Abortion in Canada: Always Legal, Not Always Accessible

Jula Hughes 2023-02-03T12:51:03

In Canada, abortion is not a criminal offence. There are no legal restrictions on abortion, including no restrictions with respect to gestational age or on the reasons for which a pregnant person may choose to have an abortion. As lawful medical procedures, abortions fall under provincial jurisdiction over health and there is some regulatory variability between provinces. Information about abortion access is similarly affected by provincial jurisdiction over education. Prior to decriminalization, advocacy on abortion access was national in scope, but since 1988, most activism has been focused on access and funding and has been provincial or even local.

Canadian Abortion Law

Abortion was a criminal offence until 1969 when Canada substantially decriminalized abortion by creating an exception to the offence of procuring a miscarriage in what was then s. 251 (later s. 287) of the *Criminal Code* if the abortion had been approved as necessary for the health or life of the "female person" by a hospital committee styled a "therapeutic abortion committee" (TAC). A prohibition against advertising abortifacients in s. 163 remained untouched by the 1969 amendments. For legal abortions, the *Criminal Code* set out the administrative regime required for the approval in considerable detail. The administrative regime effectively limited abortions to those performed in a hospital following approval by a TAC.

The administrative regime was challenged on constitutional grounds by Dr. Henry Morgentaler and two other doctors, all abortion providers, in response to a criminal charge for providing abortions in community-based clinics without the required hospital certificate. Dr. Morgentaler's case was decided by the Canadian apex court, the Supreme Court of Canada, in 1988. A seven-member panel of the Court was divided in its reasons but a majority of five judges held the TAC regime to be unconstitutional because it violated a woman's right to security of the person under s. 7 of the *Canadian Charter of Rights and Freedoms*. The sole female judge, Madam Justice Bertha Wilson, held that the provision additionally violated a woman's right to liberty under s. 7. The two dissenting judges would have upheld the legislation on the basis that the constitutional text and its history did not support a positive right to abortion, and that the administrative delays inherent in the TAC regime were a function of externalities rather than the law.

The Morgentaler decision rendered the TAC regime of no force and effect. While no longer operative, s. 287 remained on the books until its repeal in 2019. The prohibition against advertising abortifacients was removed in 2018, one year after a combination drug of mifepristone and misoprostol became commercially available under the name Mifegymiso and three years after its approval by Health Canada.

Abortion Access

In the absence of any federal criminal legislation regarding abortion, the procedure is regulated at the provincial level as part of provincial jurisdiction over health. Provinces are constitutionally barred from exercising their health jurisdiction for the purpose of regulating public morality, and legislative attempts to do so have been found to be *ultra vires* because they intrude on exclusive federal jurisdiction. Despite this, access varies depending on location. This is only partially a function of law, and as will be seen below, it can also be a function of the geography and the complexity of the Canadian federal structure. Some jurisdictions have historically excluded clinic-based abortions from Medicare coverage. Now only New Brunswick continues to restrict funding hospital abortions, which are subject to a gestational limit of 13 weeks.

Other barriers arise from geographical location as much as jurisdiction. There tends to be good access in the major urban centers through community-based clinics as well as hospitals. For example, in Alberta there are clinics in Calgary and Edmonton, and there is only one hospital providing abortions in the province, which is located in Calgary. For context, Calgary is in the south of the province and Alberta covers a territory nearly twice that of Germany. This would be similar to having a clinic the sole hospital provider for Germany and Denmark be located in Munich and a clinic in Cologne.

The approval of medical abortions has improved access for some remote communities, but access is uneven. For example, Quebec has been slow to roll out training to prescribing health care professionals and few clinics provide the service, and even fewer are located out of the major city of Montreal. There are provincial differences as to who can prescribe Mifegymiso, in some provinces this is limited to physicians, while in other provinces, pharmacists and nurse practitioners may also issue prescriptions. Furthermore, some provincial Medicare plans cover the medication, while patients have to pay out of pocket in other provinces.

The Role of Social Movements

Before 1988, there was a national feminist movement advocating for the full decriminalization of abortion. Since the judgment of the Supreme Court of Canada in Morgentaler, 1988 abortion is provincially regulated. As a result, the roles and impacts of social movements, particularly the Canadian feminist movement, has varied across the country. For example, in British Columbia, Canada's westernmost province, feminist activists responded to frequent, generally peaceful protests outside of abortion clinics by pushing for so-called "bubble zones" in the vicinity of clinics because of their impact on patient experience of safety and confidentiality. In British Columbia the *Access to Abortion Services Act* indicates that "no one is allowed to argue with someone seeking abortion services, use film or videotape as a means of intimidation, or interfere physically with patients." Similar legislation is now on the books in Ontario, where dramatically and exceptionally, anti-abortion protest turned violent in the bombing of a Toronto clinic in 1992.

Prochoice activists have continued to protest provincial legislation impeding access. In New Brunswick, one of Canada's easternmost provinces, feminist activists rallied against Regulation 84-20, which required two doctors to approve any abortion in New Brunswick as "medically necessary" in order to cover it under provincial health insurance. This regulation was amended in 2014 after years of feminist organizing around the issue. Prince Edward Island only established a funded provider in a provincial hospital in 2017, following a court challenge and decades of local activism. The provincial nature of healthcare legislation in Canada is a consistent theme in the Canadian abortion story. One impact of dealing with legislation at the provincial rather than federal level is that advocates have had to respond to a very varied landscape of provincial regulation ranging from access enhancing to restrictive legislative measures, while the previous federal criminal law had provided a unified advocacy target.

Legislation has at times resolved issues as is the case for bubble zone legislation, while at other times it has given rise to renewed debate and advocacy. This was certainly the case after the partial decriminalization in 1969, favouring either further liberalization or renewed restrictions. Since 1988, there have been repeated attempts at the federal level to revive the debate about national legislation and limiting reproductive rights, chiefly through private members bills (i.e. legislative initiatives by members of Parliament who are typically not part of the governing party), but to date these have not been successful. A recent private members bill sought to curtail abortion rights to prohibit sex-selective abortions in Canada, and went so far as to framing the issue as supporting women and equality rights.

Sexual Health Education

Sexual health care and education also fall largely in the jurisdiction of provinces and territories. This has resulted in inconsistencies in terms of curricula content, allotted instruction time, designated instructors (in some jurisdictions, sexual health is part of the physical education curriculum, and in others it is part of a different subject), relevance (curricula can be up to 25 years out of date) and deliverability. In practice, sexual health information is delivered in three ways: to youth via the education system, through non-profit institutions, and through public health initiatives. These groups may have overlapping audiences and locations to provide services but are not obligated to work together.

Provincial and territorial education bodies set the curricula and determine the age-appropriate materials and subject matter by region. Public schools (including publicly funded Catholic schools) are obligated to adopt sexual health curricula, but private schools are not necessarily required to do the same. Many teachers receive little or no training in providing sexual health education and there is no guarantee that it will be delivered. Sexual health education curricula in Canadian schools largely do not include any information related to abortion. However, there are reported incidents of anti-abortion instruction in schools.

There are some federal initiatives related to sexual health education. Health Canada and the Public Health Agency of Canada currently fund sexual health

related initiatives to be carried out by non-profits. The existence and extent of education initiatives is subject to change depending on the political leanings of the government of the day. Some schools outsource their sexual health programming to organizations external to the school system. Sometimes these programs include the federally or provincially funded non-profit programming with trained professionals. However, some anti-abortion organizations offering 'free sexual health' classes with anti-abortion, homophobic, or abstinence content also provide school programming.

Religion and Abortion in Canada

Religion is often strongly associated with anti-choice sentiments. We would argue that the reality is more complex as religious people and organizations are far from uniform in their views on abortion. Also, the impact of religious opposition to abortion is not homogenous. On the one hand, the currency of religion-based arguments against abortion access has lessened in discourses in the public and legal spheres (where abortion access tends to be fought). On the other hand, religion continues to play an informal practical role in the access to abortion services. Historically and even now, many of Canada's medical facilities have been run by religious (especially Catholic) communities and organizations, and some of these facilities have impeded abortion access through hospital or clinic policies and practices. However, these institutions are commonly publicly funded and are therefore subject to anti-discrimination legislation. In some cases, patients have been using these anti-discrimination laws to assert access to sexual health care, resulting in legal liability for Catholic hospitals when they restrict services in contravention of equality laws as they comply with Catholic teaching on sexual and reproductive health.

Christian religious references and symbols also play a role in anti-abortion advocacy and, occasionally, violence in Canada. Anti-abortion rallies and picketing often involve praying and other religious practices. Another area where religion plays a role in access to abortion is the scope for conscientious objection by individual providers. Canadian law generally recognizes that the constitutional guarantee of freedom of religion includes the right of health care providers not to participate in the provision of abortion services. That said, Canada's rules regarding the obligation to refer people to abortion services when a practitioner does not wish to provide a patient with information about abortion services on religious or conscience grounds remain contentious.

Despite the common association of religion with anti-choice positions, this presents a partial picture at best. Historically, a number of religious communities and individuals have also advocated for increased abortion access in Canada. Religions like Judaism have specific allowances for abortion access. Many Christians and Christian leaders are also part of the advocacy for better access to reproductive health services, including abortion. Some Churches, such as the United Church of Canada have longstanding policies and programming related to affirming the right to abortion access. Many of Canada's religious communities have clear ethics positions that affirm the importance of abortion access. This is somewhat similar to the position of some protestant denominations in Germany who take a (cautiously) pro-choice stance.

In 2018, the Canadian government adopted a policy to no longer fund anti-choice and anti-LGBTQ activities through its Canada Summer Jobs Program, which is a program that is designed to help organizations hire students throughout the summer months. Anti-choice organizations objected on freedom of religion and freedom of expression grounds. A judicial review of the government policy was unsuccessful at first instance. An appeal is pending.

What is next?

The decision of the USSC in Dobbs prompted a significant public debate regarding whether Canada needs a new abortion law to protect abortion access from potential court intrusion. Leading feminist advocacy organizations have taken the view that the current status quo is preferable to statutory entrenchment of abortion rights. Two key reasons for this perspective are the risk inherent in reopening the abortion debate in the Canadian parliament and the absence of a unified vision on how a new abortion law could protect abortion rights better than the existing constitutional jurisprudence. It seems unlikely at this point that Canada will revisit the law as it currently stands, at least at the behest of feminist advocates.