal of the jury's verdict and with widespread sympathy for Morgentaler put enormous pressure on the government to act, prompting then Federal Minister of Justice, Otto Lang, to propose an amendment to the *Constitution* (Dickens 1976, 241). The amendment, commonly known as the *Morgentaler Amendment*, prevents appeal courts from nullifying a jury verdict. Morgentaler was subsequently charged and acquitted two additional times in 1975 and 1976 before the Bloc Québécois won a majority of federal seats in Quebec and promised not to pursue further legal action against him (NAF 2010).

Despite the court's refusal to engage with his defence, Morgentaler succeeded in effectively decriminalizing abortion in Quebec. This success was not based on a masterful legal defence, as his arguments were consistently rejected, but on a deeper understanding of the role of the courts in fostering public discourse. Morgentaler's attempts to stall litigation until social acceptance of abortion was able to grow in Canada, spurred by the United States *Roe v Wade* decision and a powerful feminist movement in both countries, demonstrates the above mentioned rejection of an ideal understanding of law. The nature of public discourse on the issue, and a more favourable political climate, meant that Morgentaler's legal loss resulted in progressive change.

Notably, at the level of legal outcome, the courts did not recognize abortion as necessary to the realization of women's equality. However, the context of this decision and the process of a public court challenge created an important precedent and spurred public discourse on the issue

128. *R. v Morgentaler*. [1974] 47 DLR (3d) 211 (Can).

that, until then, had been largely taboo. The success of these cases was measured in the resulting policy changes and the creation of a public dialogue in which a more sophisticated rights discourse could unfold. Though this kind of focus changed dramatically following the creation of the *Charter*, it is significant in establishing a public discourse on an issue previously considered beyond the realm of social and political debate.

R v Morgentaler (1988)

In 1988, when Morgentaler re-entered the Supreme Court, the *Charter* created new tools to secure change, and his legal strategy changed accordingly. Never before had individual rights had such force in Canadian policies. The process of integrating these rights into existing Canadian laws, however, was not immediate, and different sections came into force at different times. As a result, Morgentaler did not have every section at his disposal; notably, section 15, which protects equality rights, only came into effect in 1985, three years after his case entered court.¹²⁹ The only legal tools available to him were those already in effect in 1982.

Morgentaler went ahead with the section 7 defence, which guarantees everyone life, liberty, and security of the person, when his Supreme Court case was heard in 1986; a similar clause had been successfully used in the United States' landmark *Roe v Wade* case, which legalized abortion under certain parameters in 1973. The Supreme Court of Canada ultimately ruled in Morgentaler's favour in 1988, finding that a constitutionally guaranteed right to security of the person protected women. However, the Court stopped short of acknowledging women's full bodily autonomy by reiterating that their interests were in competition with the state's interest in the foetus, in addition to the state's interest in women's health. As such, while the ruling struck down the existing abortion law, it also reinforced the apparent legitimacy of outside

129. Details of case chronology in chapter 3.

interests on women's bodies. In response, Shelley Gavigan warned that the *Morgentaler* decision "was fragile, incomplete and contradictory" (1992, 126).

Still, White cautions against dismissing the importance of the security of the person defence: "I think it's a good section and I think feminists need to pay attention to section 7 as well as section 15" (Interview.). Section 7 has provided not only an important stepping stone for feminists in the pursuit of equality, but also legal protections that recognize the importance of women's autonomy during pregnancy. A ruling on abortion as a matter of women's equality would nonetheless be an important step in recognizing women's citizenship claims, as evidenced by the worrisome hierarchy the *Morgentaler* case reinforced.

The ruling validated the interest of the state in the fetus and "invited Parliament to limit women's access to abortion (and indeed other medical procedures) in the later stages of pregnancy"—an invitation the Mulroney government wasted no time accepting (ibid. 126–127). While Mulroney's new law, which would have "recriminalized abortion unless procedures were performed by a doctor and the life and/or health of the mother were threatened," was defeated by a tie vote in the Senate, it nonetheless demonstrated the shortcomings of the ruling (Brodie 1992, 110).¹³⁰

This narrow defeat led to a policy vacuum around the regulation of abortion services, which had defaulted to a healthcare issue and fallen to the provinces to regulate. Provincial responses to this shift further demonstrate the fragility of the decision. Many governments placed unreasonable restrictions on access to the procedure, with some creating barriers reminiscent of TACs. Interestingly, the federal government's failure to create new legislation regulating abortion has been of considerable value to the pro-choice movement. In the absence of

130. In the wake of this failed attempt to implement a new law, no government since has overtly attempted to legislate abortion (Overby, Tatalovich, and Studlar 1988, 383).

legislation, the rights framework grew, and it became increasingly apparent that there was no need for criminal restrictions on the procedure.

Section 7 protections stopped short of acknowledging the impact of pregnancy, birth, and parenting on women's lives, largely ignoring the social and political implications of enforced pregnancy at all stages. However, though this was of course not a predictable outcome, the policy vacuum left in the wake of the decision, even more so than the case itself, proved to be an asset of enormous proportion to the feminist movement. The lack of a clear legal or political institutional model gave the feminist movement the ability to represent the *Morgentaler* ruling in a more progressive light, as an issue of women's equality, which interprets abortion access as necessary to women's full community membership. However, the growth of a rights frame following the procedure's decriminalization has made many feminists wary of further engagement with the law, even in the hopes of creating progressive legislation:

I think there are some people pushing to have some law put in place and I think it would be a real danger, because I can't see a law being any better than having no law at all right now. So I'm definitely on the side of those that say 'Leave it as it is'... once you start creating legislation I can only see impediments and restrictions coming into it in some way. (Lippman, Interview.)

The court case, which is now widely credited with validating women's rights to bodily autonomy, came dangerously close to creating new avenues for the government to restrict women's rights. It was massive lobbying against the government's proposed law, by feminist groups and physicians alike, that resulted in its failure (Brodie 1992, 110–113). The importance of political and social activism in this case cannot be dismissed. It was this activism alongside of the *Morgentaler* case that led to a largely positive outcome to secure and advance women's right

to choice in regards to abortion. The mobilization around the *Morgentaler* case, and the public discourse it created, led to a social climate in which people understood the importance of abortion as a right for women. Indeed, the growing consensus that abortion is a woman's right only increased when the limitations of the *Morgentaler* decision, specifically the extent of fetal rights and the rights of biological fathers, were challenged in court.

Testing the Limits of the *Morgentaler* Decision: Maternal, Paternal, and Fetal Rights

Immediately following the decriminalization of abortion in Canada, the extent of men's rights over their potential future offspring was tested in court. Men in three provinces (Manitoba, Ontario, and Quebec) attempted to acquire injunctions against their pregnant former partners, but only two such injunctions were granted and only one of these injunctions was challenged in court.

The case of *Tremblay v Daigle* originated in Quebec in 1989 when Jean-Guy Tremblay was granted an interlocutory injunction to prevent his former girlfriend, Chantal Daigle, from accessing a legal abortion.¹³¹ Greschner explains that Tremblay sought the injunction on the basis of his belief that a fetus has "a right to life [under Quebec law]," and, that by Tremblay's logic, "a potential father has a right of veto over a woman's decision to have an abortion" (1990, 656). She stresses that these claims were based on his own interpretations, and not explicitly stated in either the Quebec or Canadian *Charter*. Interestingly, injunctions are intended only to ensure substantive rights and, "neither the right to life of the foetus nor the potential father's rights could be found in Quebec legislation," meaning that the granting of the injunction itself was not explicitly legal (*ibid.*, 656–657). Nonetheless, the court case went ahead.

The court found in Tremblay's favour, basing their judgment on their perception of

131. This case is first mentioned in chapter 3.

Daigle's exercise of choice before she became pregnant. It was revealed in her testimony that, shortly before becoming pregnant, Daigle had stopped taking birth control pills at Tremblay's insistence (Kaposy and Downie 2010, 298–299). Importantly, they did not take into account the implications of the physical and emotional abuse she suffered at the hands of her partner on her ability to exercise reasonable judgment.¹³²

In their ruling, the court found that a fetus is a human being under the Quebec *Charter of Human Rights and Freedoms* “and therefore enjoys a ‘right to life’ under s. 1,” and that this right should prevail over those guaranteed to the woman under the *Charter*.¹³³ The court also upheld the father's argument that he had a necessary interest in placing the injunction. Their interpretation of Daigle's apparent desire to become pregnant as effectively negating her right to bodily autonomy was upheld in appeal.

Daigle further appealed her case to the Supreme Court, but sought an abortion in the United States while awaiting her appeal, not desiring to have her pregnancy progress any further. While the Court agreed to hear the case, in order to rule on the important and time-dependent issue of the extent of women's autonomy while pregnant, the verdict for Daigle, with regards to her pregnancy, was moot. The Court ultimately ruled in Daigle's favour, overturning the decisions of the lower courts and finding that the fetus has no legal status in Canada.

While this case created an important legal precedent, it was deeply disturbing for many Canadian women, particularly in Quebec. Greschner attempts to capture the mood surrounding the case in Quebec, explaining that:

Women followed every move of Tremblay and the courts, anguished with her, talked amongst ourselves late at night about the pain and horror she must be feeling, concurred

132. See chapter 3 for more information on Daigle's defence.

133. Ibid. at III.

with each other that she should ignore the court injunction, and participated in some of the largest pro-choice demonstrations ever held in Canada as a sign of our support. (1990, 755)

Catherine Stettin also discussed the horror women in Quebec felt watching the case unfold (Interview.). The fact that the court was entertaining a case brought forward to restrict a woman's bodily autonomy during pregnancy was a shock to many women, who may have seen their fates tied to the court's decision. Stettin additionally noted Tremblay's later convictions on domestic assault (Interview.) Tremblay's known abusive behaviour was an issue raised by Daigle in the case, but the issue was largely ignored in the legal deliberations. Many women no doubt felt some grim satisfaction when Tremblay reentered court to answer for some of his crimes.

The refusal of the lower courts to validate Daigle's decisions, couched in a flawed understanding of choice that was highly abstracted from reality, undermined many of the advances of the feminist movement. Moreover, even the Supreme Court judgment did not "proclaim her freedom," choosing instead to base their decision on "the failure of the legislative assembly to grant the specific rights asserted by Tremblay" (ibid., 636). While the precedent set in the case has since been interpreted as a validation of women's autonomy, its impact on the social climate was more disheartening. Gavigan explains that the general sense of defeat stemming, not only from this case but from previous litigation relating to abortion, was rooted in "the clear empathy expressed in many of the cases for the men, especially the husbands, especially by the male judiciary" (1992, 136). Still, despite these shortfalls, feminists stressed the ruling that the fetus did not have any legal rights in Canada, turning the focus from the court's treatment of Daigle to the precedent, which, as they framed it, further confirmed women's rights to abortion access.

The flaw in Daigle's victory, in legal terms, was that it failed to recognize her rights, focusing instead on procedural concerns. Moreover, the dismissal of her own reasoning, specifically her desire not to be connected to her abusive former partner, and the power relationships at play in the decision, were an affront to feminists. The court's decision to effectively ignore the allegations of the abuse Daigle had suffered while formulating their decision sent a clear message to women suffering in similar situations across the country: domestic abuse was not considered an important issue, and certainly not a strong legal defence. The fact that Daigle chose to stay in an abusive relationship was presented as a "choice." Misguided understandings of choice were not, it soon became apparent, limited to the regulation of women wishing to terminate their pregnancies. The same issue arose in a Manitoba case almost a decade later, concerning the rights of women choosing to carry their pregnancies to term.

The case of a pregnant Manitoban woman with a drug addiction is therefore notable in considering the legal context of abortion rights and women's citizenship. In *Winnipeg Child and Family Services (Northwest Area) v D.F.G.*, the group in question was seeking legal backing to forcibly imprison a pregnant woman against her wishes, to prevent her from consuming drugs that might negatively impact the development of the fetus she was carrying. While the Supreme Court ultimately ruled that a woman could not be "detained against her will" to ensure the health of her fetus, the ruling was not unanimous (Kaposy and Downie 2010, 300). Justice Major John dissented, arguing that "once a woman has chosen not to have an abortion and to continue her pregnancy, she must be responsible for the foetus's well-being, and the state may justifiably act to ensure the foetus's health if the woman cannot or will not do so" (ibid.). Kaposy and Downie correctly point out the problematic assumption this reasoning is based on, namely that "women

who continue to be pregnant must have rejected the abortion option” or that the decision to remain pregnant requires the forfeit of bodily autonomy (ibid.).

The difficulties associated with criminalizing any aspect of pregnancy, including its voluntary termination, come to the forefront in the above cases. In each case, the courts suggest problematic interpretations of choice and autonomy associated with women’s reproductive rights. The notion that women must forfeit their autonomy as soon as they become pregnant, regardless of whether or not they want to carry the pregnancy to term, presents a troubling view of women as second-class citizens, valued for their ability to reproduce rather than as full and equal members of Canadian society unto themselves. This brings us to a consideration of issues of access to abortion rights, and the uneven context across the provinces.

Provincial Access

Provincial litigation following the decriminalization of abortion in Canada has focused on limitations to access. Following the *R v Morgentaler* decision, most provinces attempted to restrict access to legal abortions, in whole or in part. These attempts were indicated in a variety of ways, often by limiting the allowable locations for the performance of the procedure, defining specializations required by individuals to perform the procedure, and/or regulating the requirements women needed to fulfill in order to have the procedure covered under their provincial health care coverage. While these cases have been numerous and varied, this section will focus on three of particular note in considering women’s rights to equal citizenship: *Morgentaler v New Brunswick* (1989), *R v Morgentaler* (1993), and *Jane Doe v Manitoba* (2004).

The New Brunswick government moved to create barriers to abortion access even before the procedure was decriminalized. As discussed in chapter four, following a request from *Morgentaler* to open a clinic in the province, then Premier Richard Hatfield amended the

province's *Medical Act* in 1985 to prohibit the performance of abortions outside of approved hospitals, thus putting practitioners at risk of committing professional misconduct (Dunsmuir 1990). New Brunswick also created more extensive policies, which allowed the government to exempt abortion services from provincial health care coverage unless women met extensive bureaucratic conditions (ibid.).¹³⁴

Morgentaler challenged these provisions immediately following his Supreme Court victory, in *Morgentaler v New Brunswick (Attorney General)* in 1989. Importantly, Morgentaler was successful in challenging these acts. However, rather than appeal the decision, the New Brunswick government turned to create more airtight restrictions in the legislation. Then Premier Frank McKenna moved to amend the *Medical Services Payment Act* to include a provision directly echoing the policy the court had just rejected as a defence, rendering it official. This move ensured that all future abortions performed on women who were residents of New Brunswick, both within the province and across Canada, would be subject to strict guidelines before reimbursement could be demanded.¹³⁵

The creation of new policies intended to restrict access to abortion services for women was a widespread phenomenon, marking a pattern indicated starkly first in New Brunswick. For example, in 1989, the government of Nova Scotia approved a regulation prohibiting the performance of an abortion “in any place other than a building, premises, or place approved by the Minister of Health and Fitness as a ‘hospital.’”¹³⁶ When Morgentaler subsequently opened a clinic in the province he was charged with “14 breaches of the *Medical Services Act*”.¹³⁷

A Nova Scotia judge promptly acquitted Morgentaler, on the grounds that the province

134. For a detailed description of the barriers to funded abortion access in New Brunswick, see chapter four.

135. This policy is still in effect as of this writing.

136. *R. v Morgentaler*. [1990] 99 NSR (2d) 293 (Can) at 55.

137. *Ibid.* at 2.

was “in pith and substance” attempting to legislate criminal law, which falls outside their jurisdiction.¹³⁸ The province appealed the case all the way to the Supreme Court, making it the doctor’s third Supreme Court appearance. The Court ultimately upheld the trial judge’s acquittal, finding the government’s actions to be an “indivisible attempt by the province to legislate in the area of criminal law.”¹³⁹ The Morgentaler clinic in the province has since closed, but the Nova Scotia government amended its legislation to allow for private clinics. Like the New Brunswick case before it, this case turned on jurisdictional claims rather than rights issues, leaving women’s rights vulnerable and failing to engage with the foundations of women’s claims to abortion access.

Unlike the previous cases, *Jane Doe v Manitoba* was initiated by two women (whose identities were protected) who had to negotiate provincial barriers to access abortion services, rather than the officials involved in providing and restricting services, as in other provinces. They were also permitted to testify “on behalf of certain pregnant women who are persons pursuant to *The Health Services Insurance Act*... who require access to therapeutic abortion services.”¹⁴⁰ Their case challenged the constitutionality of Manitoba’s refusal to cover clinic abortions under the province’s health insurance plan, using three sections of the *Charter*: conscience (section 2(a)), equality (section 15), and security of the person (section 7). Jane Doe I and Jane Doe II argued that “the right to reproductive freedom is central to a woman’s autonomy and dignity as a person,” and further, that “the ability to assert that autonomy and to exercise self-determination regarding one’s own body is fundamental to the preservation and protection of a woman’s dignity.”¹⁴¹ They also argued that the law violated section 2(a) of the *Charter*, which guarantees freedom of conscience, because “the impugned legislation interferes with a woman’s

138. *R. v Morgentaler*. [1991] 104 NSR (2d) 361 (Can) at 2.

139. *R. v Morgentaler*. [1993] 3 SCR 463 (Can) at 24.

140. *Jane Doe v Manitoba*. [2004] MBQB 285 (Can) at 547.

141. *Ibid.* at 37.

ability to make a moral or ethical decision as to whether or not she wishes to terminate a pregnancy.”¹⁴² Further, those delays in access to funding violate guarantee of security of the person. Importantly, the government amended its insurance policies before a judgment was rendered, to include clinic services, but “maintained that it was under no legal obligation to do so” (Erdman 2007, 1098). The judge ruled in favour of the complainant, finding that,

[T]he exclusion of clinic services from public health insurance was a gross violation of women’s rights to liberty and security of the person as guaranteed by section 7, as well as a violation of the right to freedom of conscience under section 2(a) and women’s equality rights under section 15(1). (ibid., 1102)

This case was important to feminist legal studies, even though it was quickly set aside on appeal, because it was not found to be “on an appropriate case for summary judgment,” for which “a trial is warranted.”¹⁴³ The apparent failure of the challengers to provide compelling proof of the stress they suffered as a result of delayed access to services, as well as the increased physical risk, was of central importance. Erdmann stresses that the *Morgentaler* decision “set an onerous evidentiary burden under the threshold requirement of section 7”, which made further litigation, such as this case, difficult (2007, 1108). Though there are serious “policy implications” from this case, the vulnerability and resources of the individuals in question, placing this burden on them or other women who would bring forward charges, is troubling (ibid., 1115). Interestingly, despite their apparent interest in the implications of such a decision, there has been no effort made by governments, provincial or federal, to research the consequences of delayed public access; notably, “no Canadian government... has commissioned a comprehensive study of access to abortion services” (ibid., 1109). Without government

142. Ibid. at 39.

143. *Jane Doe v Manitoba*. [2005] MBCA 109 (Can) at 9.

support, and the burden of a narrow legal definition of what constitutes an acceptable source of truth, the bar set by the courts is unlikely to be met.

There were, however, other issues which gave the appeal court pause. The lower court found the law in question unconstitutional on the grounds that it created barriers to access, despite the fact that it was, by definition, “positive in character” (ibid., 1114). The law was intended to grant some coverage, and thus criticism that it did not go far enough in this regard was dismissed. This was despite the characterization of the existing law as unconstitutional. The court’s liberal view of rights only solidified this finding, when the appeal court found that section 7 of the *Charter*, which guarantees individuals life, liberty, and security of the person, had never been used to enforce a positive right to health (ibid., 1114).

These cases are demonstrative of a shift in public deference to the courts in an age of rights. Feminist scholarship cautions that such a shift signals a limitation on rights discourse, which is constrained through the use of legal language and takes place almost exclusively in the courts. The necessity of using legal strategy means that the larger rights questions may be ignored in favour of procedural claims, which may present more winnable cases. New Brunswick and Nova Scotia are clear examples of this; rather than addressing blatant violations of women’s rights, their regulations were challenged on jurisdictional grounds, to varying effects. While social movement activism and political decisions have influenced the outcomes of these decisions, neither has engaged with fundamental questions of women’s rights, obscuring the centrality of abortion to women’s citizenship.

When more feminist language was adopted, as in the Manitoba case, the lower court’s response was favourable, but the dismissal of its progressive ruling and refusal of the Supreme Court to hear an appeal undermined the gravity of the decision for women. The risks the women

in question took in bringing the case forward, when they wished to have their identities protected, were profound, as were the implications of legal recognition of the equality frame. When the case was effectively shut down by the high courts, public discussion was similarly stalled.

Problematic standards of evidence proved to be an issue in this case, when abortion was not recognized as an equality claim because the courts found that the women had not effectively demonstrated their hardship in seeking services, or the real consequence of being denied these services. The women's testimony of the nature of their stress was not seen as sufficient without "medical evidence concerning risks of delay waiting for abortion in hospital or nature of stress suffered by plaintiffs."¹⁴⁴ The prioritization of certain kinds of knowledge, specifically through institutions such as organized medicine, considered to be patriarchal in nature, is a major preoccupation in feminist thought (Smart 1990, 647). The need for the women to have medical personnel recognize the levels of stress they were experiencing, solely for the benefit of the court, would have necessitated further delays in their attempts to terminate their unwanted pregnancies. Moreover, such a burden of proof to legitimize women's experiences is inherently dismissive of such experiences as valid claims for equality and rights.

There is extensive medical knowledge relating to the risks associated with delaying abortion, and there is an abundance of medical records detailing botched abortions and even suicides from the decades of highly restricted abortion access. The desperation implicit in the desire to terminate an unwanted pregnancy is, arguably, widely recognized in Canadian civil society, and such a discourse is part of accepted knowledge. This ruling indicates that such recognition of women's experiences, however, does not extend to the legal sphere. The nature of

144. Jane Doe v Manitoba. [2005] MBCA 109 (Can) at 1.

legal discourse is less swayed by fears of social repercussions, financial burdens, and physical risk, than is society at large. Like Daigle before them, Jane Doe I and Jane Doe II were expected to justify high degrees of personal distress in order to access a safe and legal service. In effect, they were required to construct themselves as victims, rather than empowered actors, to justify state recognition of their rights to abortion services.

Unfortunately, the focus on legal rights has obscured the realities of the manner in which courts function. Litigation does not occur in a vacuum, but is influenced by political and social climates. The success of feminist litigation can be measured, in large part, by the social perception of rights and issues that were shaped during and after litigation took place. Therefore, without social and political action, litigation does not have the same power. It is crucial, when looking back at historic legal victories, as well as losses, that we do not de-link these outcomes from the contexts in which the decisions were made, ignored, or enforced. Attempts to understand advancements in rights retroactively through the study of court decisions does not offer a complete picture of the role litigation plays in rights protections. In the case of abortion rights in Canada, despite virtually undisputed examples of significant legal success, the courts alone are not responsible for a growing acceptance of abortion as a woman's right to choice. Instead, such advancements must be understood in the context of social movement activism and political activity.

Conclusion

Feminist scholarship takes a critical view of litigation, but is largely supportive of feminist engagement with the courts, so long as it occurs in tandem with social and political activism. While abortion-related litigation has been overwhelmingly successful in legal terms, especially following the entrenchment of the *Charter*, a closer look at the specific nature of the challenges and the nature of the victories highlights the limitations of legal success. For example,

abortion was decriminalized under a provision for security of the person, which not only failed to acknowledge women's rights to the procedure, but also validated the interests of the state in women's reproduction. Changing political and social climates, rather than the courts, were responsible for influencing the perceptions of women's rights. Cases concerning provincial regulation of the procedure have also largely avoided a rights framework, and have been generally argued on jurisdictional grounds instead. Even when a Manitoba judge recognized the multiple *Charter* violations two Manitoba women faced when they were refused reimbursement for clinic abortions, an appeal stalled proceedings, which the Supreme Court subsequently refused to hear.

While litigation is an important tool for feminist advocacy, it is limited if taken in isolation, indicated starkly in the case of abortion rights. Litigation has been indispensable to the realization of abortion access in Canada, and recognition of women's rights through the courts and the *Charter* has given legitimacy to feminist claims. However, using litigation, feminists have yet to receive an acknowledgment of the importance of abortion to women's rights as an issue of women's equality fundamental to their full community membership. Often, the power of the courts is not simply in its decisions, but in its ability to create public dialogue on important issues. Even when the nature of the ruling is not as progressive as social movement advocates have hoped, or even when outcomes are seen as setbacks, understanding the law as part of a broader social and political project of rights means legal decisions can be interpreted in different ways. The *Morgentaler* decision of 1988 is clearly evidence of such an interpretation. While the decision validated the state's interest in reproduction, the influence of social movements in the interpretation of the case and the federal government's decision not to pursue the creation of a new law following its initial failure, have meant that the decision is broadly understood as

recognizing women's rights to abortion access. An evaluation of the success of feminist litigation absent these influences would not only present a misleading portrayal of feminist involvement in the courts, but would distort the nature of the successes that have been achieved. Moreover, denying the validity of the courts as a means to assert change would undermine major gains made by women's groups within this domain. Overstating the importance of court support could likewise damage the ability of the feminist movement to challenge the state and social structure in progressive new ways; it would also overlook the ability of feminists to influence the courts themselves. A balance in both approach to, and interpretation of, feminist litigation is thus needed for progressive change to the regulation of abortion access in Canada.

The specific needs and interests of an individual only "becomes a right in so far as a duty binds another to respect that interest" (Cook, Dickens, and Fathalla 2003, 156). The full and meaningful recognition of women's rights to reproductive and sexual health is, in the current context, perhaps an ambitious goal, but it is an important one and can be understood as very basic to democratic citizenship rights. While the realization of such a goal will necessarily have to extend beyond the legal sphere to encompass governing bodies and social norms, the language of rights resonates with Canadians and has the power to fast track the perceived legitimacy of what may still be seen as a controversial issue. Feminist litigation, despite its shortcomings, remains an important tool for the realization of women's rights to abortion access when used in combination with social and political advocacy. Thus, in order to assess the potential implications of ongoing litigation, and the utility in launching new cases, it is important to understand the social climates in which this litigation is taking place.

Chapter 6. It's Pro-Choice or No-Choice: Social Movement Activism in a Policy Vacuum

*I think sometimes we're more afraid of the anti-choice movement than we should be. You imagine them as this huge, monolithic monster that's going to trample all our rights. The fear and the silence is really, really sad. That's one area the anti-choice movement has really won.*¹⁴⁵

The realization of abortion rights necessitates not only political and legal recognition, but also normative acceptance of abortion as necessary to women's citizenship. Choices, after all, only become rights "in so far as a duty binds another to respect [them]" (Cook, Dickens, and Fathalla 2003, 156). Citizenship is a far-reaching concept encompassing all aspects of community membership, including the "complex and multifaceted relationships of individuals to territories, nation-states, labour markets, communities and households" (Bakan and Stasiulus 2005, 11). These relationships overlap with, and extend beyond, the public sphere, as do the barriers that prevent women from accessing safe and legal abortion services. Indeed, some of the most significant obstacles women face when attempting to assert their rights to bodily autonomy manifest outside of the formal political sphere, including social stigma and harassment. These manifestations of anti-feminist backlash position abortion as a moral question and deny its political significance.¹⁴⁶

Social activism has been instrumental in influencing political activity and the success of litigation, both through direct intervention and by shaping what are seen to be social norms. In this way, a province's social climate can have a profound impact on whether or not services are offered, safe to access, and funded. The importance of the social perceptions of abortion outside

145. Joyce Arthur (Executive Director and founder of the Abortion Rights Coalition of Canada, 2005–Present). Interview by author. 30 September 2011. Recorded and transcribed by author. Kingston, Ontario.

146. Gallup polls conducted in 2002 reported that 57% Atlantic Canadians found abortion "morally wrong" and 42% "morally acceptable" (when asked about their personal beliefs, regardless of legal considerations). In Ontario, 54% found abortion "morally acceptable" and 44% "morally wrong," compared with a stark imbalance in Quebec, where 68% of those polled found abortion "morally acceptable" and only 28% believed the procedure to be "morally wrong" (Mazzuca 2002).

of formal political and legal contexts should not, however, be overlooked. This chapter explores the provincial social climates of New Brunswick, Ontario, and Quebec, representative of a spectrum of abortion access in Canada. Focusing on manifestations of social activism, social stigma, and women's attitudes regarding their right to abortion services, it explores the social climate on women's experiences of citizenship. Ultimately, it finds that these attitudes are largely shaped by social perceptions of women's expected roles.

This chapter begins with a broad discussion of some of the most visible manifestations of social attitudes in Canada, through an analysis of both pro- and anti-choice social movements. Groups representing both perspectives have formed across the country and are often organized by a central, national body. It is therefore useful, before exploring their unique representations in the provinces, to better understand their motives at a national level. Interestingly, while the tactics and rhetoric of anti-choice groups are strikingly similar across the country, public perceptions of their activities are coloured by historical incidents, as well as their prevalence and boldness. For example, demonstrators outside of clinics may be perceived as a greater threat in a location with a history of violence against abortion providers. The routine activities of social movements are important to a province's social climate, through their ability to both shape and reflect attitudes towards abortion. Anti-choice group tactics include demonstrations outside of medical facilities, harassment of women seeking abortions and abortion providers, and threats of violence, which can have a profound impact both on the ability of women to access services, and the decisions of doctors to perform them. Fear of judgment, exposure, and violence prevent many women from attempting to access services, just as threats and demonstrations deter healthcare professionals from providing these services. Social movement activism is thus a significant determinant of women's experiences of citizenship in a given province.

Discussion in this chapter will shift next towards provincial social climates. Starting with New Brunswick, where social attitudes towards abortion are characterized largely by silence, each of the three case studies will address provincial manifestations of social movement activism and general social perceptions of the procedure, supported by original interviews with social movement actors and members of the medical community, as well as politicians and legal scholars. The taboo nature of abortion in New Brunswick provides a valuable starting point for this chapter by showcasing the links between widespread social perceptions of abortion and the realization of access.

The next case study is that of Ontario, which, while it has good levels of access to the procedure in many parts of the province, has not been home to either a strong moral or rights frame. Instead, residents have largely attempted to avoid these debates, and the resulting impact on the social climate has been ambivalence on the issue. Ontarians now assume that, because abortions are covered under their provincial health insurance and available in urban centres, the issue has largely been resolved. Indeed, when they do express concern about its regulation, it is often in relation to the activities of the federal government, rather than to the happenings in their home province.

Lastly, Quebec's overtly pro-choice social climate is discussed. The only province to respond to their newfound jurisdiction over abortion by endorsing a rights-based understanding of the procedure, Quebec's social climate is progressive on the issue of abortion. The topic is not taboo; indeed, it is taken for granted that the rest of Canada is not as open or supportive of a woman's right to choose. Quebec understands abortion as a right of women's citizenship, and as an issue with clear political implications.

The goal of this chapter is to establish which provinces have normatively accepted

abortion access as a citizenship right, and which have attempted to depoliticize reproduction by embracing a moral frame. The differences apparent in the way women understand their community membership between the provinces as a result of these attitudes is striking. Women in Quebec, where abortion is a clear-cut rights issue, do not see themselves as victims of an unwanted pregnancy, but as entitled citizens exercising their rights. They are not only understood to be full citizens by the public, but “believe themselves to be” (Erdmann 2007, 1155). This level of empowerment was not evident in Ontario or New Brunswick, where women’s rights to abortion access remain vulnerable.

Social attitudes regarding abortion are not only important for their ability to influence political and legal activity, but are also responsible for creating a climate in which women either believe themselves to be full citizens or see themselves as social exceptions in need of sympathy and support. When women internalize their worth they are more able to function as empowered citizens, and more likely to react to caricatures of femininity that seek to limit their rights with incredulity, demanding progressive social change. An enforceable right to abortion access is necessary for women to realize their equality, and such a right can be created only in a social climate which respects the value of women as equal citizens.

Social Consensus and Social Movements: Views on Abortion in Canada

Even before the *R v Morgentaler* decision, which decriminalized abortion in Canada, Brodie argued that the “‘court of public opinion’ had forged a tentative social consensus” on abortion, favouring improved access to abortion services (1992, 60). Widespread acceptance of the necessity of access has grown steadily following the *Morgentaler* decision; Canada-wide polls demonstrate that the “small majority” of those supporting “a woman’s right to have an abortion” has increased, and “three-quarters of Canadians now support this choice” (EI 2010,

6).¹⁴⁷ The failure of the federal government to create a new law regulating abortion has likely contributed to the ability of social movements to reinforce the belief that abortion is a woman's right. While the rights framework continues to dominate in Canada, the *Morgentaler* decision also had the unintended effect of mobilizing the anti-choice movement in response to the progressive changes the case created.

Preceding the push to decriminalize abortion in Canada, just as before the *Roe v Wade* case in the United States, there was virtually no anti-choice movement, despite the prevalence of illegal, back alley abortions. The movement rose in response to fears by fundamentalists that abortion was being reframed as a legitimate practice (Blanchard 1994, 36). A prominent legal scholar and former social activist, who asked that their identity remain confidential, recounting their experiences before the decriminalization of abortion, shared this view:

I agree with those who argue that the right to life movement really kicked up steam after *Roe versus Wade* and *Morgentaler* decisions. The church began to organize, both the Roman Catholic Church in Canada and the conservative Protestant church in the States, after the legal victories. I think that it is one of the paradoxical aspects of the *Morgentaler* victory that it unintentionally contributed to the development of the backlash that followed. (White, Interview.)

Anti-choice groups in Canada represent only a small amount of the population, but are known to be vocal and highly organized. Through demonstrations, litigation, and publicity campaigns, they have succeeded in keeping the moral frame in public discourse. These groups

147. Canadian Gallup polls also recorded this shift. Since the polls began to question whether abortion should be legal "under any circumstances, legal only under certain circumstances, or illegal in all circumstances" 35 years ago, significant change is evident. An overall rise was evident, not only in those who felt that abortion was permissible, from 84.2% of respondents in 1975 to 91% in 2000, but a shift towards those deeming it permissible in all circumstances versus certain circumstances was also evident, from 23.2% of 84.2% in 1975, to 39.3% of 91% in 2000 (Canadian Gallup Polls 2000. Variable abort: Abortion Legal Under ___ Circumstances. November.; Canadian Gallup Poll. 1975. Variable q10a: Approve of Legal Abortions. July.).

differ in focus, some “are concerned with abolishing abortion services [while] other groups are more concerned with the perceived legitimacy of the procedure, that is, so long as it is publicly demonized its availability is less of a concern” (Blanchard 1994, 36). Regardless of their goals, their limited success in legitimizing challenges to women’s rights in Canada is a serious threat to women’s citizenship.

Anti-choice groups root their opposition to abortion in a moralistic rhetoric, which relies on socially traditional understandings of women’s roles. Often, these groups are linked to religious movements; the mission statements of anti-choice groups, both federal and provincial, typically make reference to God and the importance of family. Indeed, the anti-choice movement was founded on religious groups that “opposed abortion both as a cause and effect of women’s refusal to accept the dictates of traditional morality” (McLaren 1997, 138). Importantly, the push for the return to traditional gender roles often transcends religious links, forging “a common bond between cultural and religious fundamentalists across religious groups and perspectives” (Blanchard 1994, 119). Religious doctrine alone does not account for resistance to abortion, as pro-choice groups like *Catholics for Choice* demonstrate. Moreover, the most overwhelmingly Catholic province in the country, Quebec, boasts the most progressive views on abortion. Resistance to women’s equality is the only consistent link between anti-choice groups. The recreation of oppressive gender hierarchies, which negate women’s bodily autonomy, can hardly be understood in any other light. Thus, the opposition to abortion is not limited to this single issue, even when it is the primary focus of the group; it is about a broader view of the order of society, in particular, the role and freedoms of women.

In order to advance their claims, the anti-choice movement employs a variety of tactics, including demonstrations, harassment, picketing, arson, and even murder. While some of the

more violent actions are not typically condoned by anti-choice movements, they have been known to express public gratitude for them; it is evident that “the more moderate organization leaders find benefits in at least some kinds of violence but feel a necessity to distance themselves from it” (Blanchard 1994, 99, 101). The use of specific tactics by anti-choice groups varies by province, seemingly in accordance with broader social views on the issue.

Pro-choice groups are also present in all of the Canadian provinces, but are markedly less vocal. Often, these groups are associated with clinics (Planned Parenthood) or litigation (LEAF – Women’s Legal Education and Action Fund). While many groups still engage in consciousness-raising campaigns and counter protests, they are less visible in large part because they are perceived as having already achieved their goals. Many Canadians believe that the *Morgentaler* decision created legal rights to abortion in Canada and are unaware of continuing access issues until they, or someone they know is in need of care. While pro-choice activism remains crucial to the maintenance of existing levels of abortion access, and future improvements to access, activists are forced to work in opposition to anti-choice attempts to roll back rights.

Silence in New Brunswick

New Brunswick is home to some of the most regressive abortion regulations in the country, but rather than demonstrating an overwhelmingly anti-choice social climate, public sentiment is obscured by silence. With the exception of a small faction of vocal anti-choice groups, within the province the subject is largely considered taboo. Alison Toron, a volunteer escort at the Fredericton Morgentaler clinic, characterized provincial attitudes as a “sort of ‘don’t ask, don’t tell’” on abortion issues. That is to say, individuals may or may not have a stance on the issue, “but we [New Brunswickers] just don’t talk about it.”¹⁴⁸ The motivation for this

148. Alison Toron (volunteer escort at the Fredericton Morgentaler clinic, 2008–Present). Interview by author. 11

silence, according to the same activist, has multiple roots—including the prevalence of groups with religiously motivated, socially traditional views. These views are not limited to abortion but also include reproductive rights and sexual health at a broader level. She attributes the dominance of this rhetoric to a kind of “mass inertia” whereby “people just don’t discuss the issue and so it’s able to not move forward by reasons of silence” (ibid.).

Without a strong public discourse, the moral frame embraced by the anti-choice movement gives the illusion of dominating by default, particularly when some of its strongest supporters are in positions of power, for instance, members of the legislative assembly. This sense of power through silence has afforded the anti-choice movement some boldness in their actions, and dramatically influenced discourse on the issue, but ultimately their small member base limits their activities.

The main anti-choice group in the province, *New Brunswick Right to Life*, focuses their energies on challenging provincial policy, by organizing marches and collecting signatures for petitions, and by attempting to disrupt the function of the Fredericton Morgentaler clinic, the province’s only abortion clinic. Indeed, the group is so focused on the operations of the clinic that they purchased the building next to it to serve as their base of operations, converting it into a crisis pregnancy centre called the *Mother and Child Welcome House*. Crisis pregnancy centres are anti-choice facilities which advertise using the language of clinics, stating that they will help women facing unplanned pregnancies understand their *choices*—but are known to provide misinformation about abortion and attempt to dissuade women from accessing them.¹⁴⁹ This centre also acts as a home base for the protestors, who demonstrate in front of the clinic when it is open. Indeed, the constant presence of anti-choice demonstrators was becoming so problematic

January 2011. Recorded and transcribed by author. Fredericton, New Brunswick.
149. More details are provided in chapter seven.

that the clinic decided to organize volunteer escorts for women entering the building—both to shield them from protestors and to guide them into the correct building, as many women who book appointments at the clinic mistake the *Mother and Child Welcome House* as the clinic, given its proximity and the language used on its signs.

According to staff at the Morgentaler clinic, these protestors, who typically number between four and eight people, employ a variety of tactics to dissuade women from seeking abortions, including silent vigils, the use of placards, and verbal harassment, but not physical violence. Former clinic employee Peggy Cooke explains that,

No one was ever physically violent but they are physical. I have seen them use their bodies. There is one particular individual who will throw herself in front of cars or move so she's between the escorts and the patients, so she will use her body to get closer to people but I have never seen anybody push or hit or anything like that.¹⁵⁰

Even absent physical violence, the harassment women endure attempting to enter the clinic is a serious deterrent, and is not to be discounted lightly. Toron recounted some of the most oft-uttered phrases by the demonstrators, which she ranked from mild (reiterating other options such as adoption) to extreme: for example, “Don’t kill your baby”; “If you have an abortion you might not be able to have a baby someday”; and even “Abortion is linked to breast cancer” (Interview.).

The clinic itself is a stand-alone building in which patients have to be buzzed in. There is no injunction around the clinic, nor any bubble zone legislation which requires demonstrators to keep their distance, which one former employee, who now works at a Toronto clinic, spoke about:

150. Peggy Cooke (Board Member and Media Spokesperson for the Abortion Rights Coalition of Canada, 2008–Present, former employee at the Toronto Morgentaler Clinic, 2010–2011, and former volunteer co-ordinator at the Fredericton Morgentaler Clinic, 2007–2010). Interview by author. 23 February 2011. Recorded and transcribed by author. Toronto, Ontario.

I actually probably think about it [violence] less now [working in Toronto] than I did in Fredericton. There was probably less chance of it in Fredericton but I worked in reception so I was sitting at the desk and there is a panic button under the desk, so it is always there and you are always thinking about it. (Cooke, Interview.)

The protestors are a fixture outside the Morgentaler clinic when it is open. They are thus a constant reminder for women, doctors, and the community at large that abortion is a contested right—one which any woman trying to exercise risks being threatened, harassed, guilted, or frightened into forfeiting. Demonstrations outside of the Legislature and supportive words from allied officials only serve to reinforce these barriers to access and subvert discussions of abortion as a woman's right.¹⁵¹ The result is a muted public discourse, which frames abortion as a moral issue. Toron explained:

For the general populace [in New Brunswick] it is a moral issue almost in the abstract. That is the problem with the kind of discourse that exists around abortion in this province. People talk about it as a black or white moral issue, at least in the public, I think things are different in private, but in the public it is framed as an abstract moral issue in that it does not actually seem to relate to actual women who need to get those services. (Interview.)

The silencing of women's rights claims is, according to many, rooted in socially traditional ideals, many of which are supported by dominant religious groups in the province; specifically, the hold of the Catholic Church was noted by numerous interviewees. According to Dr. Hughes, "there is a strong tradition of both Irish Catholic and French Catholic influence on the public discourse" which is notably "misogynist in its rhetoric," alongside a competing Protestant view,

151. See chapter four for a more detailed discussion of manifestations of anti-choice backlash.

which operationalizes its anti-choice “doctrine as being deeply felt” (Interview.). From this viewpoint, the strength of the moral frame is rooted in the combination of an “emotional sense of righteousness, [a] doctrinal sense of exclusion of women, and conservative politics” which “make up this brew of ideology that becomes very silencing for a large number of New Brunswickers” (ibid.). Toron echoed these views in her assessment of demonstrators outside the Fredericton Morgentaler clinic, explaining that, “If you question any of the protestors about their broader views it becomes clear that their views are deeply rooted in notions of social traditionalism. They are often anti-contraception and believe women belong in the home” (Interview.).

While a deeply held emotional response to the issue, which rejects rights-based autonomy claims, accounts for some anti-choice sentiment in the province, it does not necessarily shed light on broader social perceptions of abortion. Are a majority of New Brunswickers in fact anti-choice, or are their sentiments merely obscured by the nature of the public discourse? Interviewees in the province seemed inclined to believe that the province is more pro-choice than it first appears. Toron explained: “looking at our incredibly repressive policies you would think that this must be a socially conservative province where everyone is against abortion, but I really don’t find that that’s the case when I actually talk to people about the work that I do at the clinic” (ibid.).

She stressed that the traditional understandings of conservatism as falling along urban/rural or young/old did not account for views on abortion. Certainly, as the original Morgentaler cases in Quebec in the late seventies revealed, women who were the most vulnerable in cases of unwanted pregnancies were poor, rural women, who could not afford abortion services. Many women in rural New Brunswick certainly remember the struggles

associated with unwanted pregnancy; even today, services in the province are few and far between and are fraught with barriers, a reality all the more apparent to poor, rural women.

Other interviewees shared the belief that anti-choice sentiment is not widely held in New Brunswick. According to Dr. Hughes,

There are lots and lots of people who are actually pro-choice, somewhere in the spectrum, or at least not so anti-woman that they really want it to play out in this way [as it has in New Brunswick]. You get people who want to see abortion restricted in some fashion but wouldn't go quite to the kinds of extremes that are sometimes contemplated here. So I suspect that the majority of people in New Brunswick are as pro-choice as the rest of Canadians but they wouldn't say it, because the public discourse is so controlled.

(Interview.)

The general lack of dialogue on the subject has also influenced the sense of entitlement to abortion services among New Brunswick women. Cooke contrasted the attitudinal differences between women in Toronto and women in Fredericton:

They [Torontonians] take it for granted that the access is there, especially with payment because it is covered under OHIP here. So people come in and we get them to sign all this stuff. I get them to sign a billing agreement and I explain that 'this gives us permission to use your healthcare but it also makes you liable if it's rejected.' People often say, 'well it's not going to be rejected but just out of curiosity how much is the payment?' And I reply, 'well, it depends how far along you are but it's going to be at least five hundred dollars' and people are shocked. Absolutely shocked. They cannot believe it. It is a lot of money but in New Brunswick everyone is paying this, sometimes six hundred. Everybody. So people just have no concept at all that there is a world

outside of Toronto and things do not come as easily. (Interview.)

Finally, the moral frame is often reproduced in the media, if abortion is discussed at all. According to Rosella Melanson, former Executive Director of the New Brunswick Advisor Council on the Status of Women, when the media does deal with the issue of abortion, “it’s not medical, it’s moral, it’s right and wrong” (Interview.). The media’s use of the moral frame and sparse coverage, Melanson suggests, fuels a lack of discussion. The problems associated with biased news reports and/or a general absence of reporting on the issue is of particular concern in New Brunswick where the media monopoly of the Irving family has gone to extremes. The Irvings “currently own all three English language daily papers in the province: Fredericton Daily Gleaner, Moncton Times and Transcript and the Saint John Telegraph Journal” (Steuter 2004). Recent expansions have also meant that they control “Five French-language weeklies *Le Madawaska*, *La République*, *La Cataracte*, *L’Hebdo Chaleur* and *L’Etoile*” (ibid.). The resulting absence of dialogue can contribute to a widespread lack of knowledge and accountability on the part of social movement activists, providers, and politicians.

The lack of dialogue on abortion in public, in the media, and at the Legislature, combined with the imposition of a strong moral frame when it was addressed in the above forums, has made the exact nature of the populace’s views on abortion difficult to ascertain. What is clear is that the anti-choice groups in the province exercise power over the social climate. This power has created fear rather than widespread consensus.

Importantly, pro-choice activists continue to push for change within New Brunswick, despite the unfriendly climate. The central focus of these groups in the province includes ensuring that the clinic continues to run, continuing to attempt dialogues with the Legislature, raising awareness and, most prominently, engaging in legal action against the province. Judy

Burwell, former manager of the Fredericton Morgentaler clinic, noted the tireless and frustrating nature of the struggle that characterizes the New Brunswick pro-choice movement:

It just wears you down in this province. I mean, for eleven years now I have been working specifically on this issue, both as a clinic manager and also as a board member for AARC [Abortion Rights Coalition of Canada], and it just wears you down and you think ‘why do we bother?’ but then you don’t stop bothering because you don’t stop bothering. You just keep trying. (Interview.)

Ambivalence in Ontario

Ontario, the province from which the *R v Morgentaler* decision originated, handled the decriminalization of the procedure within the spirit of the law, treating abortion as a medical issue. Abortion services are now widely available in the province, which never attempted to restrict access to the procedure, though there are still access issues in rural areas. Abortion is largely treated as a non-issue in the province, whose attitudes can be characterized as ambivalent, even bordering on apathetic. While public discourse has not internalized the rights frame to the same degree as it has in other provinces, the availability of services has lessened concern about how abortion is perceived. In essence, so long as the service is available, women’s rights are seen as having triumphed, and universal acceptance of the rights frame is seen as unnecessary.

The *Morgentaler* victory satiated the pro-choice movement to a large degree, and simultaneously motivated anti-choice groups to mobilize. While pro-choice movements are certainly still in operation in Ontario, their focus is on ensuring that abortion services are available and accessible to women, rather than on large-scale consciousness-raising campaigns. In the policy vacuum created by the *Morgentaler* decision, the rights framework in Canada has flourished, but the moral frame has not disappeared. Indeed, there is growing concern that a lack of discussion of abortion, including the consequences of illegal abortions, has contributed to an

ambivalent public, who are often uninformed and even misinformed on the issue. Still, many interviewees remained positive about the nature of individual views in Ontario, suggesting that, even where people were personally opposed to abortion, “most people understand that, if you’re in that position [of having an unwanted pregnancy], it should be your choice.”¹⁵² Bell, a student activist who asked that their identity remain confidential, revealed their experiences when teaching a class which dealt with the issue of reproductive choice:

Lots of the students came from very religious families and all different kinds of religions: Jewish, Christian, Islamic, and have heard of the debate about abortion but haven’t necessarily had to talk about it, because it’s not something they needed to access or not something that was right in their face. But very few people were in favour of making it illegal. Some said, ‘you know, I think it’s wrong, I think it’s against what God wanted,’ even that it’s murder, but that they would never interfere with a woman’s right to choose that because they’ve never been in that position. (Interview.)

Robidoux, manager of the Ontario Coalition of Abortion Clinics, suggested that Ontarians are generally ambivalent but, “when push comes to shove,” are likely to express “staunchly pro-choice” views (Interview.). Others, like Methven, a sexual health promoter for Toronto Public Health, are concerned about how easily the rights of women can be revoked. Canadian women, she argues, are not “necessarily as emancipated or as feminist as we think we might be.”¹⁵³ She explained that “equality issues [may not be] as strong as lots of people seem to assume they are” and further that the fight for equality is “a really fragile, hard-fought, non-acknowledged battle that people have just taken for granted” (ibid.). Fear regarding the potential

152. Aidan Bell [pseud.] (Social activist, years unknown). Interview by author. 24 February 2011. Recorded and transcribed by author. Toronto, Ontario.

153. Tracey Methven (Sexual Health Promoter for Toronto Public Health, 1997–Present). Interview by author. 30 March 2011. Recorded and transcribed by author. Toronto, Ontario.

consequences of ambivalence, particularly in the wake of anti-choice backlash, is evident with a closer look at the means through which gains in the feminist movement were realized historically. Robidoux explained that pro-choice mobilization has been crucial to the success of the movement, socially, politically, and through litigation:

That's how we got here [mobilization], it wasn't just some legislation that came in. The Supreme Court would not have thrown this thing out in 1988 without the *Morgentaler* decisions; the jury decisions, the reversal of the jury decisions, him [Morgentaler] going to jail, it created a climate where people got it (Interview.)

Moreover, she maintains, in the years preceding the *Morgentaler* decision, when debates were being held in small towns in Ontario, it was the proximity of the populace to the consequences of unwanted pregnancies and back alley abortions that contributed to public support:

We [OCAC and CARAL] went to all these small towns before the law was overturned, there were constant debates in Midland Ontario or Peterborough or wherever, about abortion, and there would be somebody representing the anti-choice and one of the people from OCAC or CARAL or one the groups. And over and over and over again all these women who you'd think 'oh, here we go, some elderly woman coming up and she's going to chastise us for, you know.' No. 'You don't want to go through what we suffered. I saw it. I witnessed it. I experienced it.' And just spelling it out, over and over again and not just to women, but to men and women. That's the other thing. It's just that it's so clear for people what the consequences of an unwanted or unplanned pregnancy are in conditions where you don't control your income, you don't have access to childcare, you're studying, or whatever, it's devastating. It's such a step forward for women to actually be able to make those decisions themselves. (Interview.)

Robidoux's experiences are demonstrative of the power of information in the abortion debate. Anti-choice backlash has only become more powerful as the memories of illegal abortion have begun to fade. However, those individuals who lived through the time before legal abortion services were available, and who experienced the consequences of having to seek out, or watch a friend seek out, an illegal back alley abortion understand the consequences of women's inequality. Their support of access to abortion services, as Robidoux reported, is unconditional given their remembered experiences.¹⁵⁴

A lack of discussion about abortion in the public discourse has distanced people from the realities of its illegality. Anti-choice groups have worked hard in this environment to subtly rescind women's hard won rights. While Ontario has both hospital and clinic services covered under their provincial insurance plan, social barriers have made some of these services difficult to access.

The prevalence of abortion clinics in Ontario have made protestors in the province a pressing concern. The province has a history of violence towards clinic staff and past destruction of facilities that has contributed to a climate of fear.¹⁵⁵ Steps have been taken to protect staff and patients at the clinics with the most consistent and threatening protestors. Limited bubble zone legislation around certain clinics, which creates a perimeter around facilities that demonstrators cannot legally breach, have proven calming to some employees. Still, individuals who worked at clinics around the time the Morgentaler clinic was fire bombed, according to Cooke, "have a more heightened sense of what the risks are" (Interview.).

Michelle Robidoux has noted that the concerns of anti-choice violence in the province are

154. The commitment from men and women of all ages to the realization of women's rights to abortion access, as recounted by Robidoux, is also demonstrative of the fact that abortion is not simply a young person's issue.

155. See chapter four for a discussion of violence in Toronto.

once again on the rise, involving both “implicit [and] explicit threats of violence” (Interview.). She noted an increase in picketing outside at least one prominent Toronto clinic, and related stories of protestors forcing their way into clinic to harass patients in the waiting room. The reemergence of violence, which Robidoux theorizes may be due in large part to the longstanding Conservative majority in federal politics “hasn’t been that much of an issue since the mid-1990s,” and is therefore cause for real concern. A representative of Canadians for Choice also commented on this trend, noting the way the anti-choice movement has revved up their organization in recent years.¹⁵⁶

Another interviewee suggested that a diversity of cultural backgrounds, languages, and religions in Toronto influenced social views. A representative of Planned Parenthood Toronto, who asked that their identity remain confidential, explained that individuals seem to form their views about abortion at a very personal, emotional level, which is “very dependent on their cultural upbringing and their religious beliefs” as well as on the way “their friends feel about abortion and how society feels about abortion” (Wilson, Interview.). Despite the continued existence of stigma surrounding abortion, Cooke explained that the attitude of most Ontario women she has encountered, especially those in large urban centres, has been quite simply, “entitled,” which, she was quick to point out “is a good thing because we should have these rights” (Interview.). The disbelief that women express when told they cannot be seen in a timely manner, or that they are required to drive long distances to access services, is completely reasonable, and, if access is to improve, should be encouraged.

Ontario is something of a hodgepodge of entitlement, stigma, and pro-choice deference, with pro-choice groups focused on maintaining rights rather than pushing for improvements.

156. Agathe Gramet-Kedzior (Acting Executive Director of Canadians for Choice, years unknown). Interview by author. 18 September 2011. Written notes. Ottawa, Ontario.

Interviewees characterized the resulting social climate as one of widespread ambivalence and sometimes even apathy, especially amongst those who assumed abortion rights were already secure. According to a representative of a government affiliated organization, created to promote women's health, "organizationally there's a lot of recognition that this [abortion] is a legal service, it's a needed service, it's a service that women value, but there's also tremendous recognition of there being a similarly strong segment of the population that wants the service less available, limited".¹⁵⁷ Methven also acknowledges the prevalence of discord in public discourse on abortion: "I would like to think that it's an accepted practice but I know that it's not; it might be accepted, but not openly" (Interview.).

Pro-Choice Quebec

Quebec, a province widely known for its progressive reproductive health policies and pioneering role in the pro-choice movement is, unsurprisingly, characterized by a strong pro-choice social climate which embraces the frame of abortion as a woman's right. When asked about the factors contributing to these attitudes, rejection of patriarchal power structures and socially traditional gender roles, particularly those enforced by Catholicism, were consistently mentioned by interviewees.

Before the Quiet Revolution, Quebec was a devoutly Catholic province, and the Church had a powerful hold on women, particularly relating to expectations around reproduction. Megill, a social activist, former clinic employee, and current medical student, explained that, "not that many years ago people remember having fifteen kids. My grandma was one of nineteen" (Interview.). Large family sizes were the norm, so much so that there was even concern

157. Eva Flanagan [pseud.] (Representative of a government-affiliated organization created to promote women's health in Ontario, years unknown). Interview by author. 30 March 2011. Recorded and transcribed by author. Ontario.

historically by English Canada that French Canadian families were attempting to “outbreed” the English, as Protestant women, who were predominantly English Canadians, were not expected to have such large families (McLaren 1994, 124). The realities of these demands on Catholic women, in the end, seemed to be one of the greatest motivators for their resistance to both the church and the state during the Quiet Revolution, which changed the nature of the social climate in Quebec dramatically. “I think people here saw the toll it took, they saw what it did,” Megill explained, and this awareness resulted in “the complete rejection of the Catholic Church and of the patriarchy” (Interview.).

Their resistance was, in large part, a reaction against unsustainable reproductive demands, but their ownership of the issues was what sustained it. Pat Powers, former president of Planned Parenthood Montreal, noted the fierceness with which Quebecois women protect the issues close to them. He explained, “francophone women here [in Quebec] have a notion that their liberation and their issues belong to them, not to anybody else” (Interview.). The strength of their reaction against the Church is evident in a story he recounted regarding a visit of the pope to Montreal:

When the pope, in the early 1960s, was trying to discourage Catholic women from going on the pill he especially wanted to pay attention here in Quebec and spend extra time in the province when he came through. Upon hearing that he was going to be in Montreal the women organized a huge protest. They were protesting his presence. They had signs that read ‘go home.’ He showed up expecting to be embraced by all the Catholic believers here. No, no, no, au contraire. It was exactly the opposite. They did not want to hear anything from him and they were not going to, they were not going to permit it.

The advent of *the pill* (oral contraceptive) in the 1960s was hugely empowering for women, who

now had new avenues to control their reproduction—advantages they were not about to be told to give up. Megill likened the change in attitude and possibilities to a brave new world, explaining that, “you looked at the way your grandmother lived and you looked at the possibilities you had and it was like ‘wow’. I think that is basically where it comes from there is this whole mentality of ‘never go back, never go back’” (Interview.).

The fierce protection of women’s reproductive rights, firmly rooted in understandings of the implications of birth and pregnancy as well as cultural recognition of women as citizens, including their rights to have fulfilled social and sexual lives, is as strong as ever in the province. According to a representative of the Fédération du Québec pour le planning des naissances (FQPN), who asked that their identity remain confidential:

There was a survey that came out around G8 lead up that showed, I think, 96% of Quebecers, or something absolutely ridiculous like that, are in favor of abortion services being legal and consider themselves pro-choice. We were completely abuzz about how pro-choice, how strongly pro-choice this province is. (Ross, Interview.)

The vocal and protective nature of Quebecois women’s issues was also noted by Megill, who recounted the incredulity of her female classmates at McGill medical school when anti-abortion attitudes were mentioned: “There were enough women in the class, and enough Quebecois French women specifically, that they basically said ‘Excuse me, why are we having this discussion?’” (Interview.). The forceful expression of these attitudes towards feminist issues is common in Quebec.

Social perceptions of abortion as a woman’s right have meant that the anti-choice movement does not have the same foothold in this province as elsewhere, but that is not to say they are unaffected by backlash. Activists interviewed for this study have noted a recent increase

in anti-choice activity. Interestingly, these concerns were not based on growth in the movement's numbers—rather, they were based on fears that an increase in funding is facilitating anti-choice activity. Central to their concerns is a growth in so-called crisis pregnancy centres. Dr. Lippman explained that “there is a huge amount of money being spent by various fundamentalist and religious right groups on the anti-abortion issue” (Interview.). The Manager of the *Centre de santé des femmes de Montréal*, Anne Marie Messier, shared this concern, and also suggested that these centres may be popping up because of external funding, oftentimes believed to be coming from religious organizations in the United States.¹⁵⁸

Despite the widespread availability of abortion services, interviewees also expressed concerns regarding difficulties in maintaining confidentiality in rural areas, as well as a lack of publicly available information. As in other provinces, there is an urban/rural divide in services in Quebec. Dr. Lippman drew a parallel with the provision of Plan B (the morning after pill) in small towns:

It was one thing to have Plan B be available but if I'm living in a rural region and I know I can get it from the pharmacy does that help when the pharmacist is likely to be my uncle? In a small town I know everybody in that town, so it's not as if I can take the metro and walk into a pharmacy in a region of Montreal where no one knows me. In a small town I don't have that sort of access. So I think there are a lot more constraints on choice of all kinds outside Montreal, or outside of any big city. (Interview.)

The majority of social barriers identified in the province were relatively minor in comparison with other provinces, including the confidentiality of services in smaller towns and the difficulties in negotiating the system due to a lack of information. These problems, while

158. Anne Marie Messier (General Director of the centre de santé des femmes de Montréal, 2007–Present). Interview by author. 17 June 2011. Recorded and transcribed by author. Montreal, Quebec.

worthy of attention, are not unique to the abortion issue, and are generally not related to issues of social stigma.

A long history of reproductive oppression was successfully challenged in an incredibly short period, due to the conviction by a majority in the province that reproductive control was a rights issue. Clear connections between the naturalization of women's care roles and reproduction have made this battle all the more compelling. By politicizing reproductive autonomy, Quebec was able to create a favourable social climate, which not only facilitated access to abortion but also recognized the political nature of social reproduction writ large. To attempt to classify abortion as anything but a rights question in this province is to be met with challenges about all aspects of women's community membership, and rightly so.

Conclusion

The variation in social attitudes towards abortion in the Canadian provinces is dramatic. While these attitudes both inform and are informed by the institutions formally regulating the procedure, this chapter has focused largely on their direct impact on the ability of women to exercise their citizenship rights and the way they internalize their community membership.

According to interviewees, New Brunswick's attitudes towards abortion are characterized largely by silence. While this does not necessarily signify anti-choice sentiment, it does promote the belief that abortion continues to be a taboo topic. Treating abortion as a controversial issue undermines its importance to women's citizenship; if it cannot be openly discussed, how can women be expected to exercise their rights to the procedure or assert its importance to their equality?

While Ontario has also failed to openly embrace a rights frame of abortion, attitudes in the province were more open. Still, abortion was portrayed as a kind of non-issue, largely resolved after *Morgentaler*. The entitlement common in urban centres reveals the perception that

women's rights are guaranteed, which is a positive sign, but without substantial public discourse, these issues are still portrayed as somewhat taboo. As such, women's rights to bodily autonomy are not regularly recognized, and remain vulnerable. While this recognition is often met with incredulity, and rightly so, it is often encountered under vulnerable circumstances, and can cause women to internalize a sense of exclusion from the community.

Quebec, in contrast, was the only province to embrace abortion as an issue of women's rights. This view is still staunchly defended today, as evidenced by the nature of public discourse on the subject and the willingness of individuals to speak openly on the issue. The relationship between a patriarchal social order and restrictions to abortion access was also repeatedly reiterated by interviewees from the province, and the suggestion that abortion could be a stand-alone moral issue was, in turn, met with disbelief.

The variance in social climates between the three case studies makes it apparent that not all Canadian women experience their citizenship in a uniform way; rather, their experiences are conditioned by the social perceptions of abortion in their home provinces. Public tolerance of anti-choice views, or ambiguity towards women's rights, allow not only for increased interference with women attempting to access services but, perhaps even more importantly, can lead women to internalize the belief that they are subordinate. Whether or not societies accept abortion as a political issue and, fundamentally, a rights question, speaks to larger understandings of women's social roles and value as citizens.

Different social understandings of abortion, as a moral or a rights issue, are reflective of the expectations of women's social citizenship; the rhetoric used by pro- and anti-choice groups exemplifies this relationship. When abortion is simply, or predominantly, treated as a moral question, it is depoliticized. Whether or not a woman wishes to terminate a pregnancy becomes a

question regarding the social norms of motherhood, family, and community, which are founded on the naturalization of gender roles disadvantageous to women. Recognition of abortion as necessary to women's citizenship demonstrates not only respect for women's autonomy and value as citizens, but is demonstrative of greater understanding of social reproduction. Support for, or even tolerance of, anti-choice activities is thus an affirmation of regressive conceptions of women's citizenship demonstrative of a backlash against their hard-won victories to control their reproduction. If the moral framework is seen as a viable frame through which to understand abortion, women will not be treated as full, equal citizens.

Social acceptance of the moral frame of abortion is not just a problem when it outwardly restricts women's choices (for instance, by condoning anti-choice picketing outside of clinics which deters women from seeking services), but also when it is internalized by those it is meant to subvert. If women understand their desires for reproductive autonomy as, at worst, shameful, or, at best, a special right, they continue to see the female body as an exception to citizenship guarantees—as “the Other” (DeBeauvoir 1989). The acceptance of women's rights as human rights is crucial before women can understand themselves as full citizens, deserving of equality. In the words of Joanna Erdmann, “it is not enough that women are ‘perceived [to be] full members of Canadian society,’ they must also ‘believe themselves to be’” (2007, 1155). The ability of women to exercise their rights to reproductive control can only be realized when they truly understand themselves as equal members of Canadian society.

Chapter 7. Abortion in Medicine

As physicians our place is not to judge but to support the patient in her decision. If we cannot do that we at least need to make the arrangements and refer them to a colleague who will give them the proper support, rather than just shutting the door and saying no, and leaving her out there on her own, unsure of where to go, which happens here [in New Brunswick].¹⁵⁹

In order for women to exercise their rights as equal Canadian citizens, it is not enough that abortion be legal; it must also be accessible. The realization of access requires that abortion services be safe, widely available, timely, and fully funded. The medical community is responsible for the provision of services at the patient level and is highly influential in both the nature and prevalence of the procedure. As this chapter demonstrates, the rights and moral frames are evident in the way individual providers treat abortion services. Moreover, by virtue of the way medicine is organized in Canada, doctors have considerable discretion in their dealings with patients seeking abortion services. The result is a sizable variance in women's experiences seeking abortion services across the country, including significant differences within a given province.

Doctors have played a major role in the pro-choice movement, as exemplified by Dr. Morgentaler's integral role in the decriminalization of abortion in Canada. Just as there are pro-choice advocates within the medical profession, however, so too are there physicians who refuse to support abortion services on moral grounds. Importantly, even physicians willing to advise patients on abortion and provide services are met with resistance from those both inside of and external to the profession. Indeed, while attempting to provide services, physicians are subject to many of the same barriers women face attempting to access them, including harassment and threats of violence from anti-choice demonstrators.

159. Sean Moore [pseud.] (New Brunswick physician, more than ten years). Interview by author. 11 January 2011. Recorded and transcribed by author. Fredericton, New Brunswick.

In order to situate the roles and responsibilities of physicians in the provision of abortion services, this chapter begins with a description of the procedure itself. There are many types of abortions, and which one is performed is dependent on how far along the pregnancy is, the location at which it is performed, and the tools available. The two most common methods in Canada are medical abortions and vacuum aspiration abortions, both of which can safely be performed in the first trimester, when the overwhelming majority of abortions take place. Second and third trimester abortions are considerably more rare because there is widespread access to abortion services in much of Canada, but the rationale for seeking later procedures is also discussed.

The following section moves to a larger discussion of the relevant elements of the organization of healthcare in Canada; specifically, it discusses the implications of health insurance schemes between provinces and the organizing bodies responsible for the regulation of physicians, both in Canada and the provinces. It also addresses difficulties and controversy surrounding the regulation of abortion by the medical profession. This section demonstrates the variance in access which results from the policy vacuum surrounding abortion. If abortion were formally recognized as a right of women's citizenship, the medical profession would be forced to regulate it differently, paying more attention to women's experiences with the medical community and finding new solutions to ensure their rights are not violated.

Despite the high levels of organization intended to ensure uniformity in the provision of healthcare, it is ultimately a matter of provincial jurisdiction, and each province has taken a different approach to the regulation of abortion access. The individual nature of the medical profession has further contributed to variations in access. Interestingly, as a result of the diversity of approaches in and between the provinces, many of the same issues have manifested in each.

To address this overlap, the case studies in this chapter will be arranged in a modified format. As the facilities in which abortion can be accessed in each province, namely hospitals and clinics, are largely the same, they will first be discussed with reference to each of the three provinces. Mention is also made here to anti-choice facilities posing as health clinics, often referred to as crisis pregnancy centres, and their impact. This section will flow into a more focused discussion of the unique relationship between medicine and abortion in New Brunswick, Ontario, and Quebec. As aspects of access in these provinces have already been discussed, these sections may appear abbreviated, though in totality they are comparable to those in previous chapters.

The ongoing legal and political battles in New Brunswick surrounding the issue of abortion are reflected in the way services are provided. Significant barriers to funding, the necessity of negotiating a complex web of bureaucracy, and harassment are all realities faced by women attempting to access abortion care in the province. The desire of physicians to either help women through this process or to further block their access influences the nature of services in the province. As in chapter four, the New Brunswick case study is markedly longer than that of the other two provinces given the continued conflict in the province.

The experiences of Ontario women differ substantially from those of women in New Brunswick. The procedure is fully funded in the province, but issues with insurance continue to be a problem for some women, particularly new Canadians. Communication and privacy are also emerging issues in the province, especially in Toronto, due to the diversity of language groups and the need to access translators to gain service.

The situation in Quebec is addressed next. As in Ontario, funding is not a significant issue in the province, but facility access has been an important issue. Attempts to streamline the clinic system are addressed in this section, as are some of the unique advances in abortion care.

Unlike in the other provinces, the issue in Quebec is not simply maintaining or expanding care, but examining the quality of access and considering ways to improve women's experiences when they are seeking abortion services.

Finally, there will be a brief discussion of healthcare for aboriginal women in Canada.¹⁶⁰ Aboriginal healthcare does not fall within the sole jurisdiction of the provinces, making it difficult to address within case studies. While a study of women's experiences of abortion access in aboriginal communities is a dissertation unto itself, this section will broadly overview some of the unique barriers that aboriginal women face.

The goals of this chapter are twofold. First, it attempts to demonstrate the continued fragility of abortion access in Canada through an exploration of the way services are provided. While many physicians are resolutely pro-choice and have been instrumental in ensuring that women's experiences seeking abortion services are straightforward and non-judgmental, the nature of the medical profession does not protect women from physicians who adopt an anti-choice stance. The way services are delivered on the ground is paramount to ensuring that women are able to exercise their agency as equal citizens. Unfortunately, elements of backlash are evident at multiple levels of service delivery, from the actions of specific doctors to the harassment of members of the medical community by anti-choice social movements.

The individualistic nature of the medical profession has created some unique issues for women seeking abortion services. The classification of abortion as a medical issue has allotted physicians significant discretion in their dealings with patients, and those adopting an anti-choice stance have sometimes used these powers to subvert women's choices. Absent an enforceable right to abortion access, the ability of women to exercise their rights is impacted significantly by

160. "Aboriginal" is used as an umbrella term meant to encompass a multitude of individuals from different communities and bands, including status and non-status First Nations, Inuit, and Métis.

the medical profession. The second goal of this chapter is thus to draw attention to the shortcomings of a medical understanding of abortion to regulate and understand the procedure. Treating abortion as a clear-cut healthcare issue is reductive; this frame ignores the social and political realities of restrictions to the procedure and allows a politics of backlash room to thrive. Formal recognition of abortion as a matter of women's citizenship will not only require the improvement of access to abortion services in much of Canada, but will challenge the role of physicians as gatekeepers in the realization of women's choices. Ultimately, this chapter demonstrates the problems for the provision of abortion services stemming from the failure of the federal government to create enforceable rights to abortion access, while shedding light on the assumption that abortion can be understood as a simple medical issue.

The Procedure

In Canada, there are two methods currently in use for terminating a pregnancy: surgical abortions and medical abortions (ARCC 2006a, 1). Both methods provide "a safe and effective means to end a pregnancy" (ibid.). Which form is used is dependent largely on the stage of a woman's pregnancy. Before seven weeks of gestation, medical abortions are most common. The procedure is detailed in an Abortion Rights Coalition of Canada (ARCC) position paper:

A combination of two drugs, methotrexate and misoprostol, is used to cause the abortion. Methotrexate is usually given by injection, and in five to seven days tablets of misoprostol are placed in the vagina. In most cases the uterus will be emptied within two hours, but in about 35 percent of cases, it can take several days or weeks. Pain medication is given to ease the pain of the cramps that occur when the pregnancy tissue comes out of the uterus. The process is similar to a miscarriage. (ibid., 1–2)

Unfortunately medical abortions are not always successful, so a follow-up exam is necessary to verify its success (ibid., 2). AARC notes that, "because these drugs can cause birth defects, a

woman must be prepared to have a surgical abortion if the medical abortion is unsuccessful” (ibid.). The necessity of multiple doctor visits, and the increased time and pain often associated with this method, mean that it is not desirable for all women.

After seven weeks of gestation, surgical abortions are used, most commonly a method called vacuum aspiration. The patient is provided with light sedation before the procedure begins.¹⁶¹ To begin,

the doctor will gently dilate the cervix (the entrance to the uterus) by inserting and removing a series of narrow, tapered rods. A small hollow tube, which is attached to an aspirator machine, is then inserted into the uterus. The suction is turned on and once the uterus is empty, the suction is stopped. The walls of the uterus are gently scraped with a loop-shaped instrument (called a curette) to ensure that no tissue from the embryo or placenta remains (ibid., 1).

This procedure takes five to ten minutes and does not require a sterile operating room.

Depending on the form of anesthetic used, recovery time can be as little as half an hour (ibid.).

In total, “90% of abortions in Canada are performed during the first 12 weeks of pregnancy, and just over 9% of abortions take place between 12 and 20 weeks of gestation” (ARCC 2005a, 1).¹⁶² Late term abortions are considered to be those that take place “after 20 weeks of gestation” (ibid.). These procedures are rare, making up approximately 0.4 percent of abortions each year. Many “impairments or health risks are not detectable until after the 24th week of gestation,” and women who choose late term abortions normally seek them “because the fetus is gravely or fatally impaired, or the woman’s life or physical health is at risk, or both”

161. Which form of anesthetic is used is dependent on the facility, as discussed in the “Clinics” section below.

162. The Canadian Institute for Health Information, responsible for gathering data on induced abortions, does not compile all relevant clinic data. The AARC data is therefore more accurate as it pertains to the gestational age at which abortions are performed because it collects clinic data to use in combination with the CIHI statistics.

(ibid.). Typically the women who require services after twenty weeks had chosen to continue their pregnancies, although incidents have also been reported of women in abusive relationships and “very young teenagers who have delayed abortion care because they were in denial about the pregnancy” (ibid.). Few facilities in Canada provide services past twenty weeks, so women must sometimes travel to the United States, the expense of which “may be funded in full or part by some provincial governments” (ibid., 2).

The Organization of Physicians and Health Insurance in Canada

Following the decriminalization of abortion in the 1988 *R v Morgentaler* decision, the procedure was re-classified as a healthcare issue. Healthcare falls under provincial jurisdiction but is not without federal influence. The federal government holds sway over the provinces through funding restrictions detailed in the *Canada Health Act*. Physicians have also organized nationally, through organizations like the Canadian Medical Association (hereinafter cited as CMA), which provides professional and ethical reports outlining the rights and responsibilities of individual physicians; and the Society of Obstetricians and Gynecologists of Canada (hereinafter cited as SOGC), which provides procedural guidelines detailing “safe and effective methods for the termination of pregnancy” (CMA 1988; David 2006, 1014). Collectively, these organizations provide uniform procedural, ethical, and professional guidelines for doctors working in all provinces. Provincial governments continue to be responsible for the delivery of care in their home provinces, in conjunction with provincial medical associations that monitor individual physicians, but they must work within certain federal confines.

Canada’s universal, publicly funded health insurance program is designed to ensure that “all residents have reasonable access to medically necessary hospital and physician services, on a prepaid basis” (Health Canada 2010b). Instead of a national program, individual provinces and territories handle insurance, “all of which share certain common features and basic standards of

coverage” (ibid.). For instance, provinces must comply with the five basic tenets of the *Canada Health Act*: universality, comprehensiveness, portability, accessibility, and public administration (ibid.). Failure to adhere to the principles outlined in the *Canada Health Act*, which sets out the “roles and responsibilities for Canada’s health care system,” can mean that provinces and territories will not receive the maximum amount of federal funding through the *Canada Health Transfer* (ibid.).

Reciprocal billing agreements are another example of attempts to ensure more uniform access to medical services for Canadians—in this instance, for residents requiring care outside of their home provinces. All provinces and territories are signed on to reciprocal hospital agreements which ensure that all “insured hospital services are payable at the approved rates of the host province or territory” when provincial Medicare cards are presented (Health Canada 2007, 266). This system does not require the patient to pay out of pocket or wait for reimbursement for services. The *Reciprocal Medical Billing Agreement*, which makes physician services accessed by individuals outside their jurisdiction payable to their host provinces, was entrenched four months following the 1988 *R v Morgentaler* decision (ibid., 267; CIHI 2007, 1). Every province with the exception of Quebec is part of this arrangement (ibid.). Most healthcare services are covered under this arrangement which allows patients to present their health cards anywhere in Canada and have the services they receive billed to their home province. However, a small number of services were made exempt from this act. Abortion services were excluded, alongside “surgery for alteration of appearance” and “psychoanalysis” (CIHI 2007, F-1). These excluded services were considered to be either not time-sensitive or still experimental (or to have less costly alternative treatments). The rationale for excluding abortion under the reciprocal billing agreement is not explicit. According to the Abortion Rights Coalition of Canada:

Exclusion of abortion from a health policy that benefits Canadians for most other health services discriminates against women on the basis of sex. It remains on the list of excluded services because some politicians and their provincial health bureaucracies wish to restrict access. Without unanimous consent of the interprovincial committee, this inequity will continue to exist, and pregnant women who are living away from home and are unable to continue their pregnancies will find themselves disenfranchised from their health care insurance. (2005b, 2)

Since the procedure was excluded from the reciprocal billing arrangement, many provinces have made efforts to ensure that their citizens still have access to abortion services outside their home province. Information regarding current reciprocal billing policies for abortion in Canada is incredibly difficult to access, as there is no central federal or provincial database. For women in need of these services, the lack of a centralized format poses considerable difficulty. Canadians for Choice gathered the data included below with noted difficulty in response to this deficit (CFC forthcoming, 6). As with the accessibility of the service itself in home provinces, in terms of reciprocal billing policies, New Brunswick rates very low on the scale of accessibility while Ontario and Quebec are at the upper end of the spectrum.

New Brunswick considers abortion “an excluded service” meaning that neither the physician nor the hospital can bill New Brunswick Medicare, and “a woman must pay for the total costs of an abortion in another province/territory out-of-pocket herself” with no chance of reimbursement (ibid., 13–14). In Ontario, abortion is “considered an included service,” meaning that “the costs of abortion services in a hospital in another province/territory will be covered by OHIP coverage” (ibid., 17). While “an Ontario woman in Quebec may have to pay for physician services and then submit receipts to her local ministry office for payment,” she is nonetheless

largely covered regardless of where she is in the country (ibid.). Abortion is likewise “considered an included service” in Quebec, though the province’s decision not to sign on to the *Reciprocal Medical Billing Agreement* means that Quebec women “may have to pay for physician services out-of-pocket and then apply to be reimbursed by the Quebec Health Insurance Plan” (ibid., 19). Women will generally be reimbursed for doctors’ fees “up to amounts not exceeding Quebec rates” which, given that “Quebec rates for physicians services are significantly lower than other provinces/territories” may mean they do not receive full compensation (ibid., 19–20). The manner in which provinces handle funding procedures for women outside of their jurisdiction is important to consider when gauging the policies of each province.

Decisions regarding the ethical and professional stances of physicians across Canada on specific medical issues are the responsibility of the CMA. The CMA normally creates policy during their Annual General Meeting. Doctors from all regions of Canada convene to debate and vote on specific policy positions every August at the CMA’s AGM.¹⁶³ According to a representative of the CMA, when an issue stance has been decided it must still go through the CMA Board of Directors for final approval, but position approval is more a formality given the format through which the decisions are reached (Knight, Interview.). The thorough processes through which positions are created and revised include regional discussion throughout. A CMA representative noted that this has historically meant that all the provinces, with the exception of Quebec, uniformly adopt CMA policy (ibid.).

As a result of the ethical debate surrounding abortion, CMA attempted to articulate a clear stance on the issue in December of 1988, stating that “induced abortions should be uniformly available to all women in Canada” and covered under Medicare (CMA 1988, 2). The

163. Ivy Knight [pseud.] (Representative of the Canadian Medical Association, years unknown). Interview by author. 10 February 2011. Written notes. Ottawa, Ontario.

statement also made it clear that a doctor, “whose moral or religious beliefs prevent him or her from recommending or performing an abortion” should not be compelled to do so (ibid., 1). The CMA holds tightly to the belief that “the decision to perform an induced abortion is a medical one, made privately between the patient and her physician” (ibid.). The belief that abortion is primarily a medical issue, to be decided upon between a woman and her doctor, is, however, a problematic one. As this chapter later discusses, the medicalization of abortion has depoliticized the procedure, obscuring its importance to women’s experiences of citizenship.¹⁶⁴

The stress placed on the ability of physicians to refuse to participate in the performance of abortions is a reference to conscientious objection. The concept refers to the right of doctors to refuse to provide services that would require them to act against their own moral compass. Physicians in Canada are guaranteed a right to conscientious objection in the provision of abortion services. This right to conscientious objection does not apply, however, in emergency situations. Notably, according to a representative of the CMA, a woman’s desire for an abortion does not constitute such an emergency (Knight, Interview.). In order to contravene a physician’s objection, the situation would have to be one of life and death for the woman. VanBraagen also noted that medical students cannot object to learning the procedure if their school teaches it, but they are not required to practice their skills during residency (Interview.).¹⁶⁵

The desires and objections of women seeking to terminate a pregnancy are not accounted for in this model. A woman whose physician refuses to provide a referral can seek the help of another doctor, though she may not be aware of this recourse. And, even if she is able to make an appointment with another physician in a timely manner there are no guarantees that the next

164. Consult Brodie (1992) for a broader discussion of the dangers inherent in the medicalization of pregnancy.

165. Tiffany VanBraagen [pseud.] (Ontario medical school representative, years unknown). Interview by author. 1 April 2011. Written notes. Ontario.

doctor will agree to help her access an abortion. In other words, while abortion is a recognized medical procedure, there is no legal requirement that the medical sector make such a procedure available in an accessible and timely manner. This model takes the onus off physicians to ensure their patients receive care and creates unreasonable barriers for women attempting to access a safe and legal medical procedure. Thus, the rights of practitioners are protected above those of women seeking to terminate a pregnancy. While some physicians interviewed for this research criticized the use of conscientious objection by physicians to avoid giving referrals, noting that it goes against professional and ethical standards of care, this sentiment is not shared by the entirety of the medical community, some of whom are actively attempting to block women's access to abortion services.

The power of these beliefs was evidenced by a guest editorial written for the *Canadian Medical Association Journal* (CMAJ) by Sanda Rodgers and Jocelyn Downie in 2006. Their article "Abortion: Ensuring Access" was written with the intent of educating physicians on the still precarious nature of abortion access in Canada. It also drew attention to some of the tactics taken by anti-choice medical physicians to block access, noting that "health care professionals who withhold a diagnosis, fail to provide appropriate referrals, delay access, misdirect women or provide punitive treatment" are committing malpractice and breaching the CMA Code of Ethics (Rodgers and Downie 2006, 9). This code "prohibits discrimination on the basis of sex, marital status and medical condition" (ibid.). Despite its progressive message, which was in keeping with CMA position statements, it received criticism from anti-choice physicians concerned about the apparent professional obligation to provide referrals (Blackmer 2007, 1310). These concerns pushed the CMAJ to clarify its position on referrals for abortion services. They suggested that not referring was acceptable so long as the doctor did not further "interfere in any way with [the]

patient's right to obtain [an] abortion" (ibid.). The continued lack of clarity regarding a physician's obligations to their patient in the event that they object to her decision to terminate a pregnancy threatens women's citizenship rights. Absent a clear rights-based model to frame reproductive health issues, particularly abortion, women's choices can be subordinated to the belief systems of their physicians. The type of access and limitations to medical procedures that safely allow women to terminate a pregnancy if they so choose is conditional, therefore, on the willingness of individual doctors to provide the service.

Some of the limitations regarding the provision of abortion services by provinces are the result of this structure, which elevates the preferences of individual providers above the needs of patients. For example, legal gestational limitations for abortions are nonexistent; rather, the services provided by the provinces reflect the preferences of practitioners to perform abortions up to a certain number of weeks as well as the CMA's policy statement on induced abortion, which allows for termination of pregnancy only before fetal viability (approximately 20 weeks) barring "exceptional circumstances" (CMA 1988, 2). The only hard and fast limitations instituted regarding the procedure are directly related to the funding that provinces provide their citizens, both within their home province and while travelling in others.

The provinces have a different set of responsibilities pertaining to healthcare. They are "responsible for the management, organization and delivery of health services for their residents" (Health Canada 2010b). Every province and territory has its own medical association and College of Physicians and Surgeons. The provincial and territorial medical associations are divisions of the CMA, though they are "autonomous, with specific responsibilities in their provincial/territorial jurisdictions" uniting at the federal level, as during the AGM, only "to handle more effectively issues common to all" (CMA 2012b). Provincial medical associations

thus represent “the professional interests of the Society’s members [including] the advancement of medical science [and] physician work-related issues” (College of Physicians and Surgeons of New Brunswick [hereinafter cited as CPSNB] 2005). Each province also has a College of Physicians and Surgeons responsible for licensing doctors who fall under their jurisdiction and handling disciplinary action (Collège des médecins du Québec 2009; College of Physicians and Surgeons of Ontario 2012; CPSNB 2005).¹⁶⁶ These organizations work in conjunction with provincial governments to deliver healthcare.¹⁶⁷

Case Studies: Provincial Overlap in Service Provision

Despite the high levels of organization intended to ensure uniformity in the provision of healthcare, it is ultimately a matter of provincial jurisdiction and each province has taken a different approach to the regulation of abortion access. These differences are the result of variations in funding, facility access, the training and personal views of individual providers, and backlash to the realization of services from anti-choice groups. There is significant overlap in the issues faced by each province, often with very different outcomes. This section will compare the availability of facilities between the three provinces studied by examining the nature of hospital and clinic services in each, including both the nature of services and existing barriers to access. It will also address a rise in so-named Crisis Pregnancy Centres—anti-choice run facilities that often present themselves as medical or educational facilities in their attempts to dissuade women from accessing abortion services. Next, issues related to the training of future abortion providers, which continues to be a national concern, will be briefly considered. This section will then go on to a more focused discussion of the unique issues still facing each province.

Facilities

166. Translates as the College of Physicians of Quebec.

167. The role of the government in healthcare policy is also discussed in chapter four.

Abortion services in Canada can be accessed at a variety of institutions including: hospitals, specialized clinics, private physician offices, women's health centres, and in Quebec, *des centres locaux des services communautaires* (Local Community Service Centres, hereinafter cited as CLSCs) (FQPN and CFC 2010, 5; Echo 2011, 2).¹⁶⁸ A full array of facilities is not available in every province and some provinces will fund services only when they are performed at specific facilities. New Brunswick will fund abortions only when they are performed at "registered medical institutions" but refuses to grant abortion clinics this status. Ontario and Quebec cover services performed at all above-listed locations, though clinics have only recently been included in Quebec.¹⁶⁹ Where abortions should be performed continues to be an issue in all provinces. While New Brunswick remains resistant to expanding services beyond hospitals, there is concern in Ontario and Quebec that abortion services are increasingly being relegated to clinics, CLSCs, and women's care centres.

Clinics

Clinics have become the primary providers of abortion services in Canada. In 2009, 55.5 percent of pregnancy terminations were performed by clinics, up from 33 percent in 1996 (CIHI 2009, 1; Statistics Canada 2005a, 10–11). These specialized facilities are more cost-effective for the provision of abortion services than hospitals and are known for their sensitive and respectful approach to care. According to one Montreal clinic representative, "the basic advantage of the clinic is staff that are dedicated to the pro-choice movement, dedicated to providing empathic and non-judgmental care" (Brown, Interview.).

There are procedural differences between clinics and hospitals in Canada, specifically with regard to the use of anesthesia. Many hospitals use general rather than localized anesthetic,

168. CLSCs are community health centers run by the Quebec government (only available in Quebec).

169. See chapter four.

which can turn “a low-risk procedure into a higher-risk situation” because it is associated with a higher rate of complications (Echo 2011, 8). The rationale for its continued use is multi-faceted, and is based on a combination of available personnel (different forms of localized anesthetic require unique specializations), the preference of physicians (some doctors prefer not to interact with patients during the procedure), and the state of mind of patients (some patients do not wish to remain awake for the procedure). The use of general anesthetic when it is not medically required is a serious concern and can mean that clinic abortions may be a better choice for women.

The personnel and procedural advantages that many clinics offer are threatened by challenges many women have in identifying and accessing the facilities. Widespread anti-choice demonstrations outside clinics and the prevalence of anti-choice centres are a barrier to both women attempting to access services and to the staff providing them.

In New Brunswick, Judy Burwell, former clinic manager, and Peggy Cooke, former clinic employee, both noted the presence of anti-choice protestors outside of the Fredericton Morgentaler clinic when it is open (Burwell, Interview.; Cooke, Interview.). While relatively small in number, these groups nonetheless attempt to impede women’s access to the clinic. The most common tactics recounted were harassment and misinformation.¹⁷⁰ The Fredericton clinic has had to organize clinic escorts, who work on a volunteer basis, to help women and staff bypass protestors, a model used in other clinics across the country (Wu and Arthur 2010, 10). Timothy Cain, a rural New Brunswick physician, noted that “women who seek services at the Morgentaler clinic are surrounded by protestors who confront and terrify [them] as they enter the

170. See chapter four for more descriptions of the protest activity outside of the Fredericton Morgentaler Clinic.

clinic.”¹⁷¹

Many Ontario clinics also have issues with protestors, and some clinics have been able to secure temporary injunctions. In 1994, a temporary injunction was enacted against “protesting within a certain distance of clinics and doctors’ homes, and from circulating information about abortion providers” (Downie and Nassar 2007, 161). Injunctions are in place in “Toronto, London, Brantford, Kitchener and North Bay,” but unfortunately, without police cooperation enforcing them, these protections are relatively meaningless (Downie and Nassar 2007, 161). A social activist in Ontario, who chose to remain anonymous, noted that “there has been a real lack of effort on behalf of the province to intervene on matters like [the injunction]. The clinics can call the police but the police just come and say ‘I’ll tell the person to go away’ and they come right back” (Bell, Interview.).

The type of building the clinic is located in can also pose problems for the future creation and enforcement of legislation to protect women and physicians entering clinics. Not all clinics are stand-alone buildings. The Women’s Care Clinic on Lawrence Street in Toronto, for example, is a multi-office building. Protestors still block the entrance but often do so indiscriminately. Early in 2011, Robidoux explained that a group of roughly twenty-five protestors “were harassing not just women of reproductive age, but just anybody going into the building where this one particular clinic is housed” (Interview.).

The difficulties inherent in creating and enforcing protective zones around clinics is of particular concern given the history of violence at Ontario abortion clinics, both for the women and the physicians. The Toronto clinic was firebombed in 1992, and a doctor was shot three years later (ARCC 2006c, 2). Michelle Robidoux, manager of the Ontario Coalition of Abortion

171. Timothy Cain [pseud.] (New Brunswick physician – rural, years unknown). Interview by author. Questions answered via email, written by interviewee. 2 February 2011. New Brunswick.

Clinics, noted a resurgence, not of violence directly, but the “implicit or explicit threat of violence” predominantly in the forms of increased picketing and harassment outside of clinics in Ontario (Interview.). She attributes this recent increase to shifts in the federal government.¹⁷² Violence was noted as a concern by every province on the spectrum of access.

Quebec clinics have been largely spared anti-choice demonstrations outside of clinics. This is in large part due to the progressive social climate, which is also exemplified in the nature of Quebec institutions. Anne Marie Messier, for example, is the clinic manager at the *Centre de santé des femmes de Montréal*, one of three clinics in Quebec offering services using a strictly feminist approach (Interview.). The philosophy governing these facilities is based on respect for women and their experiences. If a woman is certain about her conception date, for example, she is not required to have a sonogram.¹⁷³ By respecting women and their personal knowledge, facility staff and practitioners create a comfortable atmosphere in which women can seek care without fear of judgment. This approach treats women as equal members of society, rather than subjects in a medical hierarchy.

Despite the social climate of the province, some facilities have had issues with demonstrators. Those that do have issues with protestors have in some cases been able to secure injunctions to prevent anyone from demonstrating directly in front of the facility and blocking access. While anti-choice activism still exists in Quebec, it was not cited as a major barrier to access in the province. A representative for the FQPN pointed out that “protesting here is not a problem... it just hasn’t reached Quebec in the same way” (Ross, Interview.). The general lack

172. This issue is discussed further in chapter 3.

173. Interestingly, according to Messier, women are almost without fail correct in identifying their dates. Where women opted to have sonograms, she explained, their predicted dates were typically more accurate than those determined by the sonogram (Interview.). This finding is interesting because it reiterates the importance of respecting women’s knowledge about their bodies. When pregnancy is medicalized, women’s experiences are often dismissed; they are treated as vessels rather than individuals, an experience that can be demeaning and frightening, not to mention unsafe.

of protest and the complicity of the government in granting injunctions where problems do exist speaks to the progressive social climate in Quebec. Still, where there is protest, its newfound tendency to mimic the language and tactics of the US anti-choice movement, according to a clinic representative in Quebec, is a concern (Brown, Interview.). Though the number of anti-choice demonstrators, by all accounts, has not seen a perceptible change, and even been reportedly decreased in some areas, their high levels of organization and funding allow them to accomplish more (Messier, Interview.). A number of interviewees expressed concern that Canadian anti-choice groups were receiving funding from the USA, specifically religious rights groups (Brown, Interview.; Lippman, Interview.; Messier, Interview.). This funding was of particular concern to interviewees as it pertains to anti-choice centres (which will be discussed in the following section) (Messier, Interview.; Brown, Interview.).

The potential for violence linked to anti-choice groups has been a barrier not only for women seeking abortions in Canada, but also for the medical community working to provide women with services. There are strong links between the anti-choice movement in the United States and in Canada, and the violence present in the USA has started to migrate north. Dr. Garson Romalis, an abortion provider in British Columbia, was shot by a US gunman in 1994, and stabbed by another assailant in 2000 (ARCC 2006c, 2). The gravity of the threats of anti-choice violence has had strong impacts on the willingness of physicians to provide abortion services. According to Burwell:

A lot of doctors, even pro-choice doctors, won't perform abortions because it can be dangerous. If people in your practice find out then suddenly you've got people picketing outside your house. ... one of the nurses at the clinic was harassed in front of her kids on a number of occasions. [The man] would go to her house and harass her (Interview.).

The provision of abortion services in New Brunswick, Burwell continued, has a serious stigma attached and “it’s difficult to get doctors to perform abortions” as a result. This sentiment was shared by physicians in New Brunswick and Ontario alike, and is further evidenced by the decision of all physicians interviewed, whether or not they are practitioners, to remain anonymous. A rural New Brunswick doctor noted that:

There are various unknown individuals who attempt to terrorize physicians who provide abortion services. I am aware of an abortion-provider/physician who was asked by her colleagues to leave a group-practice clinic because they were receiving anonymous threats based on their association with her. (Cain, Interview.)

Likewise in Ontario, a physician explained that violence is indeed a factor that influences who is willing to provide abortions and in what context (VanBraagen, Interview.). They also noted increased fears surrounding incidents of extreme violence, like the attacks on Dr. Romalis (Lippman, Interview.). A representative of Toronto Public Health, Tracey Methven, pointed out that it is difficult to find physicians who will go to clinics to perform services because “they’re scared, and rightly so” (Methven, Interview). She went on to say that, “nobody wants to have to hear of somebody coming and hurting them or their family or their staff” (ibid.).

There was less concern expressed regarding violence towards providers in Quebec. Catherine McGill, who worked extensively with the pro-choice movement and clinics in the United States before beginning her career in medicine, acknowledged when interviewed that she would likely be harassed if she choose to provide abortion services at some point in her career, but that she did not feel that violence was a central concern. She also pointed to the strongly pro-choice views of the francophone community in Quebec and the protection that would offer. Violence from US activists was the only significant

concern noted by McGill, particularly given the anti-choice movement's increasingly strong affiliations with the United States, and Canada's history with US gunmen and abortion providers. While provinces experience threats of violence differently, it is apparent that the anti-choice movement has gone to great lengths to make abortion providers feel unsafe.

Crisis Pregnancy Centres

Anti-choice centres, commonly referred to as crisis pregnancy centres, are facilities run by anti-choice groups, allegedly to provide women facing unplanned pregnancies with all their options. These centres are facing growing criticism because they do not clearly advertise their anti-choice affiliations, the types of services they are able to offer (they are not medical facilities), and some are known to provide gross misinformation to women (Shaw 2006, 11).

According to a Canadians for Choice study:

It was discovered that some groups are still telling women myths about the abortion process and about the after effects of having an abortion that have been proven completely false. Inventions such as there being a link between breast cancer and abortion, the medically unrecognized "post-abortion stress syndrome" and the false idea that a woman who has an abortion will be unable to bear children in the future are myths that are told as truths by some anti-choice groups. (ibid., 54)

A woman who is not familiar with the nature of these facilities can be put in the position "of having her reproductive choices limited and her health negatively affected" (ibid.).

In the case of the Fredericton clinic, escorts are also aware that the clinic is located immediately adjacent to an anti-choice centre, which, according to one clinic escort, advertises as "a women's care centre and a crisis pregnancy centre" (Toron, Interview.). The centre advertises that it will discuss all options and has adopted the language of choice but, according to Toron, is

not explicit about its anti-choice agenda, which can be confusing for many women. Physicians have also voiced concerns about these centres:

Some of my patients have contacted so called Women's Health Clinics on the promise that they will be offered counseling on all options regarding their pregnancy. Upon arrival they have been given deeply traumatizing and inaccurate information, and then pressured to not only continue with the pregnancy, but to give the baby up for adoption. It was this misinformation and the pressure tactics more than the abortion itself that caused long-lasting emotional difficulties for these women. (Cain, Interview.)

Quebec has also experienced difficulties with anti-choice centres. Over half of the interviewees in the province noted concern over the perceived increase in these facilities (Messier, Interview.; Ross, Interview.; Brown, Interview.; Powers, Interview.; Lippman, Interview.). According to an FQPN study on abortion services in Quebec:

With names like 'Care Center' or 'Pregnancy Options,' these centers generally present themselves as being neutral and as providing support to women in their decision-making. In reality, some of these centers try to discourage women from choosing abortion. (FQPN and CFC 2010, 65)

Similar facilities exist throughout Canada (Shaw 2006, 15). A movement has recently begun in the United States to begin to regulate these facilities. The New York City Council approved legislation in March 2011 that "would require the centers to clearly disclose the types of pregnancy-related services they provide, including whether or not they have a licensed medical provider and provide prenatal care, abortions and emergency contraception" (Griffiee 2011). No such legislation has yet been attempted in Canada. However, transparency for these organizations is important, particularly when hospitals have been known to direct patients

seeking abortions to these centres (Shaw 2006, 26).

Hospitals

Hospitals used to be the primary facilities providing abortion services in Canada. In 1996, hospitals performed 66.7 percent of abortion services in the country, though this percentage steadily fell to 51.9 percent by 2005 (Statistics Canada 2005a, 10). In 2009, hospitals were performing only 44.4 percent of abortions nationally (CIHI 2009, 1). The rationale for this shift is multi-faceted and includes budget cuts, a push towards privatization by some provinces, and hospital amalgamations.

Amid increasing pressures to improve and expand healthcare services across the country, particularly given Canada's aging baby boomer population, provinces have made attempts to redistribute and cut services. With constant pressure to cut healthcare funding wherever possible, abortion services are at risk. In this context, the notion of improving services to give women real choice is difficult to advance.

New Brunswick has long been a have-not province and faces consistent pressure to spend health care funds wisely, particularly due to its aging population. The decision to restrict abortion access, however, does not fit within an economic model. Morgentaler has estimated that his legal costs will be close to one million dollars if his current case reaches the Supreme Court, and, while the government has not disclosed the amount they have spent on litigation meant to safeguard their regressive policies, it is likely that it is significantly more expensive than simply providing the service would be (Thorne 2002, 1277). The rationale used to block abortion provision in New Brunswick is moral rather than economic; however, Ontario and Quebec have faced different monetary problems.

The Mike Harris Conservative government of Ontario, who won a majority in 1995, has been attributed with undertaking more dramatic steps to curb healthcare spending (Armstrong

and Armstrong 2001). They began delisting many services, which Robidoux maintained are central to the mental health of individuals as well as their sense of self, including for example, the “removal of port wine stains” from people’s faces, which people are born with (Interview.). Anti-choice groups have tirelessly reiterated their belief that abortion is not a necessary medical service. There is therefore fear that abortion care could likewise face funding cuts, if the politicians masterminding these decisions are anti-choice. Indeed, Robidoux identifies this kind of potential attack on abortion services, which has already manifested in New Brunswick, as part of a greater challenge to “what’s seen as a right, what kind of healthcare is seen as your right, and what’s seen as your private responsibility, or a luxury, or trivial” (ibid.).

Quebec has also experienced pressure to privatize and downsize. The FQPN noted “a gradual withdrawal of government and a transfer of collective responsibilities toward the private sector” in the 1990s and 2000s, from which reproductive services “did not emerge unscathed” (FQPN and CFC 2010, 29). Two clinics were forced to close and two hospitals had to reduce services, all while demands for services increased (ibid.). Despite these constraints, in 2001 the provincial government, led by the Parti Québécois, provided funding to meet the service demands (ibid.).

Hospital amalgamations in Canada, in the face of budget cuts, have also contributed to a reduction in reproductive health services, including abortions. The consolidation of secular and religious hospitals (typically Roman Catholic) has led to “the elimination or curtailment of many family-planning health services including abortion services” (Palley 2006, 581–2). Palley notes that: “Between 1997 and 1998, the number of Catholic-operated hospitals increased by 11 percent, whereas the number of secular public-run hospitals decreased by 2 percent. Of the 127 hospital mergers between 1990 and 1998, 50 percent resulted in the elimination of some

reproductive services” (2006, 582).

The services provided in a given hospital in all provinces are at the discretion of hospital trustee boards, which are composed largely of community members rather than doctors (VanBraagen, Interview.). A board with a strong anti-choice presence, or a board not informed about the importance of abortion provision to the women in the community they serve, can easily impede access. Of even more concern is the fact that hospitals are not responsible for ensuring that services are provided elsewhere if they are unable or unwilling to meet demand.

Availability aside, the nature of hospital services in Canada can itself be problematic. The sheer size and variety of services available at hospitals means that the provision of a high level of care, understanding, and support tailored to specific services can be difficult to achieve. Women encounter numerous staff members when accessing hospital services, and there is rarely screening at every level to ensure that they are encountering personnel who will treat abortion as a standard medical procedure. The presence of anti-choice personnel can cause serious problems for providers and women seeking abortions. In fact, women have sometimes been misinformed or redirected to anti-choice groups when calling hospitals to make appointments (Shaw 2006). The Canadians for Choice *Reality Check* report recounted difficulties faced by women attempting to access abortion services in Canada. Women recounted being misinformed and disrespected by hospital personnel and by the anti-choice organizations that some hospitals, whether knowingly or unknowingly, had referred them to (ibid.).

Many interviewees shared horror stories of experiences that women had recounted to them of their hospital abortions. A woman in a New Brunswick hospital, while coming out of general anesthetic, reported a nurse leaning over her and saying, “I hope you’re happy, you killed your baby” (Burwell, Interview.). And in Quebec, women reported being refused normal

doses of painkillers to ensure that they would be “reminded” of their apparent wrongdoing (Messier, Interview.). It is clear that unless hospitals have separate wards for abortion services, they are not as able to effectively deal with these issues as is necessary. Indeed, nurses walking out and instruments disappearing were recounted as the rationale for at least one hospital ceasing the performance of abortions in New Brunswick (Burwell, Interview.).

Even when staff are pro-choice, the volume of services provided can mean that women are inadvertently exposed to difficult situations. According to Messier, it can be very difficult for a woman waiting to have abortion to be in a waiting room with women who are incredibly happy to see their first sonogram (Interview.). Judgment by staff and patients alike can be a deterrent for women seeking to terminate a pregnancy in a hospital.

Threats to the safety of providers are also a powerful disincentive to provide abortions, even in a hospital setting. An Ontarian physician noted that the rooms in which abortions are performed in hospitals are generally locked and the gynecology wings of hospitals often need to remain under surveillance (VanBraagen, Interview.). While doctors practicing in hospitals can more easily remain anonymous, given the size of the institution and the many different procedures they perform, they are routinely reminded of the potential for violence.

Despite their shortcomings, hospitals remain important facilities for the delivery of abortion care. A representative of the FQPN noted that, while hospital services can be “problematic” they must nonetheless be defended (Ross, Interview.). The rationale for maintaining hospital abortion services is to ensure widespread access for women across the country. It is not “financially viable” to set up private clinics in small regions, so it is crucial that rural hospitals in particular continue to provide services, even when they are not “ideal” (ibid.). It is important to note that Quebec has two forms of public medical facilities: hospitals and CLSCs.

CLSCs are community health centres run by the provincial government. These centres provide a wide array of services, and eighteen such centres provide abortion services (Shaw 3006, 33). The prevalence of these centres means greater access for women in outlying areas that may not have the population base to sustain a hospital or clinic.

Few provinces offer travel assistance if a woman cannot access services in her hometown or province/territory. The only funds available are from the Northern Health Travel Grant issued by Ontario, which offers some compensation for individuals living in Northern Ontario who must “travel at least 100 kilometres one-way for [a] medical specialist or designated health care facility services that [is] not locally available,” as well as funds provided by all three territories, due to their distance from relevant medical facilities, which are granted upon approval by relevant authorities (CFC forthcoming, 14). Women not eligible for this funding, or who are not granted approval in time, must pay out of pocket to travel or, in the event that they cannot, either carry an unwanted pregnancy to term or seek a back-alley abortion. A lack of services in a given area is therefore a serious barrier for low-income women. Numerous points of service in hospitals are therefore of paramount importance. This is particularly true in New Brunswick, where the provincial government will only pay for abortions performed in hospitals.

The maintenance of public services is also important for training doctors (Stettin, Interview.). During clerkship and residency, medical students train predominantly in public facilities. If they are not exposed to abortion provision during their training, they are less likely to consider providing those services in the future. A dwindling pool of providers is a central concern across Canada.

Training Future Providers

Training physicians to perform abortions, and explaining their responsibilities to refer women to another physician if they are themselves unwilling to perform the procedure, is critical

to the provision of services in Canada. Many older providers are now retiring, but often there is no one to replace them when they go (Gramet-Kedzior, Interview.). In many cases, physicians have stayed on past the age of retirement because they want to guarantee women access, but they cannot stay on indefinitely (ibid.).

The training of future providers occurs at the discretion of individual medical institutions and “is not a part of the core content of the medical school curriculum” (Echo 2011, 4). Thus, while some students are receiving a high quality education, the education of others is incomplete. This patchwork of training means there is an alarming potential for a smaller pool of next generation providers. Moreover, it also means that a large number of physicians are unschooled in dealing with the delicate process of counseling and referring patients for abortion services.

While medical schools are not required to teach the procedure, many still do. Schools who teach abortions do not require students to perform the procedure should they conscientiously object, but they are required to understand the mechanics of it, understand how to handle complications from the procedure, and know how to counsel a patient who is pregnant and wants to understand all of her options. Classes also include discussions around the barriers to becoming a provider, including the threats of violence as well as the legal environment surrounding the issue (VanBraagen, Interview.).

According to one Ontario physician, some younger doctors might be more willing to perform abortions as part of their practice until the reality of the struggles they may face in performing the procedure start to surface (ibid.). Why take on the controversy? Fears of violence can be a strong disincentive for future physicians to include pregnancy terminations in their practice. Notably, these concerns were not as strongly articulated in Quebec as in New Brunswick and Ontario. A 2010 study by CFC and FQPN reported relatively stable rates of

abortion providers, although it did note some difficulties faced in the recruitment of physicians to perform abortions in rural areas, as well as struggles in finding physicians to fill in for others in the event of absences (50). This is likely reflective of the less taboo nature of abortion in Quebec which allows doctors to practice more openly and without, or at least with decreased, threats of violence.

Another concern for the future of abortion provision centers on a lack of exposure to the consequences of restricted access to services. Physicians training in Canada today “have never experienced a time when abortions could not be obtained legally” and current providers have described “fears that, without the spectre of the results of illegal abortions, new doctors lack the moral impetus that years back compelled them [current and retired abortion providers] to become providers” (Downie and Nassar 2007, 143). Taking on the challenges associated with abortion provision without having a deep connection to its importance can be a deterrent.

In order to ensure future access to abortion services in Canada, it is necessary to ensure that the next generation of physicians is trained to perform this relatively simple procedure. It is also important that their training stresses the importance of women’s autonomy in order to make certain that the services they will provide are in keeping with understandings of abortion as a right of women’s citizenship. Moreover, it is critical that their training stresses the importance of women’s autonomy. Finally, the creation of a safe environment within which these physicians can practice is also paramount to ensuring they can provide services. After all, without a sufficient pool of providers, regardless of women’s legal status, their reproductive rights are in jeopardy.

New Brunswick: Medically Unnecessary

Restrictions on funding and facilities in New Brunswick are among the worst in the country. In order to access a publicly funded abortion in New Brunswick, as a permanent

resident of the province, a woman must meet a list of criteria outlined by the government; specifically, she must receive written permission from two doctors stating that the procedure is medically necessary, then she must make an appointment with a gynecologist in a registered hospital for the procedure, which must take place before her twelfth week of gestation.¹⁷⁴ These requirements were not created with a mind to ensuring that women receive the highest quality of care, and indeed, they have no medical foundation.

A New Brunswick woman seeking to terminate her unwanted pregnancy must first seek written approval to validate her choice from two doctors stating that the procedure is medically necessary. This can prove difficult for many women, especially, as Toron points out, because there are “thousands of people [in New Brunswick] who just don’t have a family doctor who use walk-in clinics as their primary mode of health care (Interview.). Even those that do have a family physician may not have one who willing to refer them. While standards of professionalism and an extensive ethical code require that doctors detail a full range of options for women and refer them for services, they are not required to do so if they object to abortion. According to one New Brunswick doctor, many patients in the province are not given this minimum level of support, and are often simply told no in answer to their request for assistance (Moore, Interview.). Indeed, the referral requirement was a barrier brought up by virtually every individual interviewed in the province. According to Cain:

As I understand it two physicians must *approve* a woman’s decision to seek termination

174. Exactly what is meant by the term medical necessity is unclear. The term is not defined in the *Canada Health Act* despite the fact that provincial medical insurance will only cover services that fall into this category. As a result, “a policy dilemma is created. If no policy-based principle is attached to the concept, it is unclear how provincial governments should use this legislation [the *Canada Health Act*] as a basis for making service coverage decisions” (Charles et al. 1997, 367). Exactly what constitutes a medical necessity is still left to the discretion of physicians and politicians. The ambiguity of the concept has allowed it to become a tool of “political maneuvering” by allowing a multiplicity of socially constructed definitions of the phrase to exist at any given time that “can be converted into intellectual support for a variety of different policy positions” (Charles et al. 1997, 367).

of pregnancy. I believe the referral process should be no different than that of any other medical service. I don't have to approve a patient's decision to undergo other medical procedures. It is my duty to provide counseling about options, alternatives, risks and benefits. My patients decide what is best for them, not me. (Interview.)

Exactly what constitutes medical necessity is at the discretion of individual providers, as the term has not been officially defined. As Dr. Majerovich, explained during the Speak Out for Choice event, "because the regulation does not define the term, each physician can define it, arbitrarily and subjectively, without reference to either the law or medical ethics" (Majerovich). This affords a great deal of power to individual providers to decide what constitutes necessity. Some physicians may not share a woman's reasoning and may use their own definition to block access.

If a woman is able to overcome the first obstacle, she must then attempt to make an appointment with a gynecologist in a hospital who will actually perform the procedure. Currently only two hospitals in the province fit these provider requirements and are willing to perform abortions (Shaw 2006, 23). Unfortunately, out of "fear of harassment and anti-abortion violence, only one hospital in New Brunswick will openly affirm that they offer abortion services" (ibid.). This secrecy can be a barrier for women who are not sure where they can access services, particularly when the hospital may not be willing to affirm their provision of services to make an appointment (ibid.). The wait times for hospital abortions can also be unreasonably long: according to Dr. Hughes, "It was six weeks, in December, for the hospital" (Interview.).

The availability of hospital services has a poor track record in the province. Dr. Everett Chalmers Regional Hospital was formerly responsible for almost all abortions in the province, but stopped performing them in 2006 citing "workload problems" (CBC News 2004). At

capacity, the hospital was able to perform approximately four hundred abortions per year, which accounted for less than half of the provincial average demand of about one thousand abortions annually (ibid.). Then Health Minister Brad Green worked quickly to secure the two current providers after facing public backlash at the effective removal of all publicly funded services. The need for abortions in New Brunswick has remained stable at about one thousand abortions per year, and according to Dr. Hughes, while “the government used to provide about half of them now they are providing less than a quarter” (Interview.).

If women are to access an increasingly rare hospital abortion, covered by their provincial health insurance, they must conform to one further bureaucratic requirement: the procedure must be performed before the twelfth week of gestation in the province. Given the average wait times for family physicians, and the delays in women realizing they are pregnant, these restrictions effectively block access. With wait times accounted for, a woman who is aware of her situation and has made a clear choice to not to carry her pregnancy to term, even with access to pro-choice doctors, may be unable to meet the strict twelve week date. Moreover, women who are able to meet the strict criteria may not have the means or support to travel to the hospital. Most facilities do not permit patients who obtain abortion services to drive themselves to and from the facility for safety reasons; this often means that the woman must disclose the nature of her visit to someone else who can serve as a driver.

If a woman is unable to navigate the bureaucracy to secure a publicly funded abortion, or simply prefers to have her procedure done in a private clinic, she can make an appointment at the Morgentaler clinic. The Fredericton Morgentaler clinic is the only such facility in the province. The government restricts all funding to the facility so women must pay out of pocket for the

procedure, which costs roughly \$500 to \$725 depending on gestational age.¹⁷⁵ The necessity of payment means clinic abortions are not accessible to everyone. While many clinics attempt to accommodate women who are unable to pay the fee, it is difficult without public funding to help everyone, particularly when, according to former manager Judy Burwell, the clinic has been strained financially (Interview.). Burwell also noted that the success of Morgentaler's Toronto clinic has allowed him to subsidize clinics "like the ones in Fredericton and Saint Johns" which serve smaller populations and are more difficult to maintain (ibid.).

Accessing abortion services at the clinic is preferential for many New Brunswick women. Privacy is a serious concern in the province, which Burwell characterizes as reminiscent of a small town in which "everybody knows everybody else" (ibid.). She explains that women sometimes express concern about their anonymity in hospitals, where they may have friends or acquaintances that work there, as well as concerns about facing anti-choice staff (ibid.). Clinics may be a more comforting option for these women as staff are screened and confidentiality at all levels of the process, from appointment bookings to the procedure itself, is stressed. When women enter the clinic, they are in a non-judgmental, supportive space. Clinics ensure that their staff are pro-choice and understand the difficult decisions women seeking procedures often have to make, and the barriers they encounter in exercising their choices. Burwell referred to the Morgentaler Clinics as "a pleasant place to come in a difficult situation" (ibid.).

Though it may be a more calming environment for many patients, the New Brunswick clinic is only open to patients with limited hours. In the past few years, the clinic has been open one day a week and, while this schedule may seem limited, it actually represents an increase in

175. This avenue is available only to women who have the financial means to cover the cost of the procedure. This barrier disproportionately disadvantages poor, rural, and underage women within provinces that do not provide coverage. If women are truly equal members of society, money should not be a requirement to ensure bodily autonomy.

patient intake. According to Burwell, when she began working at the clinic in 2000, it was only open every second week (ibid.). The number of patients scheduled on each day has also increased. Burwell explained that there used to be thirteen to fourteen women a day in the waiting room, but it is not uncommon to have nearly twenty now. She suggests that the reason for this jump has to do with increasing difficulties for women attempting to access hospital abortions.

The ability of pro-choice physicians to provide abortion services in New Brunswick is highly restricted both within the profession and by outside forces. Due to the highly individualistic nature of the medical community, anti-choice individuals have been able to operate counter to professional expectations without consequence. Still, despite the difficulties for pro-choice practitioners, many of the strongest advocates for improved access in the province continue to come from the medical profession. The presence of advocates in the medical system can help women to navigate it—but there is no clear means for women to identify these individuals, nor should they have to.

Women in New Brunswick face extreme barriers implemented to restrict access rather than ensure high quality reproductive health care. They often face serious financial barriers to receiving non-judgmental, high quality care, and widespread tolerance for anti-choice policies and beliefs puts them at personal as well as physical risk should they attempt to exercise their right to care. The ability of women in New Brunswick to exercise their citizenship rights has been seriously compromised by funding and facility restrictions, as well as the unprofessional and unethical actions of select individuals inside the medical profession. The contention between the adoption of a rights or moral frame by individuals within the medical profession is evident.

Ontario: High Levels of Service

Ontarian women do not face the bureaucratic barriers to access that women in New

Brunswick do. Both hospital and clinic abortions are fully funded under the Ontario Health Insurance Plan (OHIP) without the necessity of a referral. There are many hospitals and clinics across the province that provide services, though women living in more rural areas, especially in Northern Ontario, must travel to get access to services. The main barriers in the province are anti-choice physicians and activists, as well as threats of privatization (discussed in the previous section “Hospitals”) which endanger the widespread accessibility of services. Notably, language barriers have also proven to be an impediment to access felt very strongly within Ontario, resulting largely from its diverse immigrant population.

Navigating the healthcare system when you do not speak either of Canada’s official languages can be very difficult, even with a translator. Some language groups are very small and women who want to maintain their anonymity do not wish to hire a translator whom they know on a personal level (Methven, Interview.). Thus, women who do not speak either of Canada’s official languages have extreme difficulty navigating the healthcare system and, given the potentially controversial nature of their health needs, may be unable to receive confidential help seeking services.

Difficulties in accessing insurance was also a serious problem noted by a number of interviewees (ibid.; Wilson, Interview.). Delays and fees associated with obtaining provincial medical insurance are a serious barrier for many women. There is a three-month waiting period for new citizens and for Canadians moving into Ontario before they are eligible for OHIP coverage. Wilson, a representative of Planned Parenthood Toronto, explained that the organization is currently working with other groups to pass a bill to remove the waiting period but no changes have yet occurred (Interview.). Without insurance, the provision of abortion services is not guaranteed. Difficulties with insurance are not a barrier unique to abortion, but the

time sensitive nature of the procedure means abortion is particularly hard hit by such roadblocks.

While Ontario offers a progressive model of abortion access for its citizens, both within the province and while travelling in others, there are still areas of concern. The continued presence of anti-choice protestors, coupled with a history of violence against providers, has contributed to a climate of fear among some practitioners and patients. Furthermore, pushes towards privatization which challenge the necessity of reproductive health services have become a mounting concern, which threatens the security of future services. While women are arguably able to exercise their citizenship rights in practice in Ontario, they are not able to do so in a safe and non-judgmental environment in all cases, meaning their rights have not been completely realized.

Quebec: Pro-choice Practice

Quebec is home to the highest level of access to abortion services in Canada. Abortions are fully funded in the province and available at a variety of institutions, including hospitals, clinics, and CLSCs. While abortion clinics have only recently been included under provincial Medicare,¹⁷⁶ there was some concern regarding the continued availability of abortion clinic services.

In 2009, the National Assembly of Quebec put forward a bill that would elevate the standards for abortion care beyond what was necessary. *Bill 34* proposed strict guidelines for all private clinics that would have effectively turned abortion clinics into operating rooms (Brown, Interview.). The *Bill* was denounced by the Quebec College of Physicians who recommended that it be significantly amended or thrown out altogether (FMSQ 2009). The proposed amendments would not improve the quality of care in private clinics, according to the *fédération*

176. See chapter four.

des médecins spécialistes du Québec (FMSQ)—rather, they would create “cumbersome organizational and bureaucratic requirements” (ibid.). These changes would have been particularly damaging to abortion clinics:

Building a sterile operating room is costly, too costly for the Morgentaler clinic, Fémina, and Alternative, the three Montreal clinics that have said publicly they will stop offering abortions if the rules remain. About one-third of the 30,000 abortions performed in Quebec each year are done in private clinics.¹⁷⁷

After extensive lobbying, abortion clinics were made exempt from this new bill.

As in Ontario, a lack of insurance was cited as a barrier for women attempting to access abortion services in Quebec. Women without healthcare cards, either because they were new to the province or had lost their cards, are required to pay for services. This barrier is particularly serious for lower income women and homeless women. A representative of the FQPN explained that the planning, expense, and necessity of a consistent address necessary to get a new or replacement Medicare card makes it virtually impossible for some women, particularly homeless or low income women, to ensure that they have insurance cards (Ross, Interview.). Some Canadian facilities, specifically clinics, have made strides in the accommodation of women in these difficult situations. In Quebec,

Forty-six percent of institutions say they do not refuse to perform abortions because of financial reasons and instead offer financial agreements, either by offering a discount or by asking doctors to not be paid for the procedure. Two of these institutions have a fund to help women who are unable to pay. Also, 2% of the establishments are members of the National Abortion Federation (NAF) and can request support from the organization if a

177. Andre Picard. “We need fewer barriers to abortion, not more.” *The Globe and Mail*, August 13, 2009.

woman is unable to pay. (FQPN and CFC 2010, 52)

While work done to ensure equal access for all women is critical, these difficulties remain a systemic healthcare issue that requires future attention.

Overall, women in Quebec experience high levels of access within the province and encounter few obstacles in the form of anti-choice demonstrators or threats of violence, either actual or implied. The ability to exercise real choice in the province means women are largely treated as equal citizens, in theory and in practice.

Aboriginal Women and Access to Abortion Services

While a discussion of abortion access in aboriginal communities could easily be a dissertation unto itself given the abundance of distinct cultures and views across the country, some analysis of how aboriginal women experience abortion differently is critical to any study of the procedure in Canada. Aboriginal healthcare does not fall within the sole jurisdiction of the provinces. While provincial governments provide the bulk of universal health services to aboriginal peoples in the same manner they do for other Canadians, the federal government is responsible for providing “on-reserve primary and emergency care services” to those living in “remote and isolated” areas (Health Canada 2004). The federal government also covers non-insured benefits, like dental care, in such areas, if they do not fall under the purview of provincial insurance plans (ibid.). This system is complicated by movements towards increased control over health services by aboriginal communities, many of whom have assumed more control over their own healthcare programs (Lavoie et al. 2011). Abortion services for aboriginal women generally fall to the provinces, meaning that they experience many of the same barriers to access as other women in Canada, though not necessarily in the same way. Aboriginal women experience their citizenship differently as a result of, among other issues, a general lack of access to culturally sensitive services and widespread distrust of the medical system.

The need for culturally sensitive reproductive health services was highlighted in a joint policy statement between numerous aboriginal advocacy groups alongside multiple bodies representing Canadian healthcare provision.¹⁷⁸ Specifically, the groups state the importance of the development of “cultural competence among health care providers” which accounts for the unique social determinants of health faced by aboriginal women (Yee, Apale, and Deleary 2011, 634–635). The need for cultural sensitivity amongst care providers was echoed by interviewee Brenda Gatto, a registered nurse and traditional Haudenosaunee medicine woman, who was actively involved in the movement to decriminalize midwifery in Canada and the recognition of the practice as a health profession in Ontario, who explained that the history of colonialism in Canada, alongside unique cultural views, has led to problems in service provision:

Some women, not necessarily this generation but in the generation before, will recall tales of their mothers and their grandmothers telling stories of women who have been sterilized against their will simply because of the fact that they were native. And this has occurred on more than one occasion, it has occurred as recently as the 1970s. In the 1970s this was occurring in many Canadian provinces as well as the United States where women were taken into hospital for various other procedures and the sterilization was done at that same time and it was done without their consent and without their knowledge. (Interview.)¹⁷⁹

Canada’s treatment of aboriginal peoples throughout its history, including the horrors of

178. Groups represented in the policy statement include: the Aboriginal Health Initiatives Sub-Committee, the Executive Council of the Society of Obstetricians and Gynaecologists of Canada, the Assembly of First Nations, the Canadian Federation for Sexual Health, Paiktuutit Inuit Women of Canada, the Native Youth Sexual Health network, the Indigenous Physicians Association of Canada, the Canadian Association of Midwives, the National Aboriginal Council of Midwives, the College of Family Physicians of Canada, the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada, and the Society of Rural Physicians of Canada.

179. Brenda Gatto (traditional Haudenosaunee medicine woman and birth attendant, and registered nurse, years unknown). Interview by author. 29 March 2012. Recorded and transcribed by author. Hull, Quebec.

residential schools and widespread sterilization practices, has created a deep mistrust between aboriginal groups and the medical community.

In general, the health of aboriginal people is “still not as good as that of non-aboriginal Canadians” (Health Canada 2004). This is in large part due to the reality that access to healthcare is only one aspect of health. Health is also linked to “education, income, sanitation, nutrition, housing, [and] environmental quality”—areas in which many bands are still having serious issues (ibid.). Services which are sensitive to these cultural differences must be available before aboriginal communities can have real access to services. Any project designed to improve access to abortion services in Canada must take these issues into account.

Conclusion

After the *Morgentaler* decision (1988) struck down Canada’s existing abortion law, the procedure was reclassified as a healthcare issue and jurisdiction over it shifted to the provinces. Despite some federal organization in the management of physicians and funding in Canada, the individualistic nature of the healthcare profession has contributed to an even greater patchwork of services amongst the provinces, as evidenced through the case studies of New Brunswick, Ontario, and Quebec. While access to abortion services should be straightforward, given the commonality of the procedure and its relative simplicity, this has not universally been the case. Resistance to the provision of abortion care is demonstrative of a backlash against women’s hard won rights to bodily autonomy, evidenced through the adoption of a moral frame by individuals from within the medical community.

The adoption of either a rights or moral frame of abortion by healthcare professionals demonstrates the insufficiency of a medical understanding of abortion to improve access. When abortion is seen as a clear-cut healthcare issue, it is left to physicians to regulate, many of whom have already adopted an anti-choice perspective. The right of women to access abortion services

cannot be left to chance if they are truly to be equal citizens, but must be facilitated through the adoption of a rights frame. Indeed, pro-choice advocacy is necessary to ensure that current services remain accessible. Moreover, improvements to abortion provision and an expansion of services to ensure the highest quality of care for all women cannot be easily achieved if women's rights have not been formally affirmed.

Abortion is a medical procedure, but it is also a deeply personal choice rooted in a woman's citizenship. As such, it cannot be reduced to a decision between a woman and her doctor. The role of the medical community is significant in a woman's ability to exercise agency, but this role does not extend to that of gatekeeper. The guarantee of safe, non-judgmental care must be the goal. The medical community is not a private moral body and has no right to judge women for their personal choices, particularly those central to their community membership; the continued power of the divisive rights versus morality debate is, however, ongoing in the medical community, and continues to influence the actions of some physicians. As a result, barriers still exist in each province, if to varying degrees, and activism and advocacy is necessary to challenge them.

While the internal and external regulation of medicine presents many challenges to the preservation of women's autonomy, access to abortion services is nonetheless necessary to ensuring women's citizenship. Improvements to the provision of abortion services thus necessitate formal recognition of abortion as a right of women's citizenship, both to prevent anti-choice physicians from blocking women's access to safe and legal services, and to create a dialogue on the issue to pave the way for future improvements to services. An enforceable right to abortion access will challenge the treatment of abortion in medicine, necessitating changes not only to the availability of services, but in approaches to care. The realization of women's equal

citizenship rights cannot, however, occur through medical changes alone, but necessitates a clear social commitment to the rights rhetoric reinforced through law and policy.

Chapter 8. Never Going Back: Women's Experiences of Citizenship in Canada After *Morgentaler* (1988)

When abortion was decriminalized in Canada following the 1988 *Morgentaler* decision, the federal government was unable to pass a new law to regulate the procedure. In the absence of any formal regulation, the procedure was reclassified as a healthcare issue and its regulation shifted from the federal government, under the Criminal Code, to the provinces. Its new label as a healthcare issue did nothing to quell the ongoing rights versus morality debates epitomized by pro- and anti-choice groups, occurring across the country in public discourse, politics, and even medicine.

The rights frame has come to dominate public discourse in the decades following the decriminalization of abortion, but continued backlash against women's hard won rights showcases their fragility. To this end, I have argued that recognition of abortion as a right of women's citizenship—legally, politically, and socially—is necessary before women not only have the tools to participate in Canadian society as equal, autonomous individuals, but also are able to ensure that they internalize these rights.

The way in which women experience their citizenship in Canada today, specifically as it relates to issues of reproductive rights, is subject to the regulations and social climate of their home province. By synthesizing information on the regulation of abortion from each provincial case study—including its treatment by politicians, the courts, the medical community, and society at large—this chapter begins by making a case for the way women experience their citizenship in New Brunswick, Ontario, and Quebec. Specifically, this section will highlight the culmination of barriers faced by women in each province when attempting to access services and implications on their sense of community membership.

Throughout this dissertation, the need for formal recognition of abortion access as

necessary to women's citizenship has been stressed. The following section reiterates the need for such a move and begin mapping out potential routes for progressive change. Moving forward requires balancing federal and provincial responsibilities in the regulation of abortion; after all, even if abortion is recognized as a right, service implementation must still occur at a provincial level. Improved care also necessitates improved communication about the importance of abortion to women's lives, and clearer guidelines for physicians in its provision. The process of accessing services could be further simplified with improved health education for women who are fully informed about their rights.

This section also addresses the role of social attitudes in women's experiences of abortion. The way abortion is understood in society has proven particularly influential in its regulation, influencing not only the actions of formal regulatory bodies, but also the way women internalize their place in the community. Formal recognition is thus important, but not sufficient to ensuring that women understand themselves as equal citizens; social recognition of women's equality is part of a larger rights project. While codification of their rights will certainly have an impact on social perceptions, it is also important to create dialogue on abortion to challenge its portrayal as a controversial issue. Ultimately, I argue that the recognition of abortion as a right of women's citizenship in politics, law, and society can be realized in a number of ways and that this recognition is essential to a broader project of realizing women's equality in Canada.

This chapter concludes with a discussion of potential avenues for future research emerging from this dissertation. As noted in chapter two, this study has attempted to lay the institutional groundwork for an intersectional analysis of the way individual women experience their citizenship as a result of restrictions on abortion access. The theoretical framework used in this dissertation also has implications for the study of reproductive technologies on experiences

of citizenship—specifically, the way these technologies might complicate the concept of choice.

Women’s Experiences of Citizenship

New Brunswick

Women in New Brunswick facing an unwanted pregnancy are subject to both regulatory and social barriers in their attempts to access abortion services. The need to negotiate a complex bureaucracy, uncertain responses from physicians, anti-choice protestors, and an unsupportive government, all operating within a social discourse which silences any discussion of these issues, can lead many women to feel like second class citizens. The resulting physical, emotional, relational and, often, financial difficulties which ensue make women painfully conscious of the fact that they are not equal members of Canadian society. The loss of bodily autonomy from the moment women face an unwanted pregnancy means that New Brunswick women are also robbed of their human dignity and any promises of equality set out in the Charter.

In order to access publicly funded abortions, women must seek written permission from two physicians stating that the abortion is medically necessary. As this term is not formally defined, what constitutes necessity is left to the discretion of individual physicians, who can choose to refuse women on the grounds that they find abortion morally objectionable. If the woman’s choice is validated by two medical professionals, she must then secure an appointment with one of only two gynecologists in the province allowed to perform the procedure. In addition, the abortion must be performed before twelve weeks of gestation, a near impossibility given substantial wait times to access physicians at all levels. If a woman is unable to access publicly funded services, she also has the option of paying for an abortion at the Fredericton Morgentaler clinic out of pocket, if she is able. The clinic performs abortions up to sixteen weeks of gestation, but women seeking an abortion must first brave the protestors waiting outside. There is no reciprocal billing arrangement for abortion services between New Brunswick and

any other province, so accessing the procedure elsewhere also requires women to pay out of pocket.

The demeaning bureaucracy that polices women's choices is reinforced by anti-choice rhetoric from provincial politicians, who continue to deny the validity of women's rights claims, while simultaneously critiquing a lack of recognition for fetal rights in the province. The government's receptivity to anti-choice social activism has served to silence many pro-choice voices, who do not wish to lose what few services are already available.¹⁸⁰ This climate of silence has also effectively quashed any discussion of abortion in the province, meaning that many women are not even aware their citizenship has been challenged until they need to access the procedure themselves and encounter a multitude of barriers. This silence also means that those who have experienced negative treatment are unable to comfortably voice their issues. The denial of respectful, fully funded, and safe medical services, necessary to women's equal citizenship, ensures that New Brunswick women are not only treated as second class citizens by individuals within the government, medical profession, and society, but they may even believe themselves to be such.

Ontario

Ontario women experience unwanted pregnancies in a completely different way. Access to abortion services in Ontario is generally good, particularly in large urban areas, although a lack of facilities in more rural areas continues to be a problem. Services are covered under Medicare, in both hospitals and in clinics, and they are accessible within the province up to twenty-four weeks of gestation. The provincial government has also made no attempts to restrict

180. This attitude is exemplified by Senator Nancy Ruth's advice in 2010 to aid groups frustrated by the Harper Government's Maternal Health Initiative, who were advised by Ruth to "shut the fuck up" on the abortion issue, lest the situation for women get worse (see chapter 3).

abortion services since the procedure was decriminalized. The availability of services means that women can exercise their rights to abortion access with considerably more ease than in other parts of Canada. Unfortunately, the formal regulation of abortion has stopped short of validating abortion as a right, a decision that leaves women vulnerable.

Abortion continues to be treated as a healthcare issue in practice, an understanding that has failed to recognize its importance to women's citizenship. While the social climate is still quite progressive and the public largely understands abortion as a rights issue, attitudes towards its regulation are characterized largely by ambivalence. As a result, the anti-choice presence in the province has been able to thrive. These groups continue to organize regular protests outside of medical facilities, and there has been a rise in the creation of so-called crisis pregnancy centres. Pressure from these groups for the public and the government to engage with a moral frame puts women's rights at risk—particularly without a strong social dialogue on the topic reiterating the importance of abortion to women's rights. The belief that abortion is an issue that has been effectively resolved through decriminalization has led to an ambivalent population, who perceive little urgency in fighting a battle they believe has already been won. Thus, while women are generally able to access services, the belief that these services are a right of their citizenship has not been universally adopted.

Quebec

Women in Quebec are in the unique position of having both fully funded access to abortion services, and a social and political climate which recognizes these services as necessary to their citizenship rights. Abortion services are widely accessible in the province, even in many rural locations, though there is certainly room for improvement in this area. What distinguishes Quebec from the rest of Canada, however, is not the availability of services, but the way these services are understood by politicians and society at large.

Anti-choice activism is not a serious problem in the province, where abortion was effectively decriminalized over a decade before the rest of Canada. No longer a taboo topic, abortion is defended with strong pro-choice sentiment. The Quebec government even unanimously came out against the federal government's anti-choice policies in the 2010 G8 summit.¹⁸¹ But the true distinction between Quebec and the rest of the Canada is the way in which women experience their choices. For women in Quebec, their bodily autonomy is not called into question if they are experiencing an unwanted pregnancy, and nor are they required to hide their decision to seek an abortion should they so choose; the topic is generally not considered taboo, and women would not be shamed upon admitting they decided to seek out legal health care services. In sum, women's choices in Quebec are not only respected as rights decisions in society at large, but women themselves understand their choices as rights. They have internalized the belief that they are equal community members, regardless of their reproductive choices, a realization which is still out of reach for many women across Canada.

Moving Forward

Recognition of abortion as necessary to women's citizenship has already gained strength amongst Canadians in the decades following *R v Morgentaler* (1988), but the realization of an enforceable right to access across Canada requires formal validation of women's claims at a federal level. Encoding women's citizenship rights necessitates initiative by the federal government, which has a history of avoiding the potentially divisive issue. Thus, absent a significant jump in pro-choice activity to pressure the government into engaging with this issue in a progressive way, it is unlikely to resurface soon. Moreover, many pro-choice advocates are wary of state intervention in abortion rights, fearing a vague or incomplete validation of rights

181. For details, see chapter four.

could later be used to limit women's choices.

The fear of backlash informing the actions of the pro-choice movement, as well as the actions of individuals who support the rights frame but are not activists, continues to be a serious barrier to choice. Joyce Arthur explained that even some of the most progressive rights activists are afraid to push too hard against regressive policies for fear that they might lose “what they already have” (Interview.). While the belief that the anti-choice movement would retaliate is a legitimate one, rooted in historical precedent, she cautions against overstating their authority, arguing, “we give them power by staying silent and not fighting” (Interview.)

These fears also carry over into litigation. While the courts have been instrumental in creating improved abortion access for women, legal victories have not generally recognized women's rights to access; as discussed in chapter five, legal successes have often been the result of technicalities or jurisdictional issues that have later been interpreted as successes based on their outcomes. Thus, while an appeal to the Supreme Court challenging the treatment of abortion in Canada today may be the fastest way to force federal action on the matter, the outcomes of such a pursuit are far from guaranteed. Still, despite the risks associated with attempts to improve access, it is apparent that failing to push for rights recognition means accepting second-class citizenship for many Canadian women.

Recognition of the right of women to access safe, legal, and funded abortion services would be highly symbolic coming from the federal government, given its intended purpose of reflecting the views of the public into policy. The likelihood that the House of Commons, however, at least in the current federal political climate, will move to recognize women's rights to abortion access as a right of citizenship is highly unlikely. The prevalence of anti-choice politicians in the House, and the desire of the sitting and previous governments to avoid

engagement with any issue that has the potential to be highly contentious, makes a move towards voluntary, progressive change to the *Constitution* seem improbable.

Federal change does, however, remain a real possibility, but not in isolation. As this dissertation has argued, social mobilization has been instrumental in creating a strong rights frame in Canada, which has influenced decisions in politics, the courts, and even medicine. It is perhaps unsurprising then that, when asked about the future of abortion regulation in Canada, interviewees stressed the importance of social movement mobilization to shape the future of government policy.

In the quest to improve women's access to abortion services, White argues that "there isn't a substitute for community organizing, education, [and] development" (Interview.) Engagement in a "broad democratic project" aimed at making the importance of access to abortion services "understood by this generation and the next generation of young women" is imperative to the realization of equal citizenship (ibid.). Only through this type of consciousness raising campaign can the fragility of access to abortion services in Canada today be widely understood, and the need to push for positive change asserted. Even if this project does not succeed in motivating the federal government to codify women's rights, it has the power to influence other avenues of change.

Support for a rights frame of abortion is not only important to securing political change, but legal change as well. As discussed in chapter five, legal victories cannot be understood or achieved in a vacuum, they necessitate social mobilization.

Robidoux, Manager Ontario Coalition of Abortion Clinics, cites the Morgentaler cases pre-1988 as a case in point, arguing that the social climate in which the cases took place influenced the way people perceived the abortion issue, and created public support for

Morgentaler—who otherwise would not have been able to achieve the same degree of success.

The courts have a longstanding tendency to work within accepted social norms to guide their decision-making, particularly with reference to *Charter* cases, in which they have been instructed to think of the *Charter* as a living tree.¹⁸² As a result, a favourable social climate is an asset to the pursuit of equality through litigation. While feminists interpreted the existing abortion law as violating their right to security of the person, for example, this assertion had to be understood more so as a matter of common sense before it could be persuasive in court. The Morgentaler cases before 1988 helped to set the tone for this argument. Importantly, while the courts may not have interpreted the provision of security of the person as applying to women’s autonomy in the decades before, the activities of social movements raised awareness and influenced the public discourse, making their claims more powerful. “That’s what the movement does,” Robidoux explained, “that’s what we do when we push it” (Interview.).

Engagement with the courts would thus also require social mobilization, though existing precedent suggests that this might still be a more fruitful route to pursue change. Indeed, interviewees in New Brunswick, who experienced extreme resistance from their government to changing policies, cited the courts as their greatest hope for improved policies (Burwell, Interview.; Moore, Interview.; Hughes, Interview.). While a security of the person argument has gone a long way in validating women’s rights to abortion access, abortion is already widely considered a rights question rooted in women’s equality by many, a right guaranteed in the *Charter*, making this the next logical step in litigation. Indeed, White suggested that there would be room for such a case, explaining: “we [Canadians] haven’t had the section 15 argument yet on abortion,”—at least not at the federal level (Interview.).

182. The living tree metaphor is used to describe the intended organic nature of the *Charter*. *Charter* rights are meant to be interpreted progressively, in accordance with changes in the social climate.

The *Jane Doe v Manitoba* case, in which a Manitoba judge recognized the failure of the provincial government to pay for clinic services as a violation of section 7, (“life, liberty and security of the person”), section 15 (“equal protection and benefit of the law without discrimination”), and section 2(a) (“freedom of conscience and religion”), although it was set aside on appeal, has already created favourable precedent for such a case (Department of Justice).¹⁸³ All that is needed is an individual willing and able to bring such a case forward and the recognition of the Supreme Court that the issue is a valuable one for judgment. A formal interpretation of the *Charter’s* equality provision as guaranteeing women the right to bodily autonomy would not only validate the view that abortion is a woman’s right, but would potentially simplify the implementation of progressive policies by governments wishing to avoid legislating on the potentially divisive issue. The *Charter* is prized among Canadians, so creating or modifying legislation to correct for any violations of the document would give the government’s actions more legitimacy, potentially helping it to avoid some backlash from anti-choice groups, who might see the court as forcing the government’s hand.

Even if women’s rights are validated in court, it is important to note that the creation of an enforceable right to abortion access necessitates both political and legal recognition. Politicians are responsible for implementing Supreme Court rulings, and are often given some leeway in how they go about doing this. A favourable implementation thus relies on political receptivity to a rights framework, which is national in scope. It is at this point that an obvious problem emerges: the delivery of abortion services requires medical infrastructure already in existence in most provinces, control over which falls directly under provincial jurisdiction. How can these domains be reconciled without serious jurisdictional conflict?

183. See chapter 5 for details on the *Jane Doe v Manitoba* case.

Moving forward requires balancing provincial rights to regulate health issues with women's citizenship rights. The necessity of abortion services to women's community membership does not, it is important to stress, require the complete removal of provincial authority over reproductive healthcare issues. While accessible services must be available in every province, the exact form these services take could be left to the discretion of individual provinces. That is to say, as long as minimal standards for abortion care are set, some provincial differentiation in service provision is acceptable.

While healthcare is a provincial issue, the federal government has long had a hand in its regulation. The creation of the *Canada Health Act* is a clear example. While provinces are able to dispense healthcare at their own discretion, they must meet certain minimum standards in order to access the maximum amount of financial support from the federal government, in the form of the *Canada Health Transfer*, for the services they provide.¹⁸⁴ The inclusion of a provision requiring a minimum level of abortion services could easily be included in the *Canada Health Act*, along with a severe penalty for failure to comply.

Dr. Carolyn Bennett M.D., a current Liberal Member of Parliament, explained that a more transparent healthcare system in Canada could facilitate such a project. She suggests the creation of a "pan-Canadian quality audit" that would create a comparable set of healthcare data between the provinces (Interview.).¹⁸⁵ At present, no such comparison is possible, meaning that citizens are in the dark regarding the success of their province's healthcare strategies. If healthcare services were more transparent it would be possible not only for citizens to judge their provincial healthcare objectively and demand specific change, but also for provinces to learn

184. See chapter 7 for a more detailed discussion of the *Canada Health Act* and *Canada Health Transfer*.

185. Carolyn Bennett (Liberal Member of Parliament for St. Paul's, 1997–Present). Interview by author. 10 February 2011. Recorded and transcribed by author. Ottawa, Ontario.

from one another's successes. The realization of such a system would make the creation of a set of minimum standards for the provinces much easier, while additionally opening the door for a myriad of other improvements to the delivery of health services.

While the creation of minimum standards for provincial delivery of abortion care certainly does not necessitate a complete rethinking of the way these services are measured, such a project would certainly validate these changes. The belief that health and social services ought to meet broad standards is, after all, often taken for granted in Canada. Citizens may be more compliant when they are denied services if they are unaware that the same services are easily available in other provinces. A lack of information, which has persisted because of stigma, has been at the heart of continued barriers to abortion access in Canada. Increased transparency in the delivery of abortion, and other health services, would help to educate the public, and create demand for improved services.

Another change to the provision of healthcare services suggested was the creation of women's health centres across Canada. Anne Marie Messier, General Director of the *centre de santé des femmes de Montréal*, when asked about the changes she would like to see to the provision of abortion access in an ideal world, explained that she wants to see non-profit, women's health centres—places where women would not experience judgment and would be “empowered to make their own decisions” (Interview.). Bennett likewise suggested a “move towards a women's health clinic” model in Canada, where women would have access to practitioners with “expertise with reproductive health, including reproductive mental health” (Interview.). These clinics, of course, would be likely to attract protestors, so she suggested that they be a kind of “all-purpose clinic for women's health,” so that women coming in and out would be less likely to be targeted (ibid.). Of course, Bennett's ideal system would not be limited

to women's health issues, but would consist of more significant changes to the delivery of healthcare in Canada as a whole. She suggested the creation of interdisciplinary clinics, which would each have a variety of specialists on site, able to handle not just sensitive issues like abortion in house, but the majority of health concerns of their patients (ibid.). Certainly, as long as women had some guarantees going in that their rights to abortion access would not be met with judgment nor additional barriers, such a system could be hugely beneficial. Moreover, it would allow for more culturally sensitive care by granting more patient and physician interaction.

In order for any changes to the healthcare system to function effectively, however, it is crucial that physicians themselves be taken into account. The organization of the Canadian healthcare system is strongly influenced by the training, safety, and rights of doctors. Threats, both real and perceived, to all three areas could compromise the future of abortion care in Canada.

Abortion is not currently a priority in medical school curricula, despite its prominence; indeed, some schools fail to cover the procedure at all. Because the recognition of abortion as a woman's right must be exercised with the help of the medical community, the realization of these rights necessitates improved training in medical schools. Changes should be undertaken that would require all students considering a specialty in gynecology or a career as a general practitioner to receive training in the procedure as part of a Canada-wide curriculum. This training would take into account not only the procedure itself, but also its political and social significance and the barriers physicians can, even inadvertently, provide. While no physician should be required to perform a procedure they conscientiously object to, doctors must be conscious of the power relationships between themselves and their patients, and be required to

refer patients out of their own practice, as well as provide them with all their options, even if they cannot provide the procedure themselves. Moreover, the responsibility of maintaining a pool of doctors who are both willing and able to provide abortion services is the duty of medical schools and the provinces; even when individuals object, some practitioners must be available to provide the procedure if women's citizenship rights are to be realized.

The transitional period between the recognition of women's rights and widespread access will likely be met with strong anti-feminist backlash. As such, efforts must be made to ensure the anonymity and safety of abortion providers, facility staff, and women attempting to access services. While lasting change requires a shift in the social and political climates of many of the provinces, steps can be taken in the interim to protect each of these groups. The strict enforcement of bubble zones around facilities and around the houses of providers who have faced harassment, as well as an increase in such safeguards, would go a long way in giving all of those involved peace of mind.

The potential sites of policy change listed above do not require a complete overhaul of the Canadian health care system, of federal/provincial relations, or any far-fetched interpretations of existing law. The infrastructure is already in place for the realization of women's right to abortion access; it merely has to be enforced. While moving forward with this assertion of women's rights does open the door for additional questions about the way the role of women in society has been constructed and enforced, these inquiries are an important next step in the larger project of guaranteeing women's equality rights.

Future Research

Through the use of a citizenship framework informed by social reproduction, this dissertation has attempted to draw attention to the necessity of understanding abortion as a political issue. By locating abortion in the political sphere, it has also endeavoured to validate

additional sites of political struggle, picking up on longstanding feminist claims regarding the rights implications surrounding labour distribution and care work. This section addresses some additional avenues of research emerging from the findings and theoretical framework considered in this dissertation.

First and foremost, as discussed in chapter two, a negotiated model of citizenship creates a lens through which a more in-depth study of the way individual women experience their citizenship can be undertaken. While the focus of the research in this project was on the impact of institutions on the regulation of abortion, the framework it uses could easily be utilized to conduct a study of the way individual women experience abortion as a result of their race, class, culture, and sexuality. Certainly such a study in Canada would be particularly important in shedding light on the unique difficulties faced by minority language groups and aboriginal women.¹⁸⁶

By rooting the argument for autonomy in cultural expectations of pregnancy and childcare, this dissertation also calls into question more extensive instances of the socio-political regulation of women, especially pregnant women and mothers. While the latter group has been addressed in the feminist canon in significant detail, issues relating to positive rights to reproductive control are ongoing, especially as they pertain to reproductive technologies. For instance, what are the implications of fetal screening technology on women's choices? Do women have a right to complete access to information regarding, for instance, eye and hair colour, if it is available? What about embryo selection for specific characteristics? What if the traits being selected for are not socially perceived as likely to improve the potential child's life, such as the selection for dwarfism or deafness?

186. For a discussion of aboriginal women's reproductive healthcare, see chapter seven. The issues faced by minority language groups are addressed in more detail in chapter four.

The consequences of reproductive technology on women's experiences of pregnancy is also an important issue. If science is able to more accurately link women's actions during pregnancy with fetal health, does this have implications for women's autonomy? Would women be required to submit to increased testing to be considered "good mothers"? Moreover, how would technologies that reduce the age of fetal viability impact women's rights to abortion access? Further research on the medical and socio-political regulation of pregnant women, particularly in light of these technological advances, could shed light on the impact of pregnancy on women's experiences of citizenship.

Conclusion

The realization of women's equality in Canada necessitates formal, national recognition of abortion as a right of women's citizenship, alongside social acceptance of its necessity to women's equal community membership. The inclusion of social concerns in the interpretation of the way individuals experience their rights paves the way for the adoption of principles more in keeping with an understanding of citizenship as a negotiated process. Using this framework, it is not enough that abortion be recognized as a legal right; if there is overwhelming resistance from the public, not only is the formal right vulnerable, but barriers can also manifest on the ground to prevent women from accessing services.

The adoption of a moral frame by individuals has had clear detrimental implications in the Canadian provinces. Restrictive health care regulations, anti-choice picketing outside of medical facilities, and violence against abortion providers and facilities are just some of the consequences of the anti-choice movement's commitment to the belief that abortion is immoral. In order to combat these dangerous responses public discourse is needed. Individuals who embrace a moral frame of abortion rely on idealized portrayals of women and society to make their case, bracketing the realities of restricted abortion access for women's health and

community membership. Silence and stigma have been central to ensuring that the foundations of the debate are not presented as operating in opposition to women's equality. A return to consciousness raising and public discourse is necessary for these comparisons to once again come to light, and for the rights framework to continue to thrive.

Increased social awareness of the longstanding acceptance of women's inequality in much of Canada, as a result of barriers to abortion access, would also challenge existing, often limited, perceptions of citizenship. Understanding citizenship as a negotiated process, which goes beyond formal legal status to encompass notions of community membership, signals a significant shift in the boundaries of the concept. With this shift comes an increase in the range of issues perceived as political. The struggle for formal acknowledgment of a right to abortion, a right demanded solely by women, draws attention to the continued power of patriarchal institutions. A system that recognizes women as equal only insofar as they are the same as men cannot realize equality for women. Validation of the importance of abortion for women's equality, both legally and experientially, opens up discussion on a range of other issues previously considered apolitical in nature, including the enforcement of traditional understandings of social reproduction. A system which recognizes the way individuals experience belonging is thus necessary for the realization of true equality, for all members of Canadian society.

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White, Carol [pseud.] (Prominent feminist legal scholar and former social activist). Interview by author. 8 June 2010. Recorded and transcribed by author. Canada.

Wilson, Felicia [pseud.] (Representative of Planned Parenthood Toronto). Interview by authors. 31 March 2011. Recorded and transcribed by author. Toronto, Ontario.

Appendix A. GREB Letter

June 29, 2010

Ms. Rachael Johnstone
Department of Political Studies
Queen's University
c/o 213 Queen St., Apt. 1
Kingston, ON K7K 1B4



OFFICE OF RESEARCH SERVICES
Fleming Hall - Jemmett Wing, 3rd Floor
Queen's University
Kingston, Ontario K7L 3N6
Tel 613 533-6081
Fax 613 533-6806
ors@queensu.ca
www.queensu.ca/ors

GREB Ref #: GPLST-061-10

Title: "Reproductive Rights and Politics of Abortion in a Post-Morgentaler Era: Understanding the Meaning and Motivations Behind Abortion Access in Canada"

Dear Ms. Johnstone:

The General Research Ethics Board (GREB), by means of a delegated board review, has cleared your proposal entitled "**Reproductive Rights and Politics of Abortion in a Post-Morgentaler Era: Understanding the Meaning and Motivations Behind Abortion Access in Canada**" for ethical compliance with the Tri-Council Guidelines (TCPS) and Queen's ethics policies. In accordance with the Tri-Council Guidelines (article D.1.6) and Senate Terms of Reference (article G), your project has been cleared for one year. At the end of each year, the GREB will ask if your project has been completed and if not, what changes have occurred or will occur in the next year.

You are reminded of your obligation to advise the GREB, with a copy to your unit REB; of any adverse event(s) that occur during this one year period (details available on webpage <http://www.queensu.ca/ors/researchethics/GeneralREB/forms.html> – Adverse Event Report Form). An adverse event includes, but is not limited to, a complaint, a change or unexpected event that alters the level of risk for the researcher or participants or situation that requires a substantial change in approach to a participant(s). You are also advised that all adverse events must be reported to the GREB within 48 hours.

You are also reminded that all changes that might affect human participants must be cleared by the GREB. For example you must report changes in study procedures or implementations of new aspects into the study procedures on the Ethics Change Form that can be found at <http://www.queensu.ca/ors/researchethics/GeneralREB/forms.html> - Research Ethics Change Form. These changes must be sent to the Ethics Coordinator, Gail Irving, at the Office of Research Services or irvingg@queensu.ca prior to implementation. Mrs. Irving will forward your request for protocol changes to the appropriate GREB reviewers and / or the GREB Chair.

On behalf of the General Research Ethics Board, I wish you continued success in your research.

Yours sincerely,

A handwritten signature in black ink that reads "Joan Stevenson".

Joan Stevenson, PhD
Professor and Chair
General Research Ethics Board

c.c.: Dr. Abigail Bakan, Faculty Supervisor
Dr. Andrew Lister, Chair, Unit REB
Amelia Ponte-Viveiros, Dept. Admin.

JS/gi

think Research
think Queen's

Appendix B. Letter of Information for Interviewees

Letter of Information

“Reproductive Rights and the Politics of Abortion in a Post-Morgentaler Era: Understanding the Meaning and Motivations Behind Abortion Access in Canada”

This research is being conducted by Ph.D. candidate Rachael Johnstone under the supervision of Dr. Abigail Bakan, in the Department of Political Studies at Queen’s University in Kingston, Ontario. This study has been granted clearance according to the recommended principles of Canadian ethics guidelines and university policies.

What is this study about? The purpose of this research is to understand the factors that motivate different levels of abortion access in the Canadian provinces. It is designed to gather information on the experiences and motivations of different groups in the abortion debate. The study will require a single face-to-face interview, which will last approximately one hour. Some questions may be of a sensitive nature and there is therefore potential for emotional risk, though participants are not required to answer any questions that cause them discomfort. Concerns regarding identification of participants, and its impact on their status and personal life, may also pose a potential risk for some. See ‘What will happen to my responses’ for information regarding confidentiality.

Is my participation voluntary? Yes. Although it would be greatly appreciated if you would answer all material as frankly as possible, you should not feel obliged to answer any material that you find objectionable or that makes you feel uncomfortable. You may also withdraw at any time. If you decide to withdraw you will have the option of allowing all of your data to be used in the study or having all or specific portions of your interview data removed from the study and destroyed.

What will happen to my responses? You will have the option of being quoted by name in the study; otherwise, I will keep your identity confidential by quoting you only under a generic description of your position (ex: a medical professional). The data may also be published in professional journals or presented at academic conferences. If you consent, your responses will also be taped on an audio recorder for ease of transcribing.

Will I be compensated for my participation? No. There is no monetary compensation for this study.

What if I have concerns? In the event that you have any complaints, concerns, or questions about this research, please feel free to contact Rachael Johnstone; 5regj@queensu.ca; project supervisor, Dr. Abigail Bakan; bakana@queensu.ca; head of the Department of Political Studies, Dr. Janet Hiebert; janet.hiebert@queensu.ca, or the Chair of the General Research Ethics Board (613-533-6081) at Queen’s University.

Again, thank you. Your interest in participating in this research study is greatly appreciated.

Appendix C. Consent Form for Interviewees

Consent Form

“Reproductive Rights and the Politics of Abortion in a Post-Morgentaler Era: Understanding the Meaning and Motivations Behind Abortion Access in Canada”

Name (please print clearly): _____

1. I have read the Letter of Information and have had any questions answered to my satisfaction.
2. I understand that I will be participating in the study called “Reproductive Rights and the Politics of Abortion in a Post-Morgentaler Era: Understanding the Meaning and Motivations Behind Abortion Access in Canada”. I understand that this means that I will be asked to participate in one face-to-face interview.
3. I understand that my participation in this study is voluntary and I may withdraw at any time. I understand that every effort will be made to maintain the confidentiality of the data, if I have opted not to be quoted by name, now and in the future. Only the interviewer will have access to this data. The data may also be published in professional journals or presented at academic conferences. I understand that, if I consent, my responses will also be taped on an audio recorder for ease of transcribing.

Please initial one of the following statements:

I grant permission to be quoted by name

I do not grant permission to be quoted by name, but only under a generic description of my position (ex: medical professional)

Please initial one of the following statements:

I grant permission to have my interview audio recorded

I do not grant permission to have my interview audio recorded

4. I am aware that if I have any questions, concerns, or complaints, I may contact Rachael Johnstone; 5regj@queensu.ca; project supervisor, Dr. Abigail Bakan; bakana@queensu.ca; Head of the Department of Political Studies, Dr. Janet Hiebert; janet.hiebert@queensu.ca, or the Chair of the General Research Ethics Board (533-6081) at Queen’s University.

I have read the above statements and freely consent to participate in this research:

Signature: _____ Date: _____

Appendix D. Recruitment Email Template

Dear (Sir/Madam):

My name is Rachael Johnstone and I am a Ph.D. candidate at Queen's University in Kingston, Ontario, working under the supervision of Dr. Abigail Bakan in the Political Studies Department. I am presently preparing to conduct field research for my thesis, titled "Reproductive Rights and the Politics of Abortion in a Post-Morgentaler Era: Understanding the Meaning and Motivations Behind Abortion Access in Canada". The goal of my research is to uncover the factors that motivate different levels of abortion access in the Canadian provinces. I am exploring the experiences and motivations of four different groups: medical professionals, social movements/legal experts, politicians and women who have had abortions in a given province.

Your name came up in my research as a person of interest, given your involvement with (social movement/court case/policy) and I acquired your email from (name source), with the hope that you would consider participating in my study. Participation would involve a single face-to-face interview lasting approximately one hour. I will be conducting my research between (dates) in (city).

If you are interested in participating in my research, or can suggest anyone else who might be, I believe your contribution would be most helpful. If you have any further questions please do not hesitate to contact me at 5regj@queensu.ca.

Thank you for your time.

Sincerely,

Rachael Johnstone

Appendix E. Prevalence of Abortion by Province and Facility

Province/ Territory	Hospital Abortions Covered Under Medicare	Number of Abortions Performed in Hospitals (2009)	Clinic Abortions Covered Under Medicare	Number of Abortions Performed in Clinics (in 2009)	% of Abortions Performed by Population (2005)	Responses from Legislative Libraries Regarding Provincial Abortion Policies
British Columbia	Yes	5104	Yes	7357	12461/4,459,900 = 0.28%	
Alberta	Yes	2816	Yes	10334	13150/3,671,700 = 0.39%	
Saskatchewan	Yes	2019	Yes	0	2019/1,029,300 = 0.2%	No specific legislation provincially
Quebec	Yes	12826	Yes (as of 2006)	14313	27139/7,826,900 = 0.35%	

Province/ Territory	Hospital Abortions Covered Under Medicare	Number of Abortions Performed in Hospitals (2009)	Clinic Abortions Covered Under Medicare	Number of Abortions Performed in Clinics (in 2009)	% of Abortions Performed by Population (2005)	Responses from Legislative Libraries Regarding Provincial Abortion Policies
Manitoba	Yes	2778	Yes (as of 2004)	1469	4247/1,219,200 = 0.35%	“The Manitoba Government did change its regulations regarding abortion and had in fact been funding abortions at a private not- for-profit clinic in Winnipeg since 2004”
Ontario	Yes	12916	Yes	17352	30268/1,3072,700 = 0.23%	

Province/ Territory	Hospital Abortions Covered Under Medicare	Number of Abortions Performed in Hospitals (2009)	Clinic Abortions Covered Under Medicare	Number of Abortions Performed in Clinics (in 2009)	% of Abortions Performed by Population (2005)	Responses from Legislative Libraries Regarding Provincial Abortion Policies
New Brunswick	Yes	489	No	615	1104/750,000 = 0.15%	
P.E.I.	Yes (0%)	0		0	0/141200 = 0%	“There is an internal policy that states Abortions are a non-insured service and are not performed on P.E.I. The payment of TA’s for Island residents is restricted to those who meet criteria as outlined in this policy.”

Province/ Territory	Hospital Abortions Covered Under Medicare	Number of Abortions Performed in Hospitals (2009)	Clinic Abortions Covered Under Medicare	Number of Abortions Performed in Clinics (in 2009)	% of Abortions Performed by Population (2005)	Responses from Legislative Libraries Regarding Provincial Abortion Policies
Newfoundland	Yes (as of 1998)	281	Yes (as of 1998)	675	956/508,900 = 0.19%	No provincial legislation (governed federally) “As of January 01, 1998, the provincial government has fully funded the medical fees for abortions performed at either public or private facilities.”
Nova Scotia	Yes	2119		0	2119/940,300 = 0.235	“There are no regulations or statutes in Nova Scotia that specifically reference abortion.”
Yukon	Yes	128		0	128/33,700 = 0.38%	“Does not have any legislation or regulation regarding abortion”

Province/ Territory	Hospital Abortions Covered Under Medicare	Number of Abortions Performed in Hospitals (2009)	Clinic Abortions Covered Under Medicare	Number of Abortions Performed in Clinics (in 2009)	% of Abortions Performed by Population (2005)	Responses from Legislative Libraries Regarding Provincial Abortion Policies
Northwest Territories	Yes	57		0	57/43,600 = 0.13%	
Nunavut	Yes	107		0	107/32,200 = 0.33%	“A follow-up with Nunavut Dept. of Health and Social Services confirmed that there is no new territorial act or regulation and no written policy on abortion services.”

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Appendix F. Interviewee Descriptions

Federal	
Name/Pseudonym	Description
Carolyn Bennett (Honourable)	Liberal Member of Parliament for St. Paul's (1997-Present) and former family physician. She is also author of the book <i>Kill or Cure? How Canadians Can Remake heir Health Care System.</i>
Ivy Knight [pseud.]	A representative of the Canadian Medical Association (years unknown), who asked that their identity remain confidential.
Carol White [pseud.]	A prominent feminist legal scholar and former social activist (more than ten years), who asked that their identity remain confidential.
Joyce Arthur	Executive Director and founder of the Abortion Rights Coalition of Canada (ARCC)(2005-Present), which describes itself as “the only nation-wide political pro-choice group devoted to ensuring abortion rights and access for women”.
Brenda Gatto	A registered nurse who practiced for several years in the field of gynecology and reproductive health, including labour and delivery (years unknown). She was also groomed as a traditional Haudenosaunee medicine woman and birth attendant and was involved in the movement to decriminalize midwifery in Ontario.
Agathe Gramet-Kedzior	Acting Executive Director of Canadians for Choice (years unknown), which describes itself as “a pro-choice, non-profit charitable organization dedicated to ensuring reproductive choice for all Canadians”.

New Brunswick	
Name/Pseudonym	Description
Peggy Cooke * co-listed with Ontario interviewees	Board Member and Media Spokesperson for the Abortion Rights Coalition of Canada (2008-Present), former employee at the Toronto Morgentaler Clinic (2010-2011), and former volunteer co-ordinator at the Fredericton Morgentaler Clinic (2007-2010).
Allison Brewer	Former leader of the New Brunswick New Democratic Party (2005-2006) and former Director of the Fredericton Morgentaler Clinic (1993-1999).
Sean Moore [pseud.]	A New Brunswick physician (more than ten years), who asked that their identity remain confidential.
Marilyn Merritt-Gray	A Professor of Nursing at the University of New Brunswick (years unknown).
Timothy Cain [pseud.]	A New Brunswick family doctor (years unknown), who asked that their identity remain confidential
Alison Toron	Volunteer escort at the Fredericton Morgentaler clinic (2008-present).
Rosella Melanson	Former Executive Director of the New Brunswick Advisory Council on the Status of Women (2001-2011), a government agency created to study and report on issues concerning women's status in the province. New Brunswick Premier David Alward's Conservative government abolished the agency in March 2011, less than two months after this interview was conducted.
Judy Burwell	Former Manager of the Fredericton Morgentaler clinic (years unknown).
Jula Hughes	A Professor of Law at the University of New Brunswick (2006-present).

Ontario	
Name/Pseudonym	Description
Tracey Methven	A sexual health promoter for Toronto Public Health (1997-present), whose work focuses on marginalized populations. The goal of sexual health promotion is to provide information and strategies to reduce high-risk behavior and promote improved sexual health. Toronto Public Health has detailed guiding principles, which explicitly state that staff must provide pro-choice services (Toronto Public Health).
Eva Flanagan [pseud.]	A representative of a government affiliated organization created to promote women's health in Ontario (years unknown) who asked that their identity remain confidential.
Tiffany VanBraagen [pseud.]	A representative of an Ontario Medical School (years unknown) who asked that their identity remain confidential and that no identifying details be included in this research, beyond the province in which the school is located.
Aidan Bell [pseud.]	A social activist in Ontario (years unknown) who asked that their identity remain anonymous.
Michelle Robidoux	Manager Ontario Coalition of Abortion Clinics (years unknown), a pro-choice organization that works with abortion clinics in the province to reduce barriers women face when attempting to access services
Felicia Wilson [pseud.]	A representative of Planned Parenthood Toronto (years unknown), a pro-choice organization with international ties, who asked that their identity remain confidential.
Peggy Cooke * co-listed with New Brunswick interviewees	Board Member and Media Spokesperson for the Abortion Rights Coalition of Canada (2008-Present), former employee at the Toronto Morgentaler Clinic (2010-2011), and former volunteer co-ordinator at the Fredericton Morgentaler Clinic (2007-2010).

Quebec	
Name/Pseudonym	Description
Suzy Brown [pseud.]	Quebec abortion clinic representative (years unknown), who asked that identifying factors, including their name and the exact location of the clinic, remain confidential.
Seymour Fletcher [pseud.]	A representative of Medical Students for Choice (years unknown) in Quebec, an organization which promotes the inclusion of reproductive health care into medical school curriculum and residency training, who asked that their identity remain confidential.
Anne Marie Messier	General Director of the centre de santé des femmes de Montréal (2007-present), a centre that provides a variety of sexual health services, including abortion, with a feminist approach.
Catherine Megill	Medical Student (years unknown), Founder of Haven (years unknown), and former abortion clinic employee in Canada and the United states (years unknown).
Marilyn Ross [pseud.]	A representative of la Fédération du Québec pour le planning des naissances (years unknown), an organization concerned with the protection of women's sexual and reproduction health, who asked that their identity remain confidential.
Abby Lippman	Professor of Epidemiology, Biostatistics and Occupational Health at McGill University (years unknown) and member of the Canadian Women's Health Network's Expert Review and Advisory Committee (years unknown).
Patrick Powers	Vice-President of the Sexual Health Network of Quebec (years unknown) and former President of the Board of Planned Parenthood Montreal (years unknown).
Catherine Stettin [pseud.]	A representative of la Conseil du statut de les femmes (years unknown), a Quebec governmental organization which consults on issues of women's equality and rights, who asked that their identity remain confidential.

Appendix G. Anti-Choice Private Member Bills and Motions Introduced in Canada Since 1987

Bill #	Date Introduced	MP/Senator	Description
M-37	June 2, 1987 (voted on)	MP Gus Mitges (Progressive Conservative)	Motion to amend Section 7 of the <i>Canadian Charter of Rights and Freedoms</i> to include “unborn persons.” Defeated 89-62.
S-16	1988	Senator Stanley Haidasz (Liberal Senator)	A bill to amend the Criminal Code to protect the “unborn child.”
C-268	1989	MP Don Boudria (Progressive Conservative)	Bill to amend <i>Canada Health Act</i> to allow federal government to penalize any province that paid for abortions deemed not necessary to preserve the life of the woman.
C-277	1989	MP Don Boudria (Progressive Conservative)	Bill to amend Section 293 of the <i>Criminal Code</i> and repeal Sections 223, 238, and 287 to ban abortion in all cases except to save the woman’s life.
C-266	1989	MP Ralph Ferguson (Liberal)	Bill to define a foetus as a person and prohibit abortion with a couple of exceptions including when “medically authorized to save the life of the pregnant woman.”
C-261	1989	MP John Nunziata (Liberal)	Bill to amend Section 287 of <i>Criminal Code</i> to ban abortion in all cases, but permitting medical treatment necessary to prevent the death of the pregnant woman.
C-275	1989	MP Tom Wappel (Liberal)	Bill to redefine “human being” to include an “embryo” and a “foetus”, so as to define abortion as homicide.
S-7	1989	Senator Stanley Haidasz (Liberal)	Reintroduction of bill to amend the Criminal Code to protect the “unborn child” (S-16).

C-214	1991	MP Tom Wappel (Liberal)	Reintroduction of Bill to redefine “human being” to include an “embryo” and a “foetus”, so as to define abortion as homicide. (C-275)
C-220	1991	MP Don Boudria (Progressive Conservative)	Bill to criminalize abortion provision: “Every person who directly or indirectly requires a physician, nurse, staff member or employee of a hospital or other health care facility to perform or participate directly or indirectly in an abortion procedure is guilty of an indictable offence and is liable to imprisonment for a term not exceeding two years.”
C-221	1991	MP Don Boudria (Progressive Conservative)	Reintroduction of Bill to amend Section 293 of the <i>Criminal Code</i> and repeal Sections 223, 238, and 287 to ban abortion in all cases except to save woman’s life. (C-277)
C-222	1991	MP Don Boudria (Progressive Conservative)	Reintroduction of Bill to amend <i>Canada Health Act</i> to allow federal government to penalize any province that paid for abortions deemed not necessary to preserve the life of the woman. (C-268)
C-302	1991	MP Ralph Ferguson, (Liberal)	Reintroduction of Bill to define a foetus as a person, which would prohibit abortion with a couple of exceptions including when “medically authorized to save the life of the pregnant woman.” (C-266)
C-253	May 27, 1994	MP Don Boudria (Progressive Conservative)	Reintroduction of Bill to criminalize abortion provision. (C-220)
C-208	Feb. 1996	MP Tom Wappel, (Liberal)	Reintroduction of Bill to redefine “human being”

			to include an “embryo” and a “foetus”, so as to define abortion as homicide. (C-275)
M-91	March 14, 1996	MP Garry Breitkreuz (Reform)	Motion calling for binding national referendum on government funding for “medically unnecessary” abortions.
C-?	March 1997	MP Keith Martin, (Reform)	Bill to charge pregnant women who abuse alcohol, drugs etc. with criminal endangerment of fetus. Guilty women would be sentenced to treatment centre.
S-7	Nov 19, 1997	Senator Stanley Haidasz, (Liberal)	Bill to prevent “coercion in medical procedures that offend a person’s religion or belief that human life is inviolable.”
M-268	Nov 20, 1997	MP Garry Breitkreuz (Reform)	Reintroduction of Motion calling for binding national referendum on government funding for “medically unnecessary” abortions. (M-91)
M-?	February 1998	Senator Stanley Haidasz (Liberal)	Motion to set up a Special Joint Committee on the Unborn “to examine and report upon the feasibility of legislation in the area of fetal rights in order to provide some protection to the unborn child.”
S-16	May 1998	Senator Stanley Haidasz (Liberal)	Bill to amend <i>Criminal Code</i> to give full protection to “unborn children.”
C-461	Dec. 2, 1998	MP Maurice Vellacott (Reform)	Bill to prohibit healthcare providers from being forced to participate against their will in procedures such as abortion or euthanasia. (Similar to Haidasz’s conscience clause Bill S-7, 1997).
M-360	1999	MP Garry Breitkreuz (Reform)	Motion to enact law to define a human being as

			a “human fetus or embryo from the moment of conception, whether in the womb of the mother or not and whether conceived naturally or otherwise.”
C-515	June 2, 1999	MP Jim Pankiw (Reform)	Bill to “provide for a referendum to determine whether Canadians wish medically unnecessary abortions to be insured services under the Canada Health Act and to amend the Referendum Act.” If a majority said No to funding, government would have to financially penalize provinces that continued to pay for abortion.
C-207	Oct. 1999	MP Maurice Vellacott (Reform)	Re-introduction of conscience clause Bill C-461 (Dec 1998) and Bill S-7 (Nov 1997).
S-11	Nov 1999	Senator Raymond Perrault (Liberal)	Re-introduction of Haidasz’s conscience clause Bill (S-7, Nov 19/97).
C-422	Dec. 1999	MP Maurice Vellacott (Reform)	Re-introduction of conscience clause Bill C-461 (Dec 1998) and Bill S-7 (Nov 1997).
M-228	Feb. 2, 2001	MP Garry Breitkreuz (Reform)	Reintroduction of Motion to enact law to define a human being as fetus or embryo from the moment of conception (C-360).
C-246	Feb. 2, 2001	MP Maurice Vellacott (Reform)	Re-introduction of conscience clause Bill C-461 (Dec 1998) and Bill S-7 (Nov 1997).
M-392	April 18, 2002	MP Garry Breitkreuz (Alliance)	Motion asking Standing Committee on Justice and Human Rights to examine current definition of “human being” in the Criminal Code to see if law needs to be amended to provide protection to fetuses and to designate

			a fetus/embryo as a human being.
M-523	June 17, 2002	MP Garry Breitkreuz (Alliance)	Motion asking Standing Committee on Health to evaluate whether abortions are “medically necessary,” and to compare health risks for women undergoing abortions to women carrying their babies to full term.
C-246	Oct. 30, 2002	MP Maurice Vellacott (Reform)	Re-introduction of conscience clause Bill C-461 (Dec 1998) and Bill S-7 (Nov 1997).
C-452	May 1, 2002	MP Jim Pankiw (Reform)	Reintroduction of bill (C-515) to allow a referendum on tax funding of “medically unnecessary” abortions.
M-83	March, 2003	MP Garry Breitkreuz (Alliance)	Motion asking Standing Committee on Justice and Human Rights to examine whether abortions are “medically necessary,” and to compare health risks for women undergoing abortions compared to women carrying their babies to full term. Voted on Oct 1, 2003, defeated 139-66.
M-482	Oct. 23, 2003	MP Garry Breitkreuz (Alliance)	Motion asking Parliament for a <i>Woman’s Right to Know Act</i> , to “guarantee women are fully informed of all the risks before deciding to abort their baby,” and to provide penalties for physicians who perform an abortion without woman’s informed consent.
M-560	March 10, 2004	MP Garry Breitkreuz (Conservative)	Motion asking Parliament to create new <i>Criminal Code</i> offence for the “murder of an unborn child” when a third party murders a pregnant woman.

M-70	Oct. 5, 2004	MP Garry Breitkreuz (Conservative)	Reintroduction of bill for “Woman’s Right to Know Act” (M-482).
C-291	May 17, 2006	MP Leon Benoit (Reform)	A bill to amend the Criminal Code to make “injuring or causing the death of a child before or during its birth while committing an offence” a separate offence.
C-338	June 21, 2006	MP Paul Steckle, (Liberal)	Bill to criminalize abortions after 20 weeks gestation.
C-338	October 2007	MP Paul Steckle, (Liberal)	Reintroduction of bill to criminalize abortions after 20 weeks gestation.
C-484	Nov 21, 2007	MP Ken Epp (Conservative)	Bill to protect fetuses from third-party attacks: “Unborn Victims of Crime Act.” (similar to M-561 of March 2004 and C-291 of May 2004). The bill passed 2nd reading with a vote of 147-132, but died on the order paper in Sept 2008 when the election was called.
C-537	April 16, 2008	MP Maurice Vellacott (Conservative)	Bill to prevent coercion of medical personnel. Conscience clause protection similar to his previous bills C-246, C-422, C-207, and C-461.
C-510	April 16, 2010	MP Rod Bruinooge (Conservative)	Bill to ban “coerced abortion.”
M-312	March 13, 2012	MP Stephen Woodworth (Conservative)	Bill to have Parliamentary committee examine if Criminal Code definition of “human beings” should include fetuses, and to look at medical evidence, legal impact and consequences.

Source:

(ARCC) Abortion Rights Coalition of Canada. 2011 “Anti-Choice Private Member Bill and Motions Introduced in Canada Since 1987.” Vancouver: ARCC. <http://www.arcc-cdac.ca/presentations/anti-bills.html>.

Appendix H. Legislative Timelines

The House of Commons			
Session Dates	Party in Power	Prime Minister	Details
June 2 nd , 2011 – Present	Conservative Party of Canada	Stephen Harper	
November 18 th , 2008 – March 26 th , 2011	Conservative Party of Canada	Stephen Harper	
April 3 rd , 2006 – September 7 th , 2008	Conservative Party of Canada	Stephen Harper	
October 4 th , 2004 – November 29 th , 2005	Liberal Party of Canada	Paul Martin	
January 29 th , 2001 – May 23 rd , 2004	Liberal Party of Canada	Jean Chretien	Paul Martin took over party leadership on December 12 th , 2003
September 22 nd , 1997 – October 22 nd , 2000	Liberal Party of Canada	Jean Chretien	
January 17 th , 1994 - April 27 th , 1997	Liberal Party of Canada	Jean Chretien	
December 12 th , 1988 – August 8 th , 1993	Progressive Conservative Party of Canada	Brian Mulroney	Kim Campbell took over leadership on June 25 th , 1993
November 5 th , 1984 – October 1 st , 1988	Progressive Conservative Party of Canada	Brian Mulroney	

Legislative Assembly of New Brunswick			
Dates reflect Premier's term in office	Party in Power	Premier	Details
October 12 th , 2010 - Present	Progressive Conservative Party of New Brunswick	David Alward	
October 3 rd , 2006 – October 11 th , 2010	New Brunswick Liberal Party	Shawn Graham	
June 21 st , 1999 – October 2 nd , 2006	Progressive Conservative Party of New Brunswick	Bernard Lord	
May 14 th , 1998 – June 21 st , 1999	New Brunswick Liberal Party	Camille Thériault	
October 14 th , 1997 – May 13 th , 1998	New Brunswick Liberal Party	J. Raymond Frenette	
October 27 th , 1987 – October 13 th , 1997	New Brunswick Liberal Party	Frank McKenna	
November 12 th , 1970 – October 26 th , 1987	Progressive Conservative Party of New Brunswick	Richard Hatfield	

Legislative Assembly of Ontario			
Session Dates	Party in Power	Premier	Details
October 7 th , 2011 – Present	Liberal Party of Ontario	Dalton McGuinty	
October 10 th , 2007 – September 7 th , 2011	Liberal Party of Ontario	Dalton McGuinty	
October 2 nd , 2003 – September 10 th , 2007	Liberal Party of Ontario	Dalton McGuinty	
June 3 rd , 1999 – September 2 nd , 2003	Progressive Conservative Party of Ontario	Mike Harris	Ernie Eves took over leadership on April 15, 2002
June 8 th , 1995 – May 5 th , 1999	Progressive Conservative Party of Ontario	Mike Harris	
September 6 th , 1990 – April 28 th , 1995	New Democratic Party of Ontario	Bob Rae	
September 10 th , 1987 – June 30 th , 1990	Liberal Party of Ontario	David Peterson	

National Assembly of Québec			
Session Dates	Party in Power	Premier	Details
January 13 th , 2009 - Present	Parti Libéral du Québec	Jean Charest	
May 8 th , 2007 – November 5 th , 2008	Parti Libéral du Québec	Jean Charest	
June 4 th , 2003 – February 21 st , 2007	Parti Libéral du Québec	Jean Charest	
March 2 nd , 1999 – March 12 th , 2003	Parti québécois	Lucien Bouchard	Bernard Landry took over leadership on March 8 th , 2001
November 29 th , 1994 - October 28 th – 1998	Parti québécois	Jaques Parizeau	Lucien Bouchard took over leadership in January 29 th , 1996
November 28 th , 1989 – July 24 th , 1994	Parti Libéral du Québec	Robert Bourassa	Daniel Jonson Jr. took over leadership on January 11 th , 1994
December 16 th , 1985 – August 9 th , 1989	Parti Libéral du Québec	Robert Bourassa	
May 19 th , 1981 – October 23 rd , 1985	Parti québécois	René Lévesque	Pierre-Marc Johnson took over leadership on October 3 rd , 1985
December 14 th , 1976 – March 12 th , 1981	Parti québécois	René Lévesque	
November 22, 1973 – October 18 th , 1976	Parti québécois	René Lévesque	

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